and, I believe you are one of the few in [Congress] that do, then take a listen to T. Boone Pickens, do some research into the oil shale in our neighboring states, research the minuscule coastal area that would be affected by drilling in the ANWR and convince the rest of Congress to [move ahead with realistic and lasting solutions.]

Thanks for giving me the opportunity to give my 2 cents worth or, in my case, more like a quarters worth.

MARCUS, *Bellevue.*

We installed propane heating in our home when it was the energy-saving thing to do! The cost of propane then was under 30 cents a gallon. We knew it would not stay that low, but in the last five years we have seen the cost go up to over $2 a gallon. This past year, our heating cost went over $2,000 for a heating season. With the high energy prices, we get to choose, wrap up in blankets to keep warm so we can buy gas to go to the store and buy a loaf of bread and gallon of milk or buy heating fuel to stay warm and not eat. Some choice!

UNSIGNED.

My story may be coming from a different angle; you see, I am nearly 62, working for Boeing trying to get enough money to retire and move back to Idaho. My investments have lost $130,000 in the last six months. My portfolio is fairly conservative or I would have lost much more. I am not wealthy by any means, so that much of a loss will set me back several years in my retirement plans.

All the while I am looking at Congress to come up with an energy policy that makes sense so our economy can flourish. At this point I am so tired of hearing that we cannot drill in ANWR or offshore that I have considered retiring early just to spend my senior years trying to [make a difference on how the Congress represents the people]. With [the] current approval rating of 9%, [Congress should recognize that the public does not approve of its work.] If my approval rating was less that 75% I would be fired on the spot. Think about it—would you fly on a Boeing airplane that worked 75% of the time?

RULON.

The astonishing increases in fuel prices this year are hitting everyone on a national basis very hard indeed. We are a nation that runs on fuel. Everything we buy, be it a necessity such as food or the very fuel we use in our vehicles is shipped in, and the vehicles that ship those goods to us run on diesel, and guess what fuel is priced the highest.

Why this is I have no idea, but I do know that, at the rate that the cost of diesel is increasing, it will not be long until buying food will be something akin to if not worse than the Great Depression of the 1930s. Already I have been hearing of farms all over the USA that cannot afford the fuel it takes to harvest their crops. As a result, the crops are left to rot in the fields.

My own family is rapidly approaching the point of deciding between food, the mortgage, and fuel to get to work. Personally, I drive a diesel pick-up and, in July of last year, 28 gallons (1 tankful) of diesel would cost me $65–$70. Now it costs me close to $140 for the same amount of diesel, despite my diesel pick-up getting amazing economy. I am still getting hit hard by these prices, which have more than doubled in one year.

One thing in particular that I cannot figure out is why the Western states are paying much higher fuel prices than other states. Where I am coming from on this is a interesting innovation on fuel price tracking called the ''Gas Temperature Map'' http://gasbuddy.com/gb__gastemperaturemap.aspx. See for yourself, Western States are paying significantly higher prices than many southern & eastern states are. Why, I have no idea nor do I have the time and resources to research it effectively, but I am sure a lot of other Idahoans would also be interested in why this is the case.

There is much more I could say on this, but I realize you are a busy man, so I will save it for another time. It is my sincere hope that yourself and other Representatives like you can find a way to somehow turn this nightmare around.

DAN.

Thank you for the opportunity to tell you how the high cost of fuel is affecting me. I live on the west side of Idaho Falls. I work on the east side of the city. I realize that people in bigger cities have much bigger commutes, but we have no real public transit so I have to drive. I own a Honda Civic, but am considering a scooter. Because of the winters in Idaho, that is not a practical option. With the price of fuel, food and health insurance going up every day, all I can afford to do is drive to work and back. I have had to cut out movies, trips, and dining out. I received a letter from Delta airlines that was titled ''An Open Letter To All Airline Customers.'' I hope you have seen it and are in a position to do something to stop unnecessary price gouging. Nuclear fuel is very clean and safer than most other forms of fuel, why are we not looking into that more closely? Thank you again for this opportunity.

KAREN.

The energy issue in the state of Idaho is out of hand, and one that families cannot afford. The state government should be offering land for development of wind energy, and renewable recourses, Just make them paint the towers with camo about halfway up. There should be far more incentives for home owners to add solar power to their homes, and incentives for companies that do that kind of work to come into Idaho. Allowing logging companies to go into our forests and do selective harvest makes a win-win situation for everyone man and animal. A lot of the social services done in this area do not require a car and should be revoked from those who abuse the use of city, county, and state cars. That ticks me off more than the price of fuel.

LYLE and FAMILY, *Idaho Falls.*

Tax credits for clean energy are absolutely essential to our energy future and to our economy. Society suffers from the lack of alternatives while oil companies reap large profits. In spite of all the tax benefits that oil companies receive, they show a reluctance to make investments in a timely fashion and realize large profits, which they return to investors and management.

MARY.

I am a 68-year-old taxpaying American citizen, and military veteran. I live in Coeur d'Alene and work in Spokane, Washington. It is getting increasingly more difficult to afford the gas to drive to and from work. Carpooling or the use of public transportation is out of the question as I work in the construction industry on various jobs throughout the Spokane area.

The time has come to start drilling for oil in Alaska, Colorado, Wyoming, and offshore. From what has been in the news and from what we read in various publications, all from very intelligent engineers and scientists, we know the oil is there. We have shale deposits in several states that we could be using. We need to work harder on wind and nuclear power. The states want to drill, and we need to lift the federal bans.

We should either sell or give the abandoned military bases to companies willing to build refineries on them. The time has come to quit asking—it is time to demand that this be done. We have the resources, let us use them. The United States of America should not have to go begging to other countries for oil when we have it within our own shores.

We, the people, should not be suffering these exorbitant prices due to the incompetence in all areas of our government, and speculators in the stock market.

WAYNE, *Coeur d'Alene.*

(At the request of Mr. REID, the following statement was ordered to be printed in the RECORD.)

SPECIAL OTIS BOWEN LECTURES

• Mr. KENNEDY. Mr. President, I ask unanimous consent that remarks by Ralph Neas be printed in the RECORD.

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

REMARKS OF RALPH G. NEAS, CEO OF THE NATIONAL COALITION ON HEALTH CARE, THE SPECIAL OTIS BOWEN LECTURE, UNIVERSITY OF NOTRE DAME, MARCH 26, 2009

Thank you. It is truly an honor and a privilege to be here with you today as a participant in the Otis Bowen lecture series.

I want to express my appreciation to Dr. Mark Walsh for inviting me, and commend all the conveners and hosts of this gathering. I congratulate Indiana University and the University of Notre Dame for the collaboration that brought IU's medical school to the Notre Dame campus.

I want to especially thank Otis ''Doc'' Bowen, the 44th Governor of Indiana, and the Secretary of Health and Human Services during the Reagan Administration. His leadership, commitment to the public interest, and his contributions to Indiana and the Nation are exemplary and should serve as a model for us all to emulate.

Dr. Bowen, both Dr. Henry Simmons, the visionary founder and president of the National Coalition on Health Care (NCHC), and former Governor Robert Ray of Iowa, the Co-Chair of NCHC, send their warm regards. Dr. Simmons was one of President Richard Nixon's top health care advisors in the early 1970s and worked on the Grace Commission which in the 1980s found that one-third of all income taxes were consumed by waste and inefficiency. He has devoted his professional life to improving health care for all Americans. And Governor Ray worked with Dr. Simmons and you many times over the past several decades. I am so proud to be working with them.

Our timing is propitious. Indeed, the conveners of this event were prescient. We gather tonight at an extraordinary moment in history: The Nation is facing the worst economic crisis in more than seven decades and Americans urgently need a better health care system; our health care system is dysfunctional and represents an unsustainable drain on our economy as a whole. It is inefficient and inequitable; urgent action is required to systematically address what is an incredibly challenging and morally troubling policy problem affecting every American.

In short, the health care system in the United States is in desperate need of significant reform. However, we should emphasize at the beginning that we need an American solution. We can and should borrow from the best of what works elsewhere. But we should recognize our unique history and the special characteristics of the American people.

The good news is that the President and Congress are seriously considering health

care reform. In fact, in just the past month we have seen a presidential address to a joint session of Congress, a presidential budget, and a presidential summit, all prominently featuring systemic, systematic health care reform. In addition, the Senate and House of Representatives have already commenced comprehensive hearings.

We must succeed. Too much is at stake: the health and well-being of millions of American families, and the future of the Nation's economic and fiscal health. Also at stake, I believe, is whether we can help restore the trust and confidence of the American people in their government.

So I cannot imagine a better time for us to be having this conversation. And I couldn't be happier that it is happening here. The University of Notre Dame, and people connected to Notre Dame, have been central to my life in more ways than I can count.

I was a student here during the 1960s. As a young person I had watched on television as Bull Connor turned dogs and fire hoses on civil rights marchers. I had watched Martin Luther King champion human dignity in the face of bigotry and violence.

Early on, I wondered whether I had a vocation to the priesthood, but I found in Dr. King and the Kennedys an inspiration to public service as a different kind of vocation. And that brought me to Notre Dame. Father Ted Hesburgh became the first of many Notre Dame role models, teachers, and mentors who have sustained and guided me ever since.

The last time I spoke at Notre Dame was about 25 years ago, in 1983. I was just a short time into my tenure as executive director of the Leadership Conference on Civil Rights, and I was asked to address a conference for Catholic laity on work and faith in society sponsored by the U.S. Conference of Catholic Bishops. I believe, like the late Senator Phil Hart of Michigan, that politics can be a high vocation—that a politician can be a lay priest of society.

In preparing for that speech, I realized that I had learned about human dignity and equality before God from my church and my family long before I learned about the legal principle of equality under the law from my college and law school professors. Those principles have guided my life's work and are central to what I am here to talk about today.

Another principle that has guided my political life is bipartisanship. I had the extraordinary good fortune to work for two remarkable Republican senators early in my public service career—Edward W. Brooke of Massachusetts, and David Durenberger of Minnesota. They were politicians and public servants who were less interested in ideology and political positioning, and more interested in moving the Nation forward, in finding workable solutions to the Nation's problems. They weren't just willing to work across the partisan aisle; it was central to who they were.

These principles were at the core of my decision last month to accept the position as CEO of the National Coalition on Health Care. After I decided to step down as president of People For the American Way, I had spoken with many other health care coalitions and institutions. But I had a keen personal and professional interest in working to achieve health care reform in the most non-ideological and most non-partisan way possible. And I was impressed by what a great fit there was between the National Coalition and my skills, background, and approach to public policy.

The National Coalition on Health Care is the largest, broadest, most diverse coalition working to achieve comprehensive health care reform. It is an alliance of 79 organizations representing business, unions, health care providers, associations of religious congregations, minorities, people with disabilities, pension and health funds, insurers, and groups representing patients and consumers. Our member organizations represent more than 150 million Americans. They speak for a cross-section, and a majority, of our population.

Our board includes Frank Carlucci, who served several Republican and Democratic presidents in a range of intelligence, national security, and ambassadorial positions, and Israel Gaither, the National Commander of the Salvation Army. It includes John Sweeney, the president of the AFL–CIO, and William Novelli, the CEO of AARP. It includes John McArthur, dean emeritus of the Harvard Business School, Cheryl Healton, President of the American Legacy Foundation, and John Seffrin, CEO of the National Cancer Society. These are organizations and leaders who individually play a major role in our society and in public policy making. Together they represent an extraordinary breadth of expertise and resources.

The Coalition is rigorously nonpartisan. Former Presidents George H. W. Bush and Jimmy Carter are our honorary co-chairs. Former Iowa Governor Robert Ray, a Republican, and former Congressman Bob Edgar, a Democrat from Pennsylvania are its co-chairmen. We believe it is essential to make reform a bipartisan process and a bipartisan achievement.

I am especially proud of two of the pillars of the Coalition.

One of those pillars is religious organizations. The U.S. Conference of Catholic Bishops is a member of the National Coalition on Health Care because the Catholic tradition affirms that access to health care is a basic human right and a requirement of human dignity. The Catholic bishops are joined in that belief, and in our coalition, by the Salvation Army, the Religious Action Center of Reform Judaism, the Presbyterian and Episcopal Churches, the United Methodist General Board of Church and Society, and the National Council of Churches.

The backing and active participation of these religious communities gives us access to their networks of local religious leaders and lay people. We are well equipped to engage policymakers and the public on the moral poverty of leaving millions of Americans without access to quality affordable health care, and on the moral urgency of tackling that problem.

Another especially significant pillar of our coalition is the medical societies, which together represent hundreds of thousands of doctors. They include the American College of Cardiology, the American Academy of Pediatrics, the American College of Surgeons, the American Academy of Family Physicians, and the American College of Emergency Physicians. Also included are the American Dental Education Association, the Duke University Medical Center and Johns Hopkins Medicine. And just yesterday the Association of American Medical Colleges, along with the Council of Teaching Hospitals, joined our Coalition. This is a very serious brain trust of physicians, medical educators, and their advocates.

During the last major health care reform effort in 1993 and 1994, many of the medical societies opposed that effort. But they working with us now, I think, for several reasons. First, the need for reform has become increasingly obvious and urgent to everyone who cares about making sure that people have access to quality health care. Second, I believe that doctors have a better view than anyone of the current system's problems, inefficiencies, and distortions. I remember a time in the 1980s when a rallying cry from conservative pundits was ''let Reagan be Reagan.'' Part of what we're trying to accomplish here is to ''let doctors be doctors!'' More than just about anything else, doctors want to practice medicine.

Also, this year, everyone has been invited to the table. My own experience tells me that is how lasting progress is made. In the early 1980s, I was selected to lead the Leadership Conference on Civil Rights, the Nation's oldest and largest civil rights coalition. Working with Republican and Democratic leaders, with business and labor and public interest advocates, we accomplished great things. The passage of the life- and culture-changing Americans with Disabilities Act. The strengthening of every major civil rights law with huge bipartisan congressional majorities, and often with the support of the business community.

That could only be accomplished by building active alliances across party lines, engaging business and nonprofit leaders, public officials and community activists. We had to find ways to address each community's needs with a pragmatic and principled eye on the ultimate goal of advancing the common good.

The members and board of the National Coalition on Health Care understand that all the elements of our health care system are interdependent. So are the health care sector and the broader economy. That is why any solution must be systemic and system-wide if it is to be meaningful and effective.

And that's also why reform must be accomplished now.

Let me make a case for urgency by discussing the nature of our health care problem.

There is no question that our system produces and includes extraordinarily gifted medical professionals. I am alive today because 30 years ago I had access to some of the best medical care the world has to offer.

But millions of Americans do not have affordable access to that care. Indeed, nearly 50 million Americans do not have health insurance—a number that grows with every layoff, or with every employer who cuts health coverage to avoid cutting jobs. Every 2 years, some 90 million Americans go without health coverage. Another 20 million are underinsured.

What does that mean to individuals and families? It can be disastrous for their physical and financial health.

People without insurance—or without sufficient insurance—are less likely to get preventive care that will keep them healthy. They are less likely to go to a doctor when they become ill. Their serious illnesses are diagnosed when they are more advanced and harder to treat. They put off treatments they need but cannot afford.

And when they do face serious injury or illness, the cost of treatment can be devastating to their families.

There are a lot of numbers and statistics that we use to analyze and describe the current state of our health care system. One that really leaps out to me—that is especially heartbreaking—is that currently one-half of all personal bankruptcies, and one half of all foreclosures, are caused by an inability to pay medical expenses.

Think about what that means.

Thousands and thousands of families, already traumatized by serious illness or tragic accident, are punished even further. They go through a medical crisis and are forced into a financial crisis. They say good-bye to a loved one—and are forced out of their home. And there is no telling the toll on communities of citizens who are sidelined—or worse—by a condition that could have been treated less expensively and more effectively if the cost of care had not kept people away.

These are not just tragic stories. They are evidence of an unforgivable level of cruelty in our current health care system.

And, of course, all these consequences are not limited to the uninsured and underinsured. The consequences are shared; the burden is shared, by everyone. The costs of emergency room care for the uninsured are shifted to other parts of the system, to other payers. According to a study by Emory University health care economist Kenneth Thorpe, the cost of providing uncompensated care to uninsured patients adds more than $1,000 per year to the average cost of employer-sponsored family coverage.

And that leads us to the second part of the problem we must address—the staggering cost of health care in this country, which is growing in ways that Americans and America cannot afford.

The cost of insurance is an increasingly heavy burden even for those who have it. Over the past decade, employers and workers have seen their health care costs rise 120 percent. On the other hand, wages only increased 34 percent during the same period (while inflation rose 29 percent). The average cost to families rose from just over $6,000 per year to about $12,000 per year. That is a huge amount for many middle class families. It is an insurmountable burden for working families.

And unless we act, it will only get worse. Richard Johnson and Rudolph Penner of the Urban Institute projected that in 2030, out-of-pocket health care costs will consume more than 35 percent of after-tax income for older married couples. That is more than double the 16 percent that health care costs took from those couples in 2000.

As a Nation, we spend $2.5 trillion in health care costs every year. That is a sixth of our national economy, or about $6,000 per capita. That is twice as much as the average of all industrialized countries, and 50 percent more than the next Nation on the list. (And remember, those countries cover all their citizens, while 15 percent of Americans have no coverage at all.)

Costs have been consistently rising at a much higher rate than the consumer price index. We as a Nation simply cannot afford double-digit growth in health care costs year after year. They make it harder for businesses to provide health care coverage for their employees—and those employees find it harder to pay the growing share they are asked to contribute to that coverage.

The increasing cost to small and large businesses is a dire challenge to their profitability, competitiveness and survival. It drains funds from research and development, makes it more expensive to hire new employees, and makes it less affordable to offer workers increased wages. Increasing costs undermine the viability of pension funds. And they increasingly put American businesses at a competitive disadvantage to companies abroad who have much lower health care costs.

And the fiscal drain to state and federal governments is ruinous. It has been estimated that by 2050, Medicare and Medicaid combined will consume more than double their current share of our gross national product. Our country's financial health—as well as that of individuals, families, and companies—requires that we get costs under control.

Closely connected to the problem of runaway costs is the national epidemic of substandard care. It may be hard to believe, but every year 100,000 Americans die from preventable medical mistakes. Another 100,000 die from infections contracted in U.S. hospitals. Millions of others are injured or affected, with cascading consequences for their families, their employers, their communities. It has been estimated that preventable health care accidents, errors, and poor quality of care are the Nation's third leading cause of death after cancer and heart disease.

A few years ago a major study by the RAND Institute examined the medical records of thousands of patients from 12 metropolitan areas and evaluated the care they received using indicators of quality developed by specialty expert panels. They found that patients got about 55 percent of recommended care. We should not be willing to accept or tolerate this mismatch between standards and actual practices.

And here is more evidence of the interconnected nature of these problems. Two different research studies have estimated that dealing with defects in the quality of our health care could reduce the total cost of health care by 30 percent. 30 percent. That's $750 billion per year. That is a huge financial incentive to deal with the quality of care and the waste and inefficiencies of our current system.

So that is the outline of the health care challenge we face—uncontrolled costs, unacceptable quality of care, and unconscionable lack of access to care for millions of Americans.

Acting urgently is both a moral and financial imperative.

The current economic crisis is putting more families out of work, putting greater strain on companies that struggle to provide health care, and putting enormous fiscal strains on Federal and State budgets.

President Obama has called for lawmakers to take action this year. In response, some pundits and critics have suggested that the Obama administration is putting too much on its plate—that it should hold off on health care reform while it figures out how to deal with the financial crisis.

But that is not possible. Health care is such an enormous part of the economy, is so interwoven with individual, corporate, and governmental crises, that it is not possible to address our economic woes without taking up health care reform. We have reached the point where the public's most pressing domestic concerns—economic growth, jobs, and retirement security, and health care—are fundamentally intertwined. The first three concerns cannot be addressed effectively unless health care costs are contained. The cost of doing nothing far exceeds the costs of taking action now. And if we implement real systemic reforms now, we will save trillions of dollars in the long run.

As economist Peter Orzag says, the road to fiscal sustainability runs through health care reform. Ben Bernanke, the chairman of the Federal Reserve System, puts it this way:

''The decision we make about health care reform will affect many aspects of our economy, including the pace of economic growth, wages and living standards, and government budgets, to name a few . . . As the public interest in these issues testifies, the stakes associated with health care reform, both economic and social, are very high.''

So, act we must. But how?

It is easy to be dismayed at the size and complexity of the problem—and by past failures to address it. But we cannot shy from reform. Nor can we let a political stalemate grind the process to a halt.

I am a veteran of many difficult battles in Washington. I've been part of them for 35 years. And I've never seen a bigger challenge, substantively or politically.

But I am cautiously optimistic about the possibilities for real reform this year. There exists a rare confluence of economic, political, and historic circumstances. There is a much broader consensus on the need for ambitious reform. And we are seeing all the stakeholders coming to the table, not with the goal of turning the table over and maintaining the status quo, but to seek some kind of resolution to the systemic problems that can no longer be denied or rationalized away.

That's what the National Health Care Coalition is committed to doing this year.

And, I'm proud to say, we're ready because we've already done our homework. I've been talking a lot about the problem. Let's talk about the solution.

The Coalition spent 18 months working with our board, member organizations, and health care experts to reach a consensus on principles and specifications for reform. There's no more detailed or comprehensive proposal on the table that I'm aware of.

The overarching requirement is that reform be both systemic and system-wide. With that as an understanding, we have laid out five principles for reform and specific and achievable approaches within each category.

The first principle is coverage for all Americans. We believe coverage should be defined clearly and comprehensively. It should include emergency care, acute care, prescription drugs, oral health care, early detection and screening, preventative care (including smoking cessation programs), care for chronic conditions, and end-of-life care. There should be no exclusion for pre-existing conditions.

We recognize a range of options—and possible combinations of options—can be used to achieve this goal: employer mandates, supplemented with individual mandates as necessary; expansion of existing public programs that cover subsets of the uninsured; creation of new public programs targeted at groups of the uninsured; or establishment of a universal publicly financed system.

Participation must be universal, and there must be subsidies provided for those least able to afford coverage. But none of these options requires a government-run system.

The second principle is cost management. The numbers that I talked about earlier make it clear that it will not be possible to achieve sustainable reform without tackling the cost issue head-on.

Cost management must be a multi-faceted undertaking. It should include: a plan to make health insurance premiums easier to compare by requiring insurers to establish separate premiums for the core benefit package and any supplemental coverage; a rational mechanism for increasing the cost-effectiveness of capital spending; cost-sharing and other tools to provide more and better information and incentives for patients to make good choices about health maintenance and care, and reduce over-use and under-use; an increased emphasis on prevention and early detection of disease; a commitment to improving quality of care; investment in a health care information infrastructure; and steps to modernize and simplify the administration, and dramatically reduce the administrative costs of the health care system.

It is true that successful reform of all the areas we have talked about will produce significant long-term savings. But it is also essential to begin immediately to bend the cost curve and slowing those double-digit increases that are outstripping our ability to pay for them. The increases in health care costs and insurance premiums for the core package of benefits should be brought into line with percentage increases in per-capital gross domestic product. And we should aim to achieve that goal within 5 years after the enactment of legislation.

There must be short-term cost constraints that would include rates for reimbursing providers for care encompassed by the core benefit package, and limits in increases in insurance premiums for the core benefit package. We are not advocating for cuts in reimbursement rates. But slowing the rate of increase is vital—and will reduce the likelihood of sudden cuts made under the stress of financial crisis.

We recommend that these efforts to manage costs be established and administered by an independent board chartered and overseen by Congress.

The third basic principle is one I just mentioned in terms of cost containment—that is a national effort to improve the quality and safety of care.

This includes accelerated development of a national information technology infrastructure, as well as increased emphasis on prevention and early detection of disease, and research on comparative effectiveness and practice guidelines to reduce waste and improve the safety and effectiveness of health care.

The members of the National Coalition on Health Care recommend that national practice guidelines be developed by panels of leading health care professional based on reviews of research on the effectiveness and impact of technologies and treatment. Conforming to these best practice guidelines could not only reduce unnecessary treatment and costs, but could also help protect medical professionals against frivolous or marginal lawsuits.

Fourth, we must make the financing of health care more equitable and reduce or eliminate cost-shifting.

Again in this area we have identified a range of mechanisms that could be used, individually or in some combination, to fund the costs of necessary reforms and assuring that every American is covered: general revenues, earmarked taxes or fees, required contributions from employers, required contributions from individuals and families, which would include co-payments, deductibles, and contributions toward premiums.

Subsidies should be provided, or financial obligations varied, based on relative ability to pay for less affluent individuals, families, and employers.

And fifth, we must simplify the administration of health care. The United States spends more than any other Nation—hundreds of billions of dollars every year—to administer our health care system. Administrative expenses incurred by private health insurers rose 52 percent between 1999 and 2002.

Our system's complexity is not only expensive; it is also confusing and frustrating for patients and doctors. And its lack of transparency undermines both accountability and the ability of individuals and organizations to make market-based decisions.

Assuring coverage for all Americans, and establishing a core benefit package, would create a consistent set of ground rules for patients, providers and payers.

An integrated technology infrastructure would not only reduce administrative complexity and costs, but help to reduce medical errors, protect patients' safety, and improve outcomes.

These principles—coverage for all, cost containment, quality and effectiveness of care, simplified administration, and equitable financing—are interdependent. And we must deal with them that way.

Taken together, the National Coalition on Health Care specifications provide an ambitious and achievable guide to our Nation's lawmakers. We know what investments and policy changes we need to make now in order to improve access and quality of health care in a way that the Nation can afford.

We have a road map. Now we need to keep policymakers focused on the journey.

President Obama, who recently hosted a bipartisan summit on health care reform at the White House—has urged Congress to give him reform legislation this year. He has put a significant down payment for reform in his budget.

While I do not think the Administration has yet been ambitious enough—dealing, for example, in a realistic way with the need to contain costs—I believe the White House has learned important lessons from the experience of 1993 and 1994. They are including all stakeholders from the beginning. They are putting forward broad principles and counting on Congress to write the legislation. And they are moving in a bipartisan fashion, inviting Republican and Democratic congressional leaders into their conversations.

I believe bipartisanship is essential not just because we need 60 votes in the Senate, but because a bipartisan consensus would be good for the country as we move forward in this enormous, and enormously important, undertaking.

We must understand fully that time is our most formidable foe. We must achieve health care reform now, not only to protect and advance Americans' health, but to shore up our reeling economy. We must take advantage of the political momentum for change. We must overcome those who might be tempted to see the failure of reform as a political opportunity.

Reform must be enacted this year—and as of today the year is already almost one-quarter behind us.

In Congress, there are at least seven major committees that have some jurisdiction and will be involved in crafting reform legislation. That means multiple subcommittee hearings and markups, full committee markups, House and Senate floor debates and votes, and the House-Senate conference committee. All of this takes time. As I tell my law school legislative process classes, there are 100 decision-making points in the legislative process, and each of them is a point at which compromise can take place.

If we are to have reform enacted this year, we must have a bill through the Senate with a bipartisan consensus by Labor Day. So each day is enormously consequential. We have no time for ideological warfare or partisan posturing. This truly is a time for pragmatism to trump ideology. We need to be focused on what works. And we cannot allow the perfect to be the enemy of the good.

We can do this.

A few years ago, my father-in-law was in Rome. He was at the Vatican when he collapsed with a heart problem. He was attended to by the Pope's doctor—the finest care he could have asked for. And when he had recovered and asked how much he owed, the answer was ''nothing!'' His health care in Italy was free. I know it's a simple story, and our quest for an American solution is anything but simple, but there's no reason we cannot achieve the same kinds of access to affordable quality care that other nations provide.

There is another story that explains why I am so committed to making this work—and why I have faith that it can.

In 1979, as a young man of 32, I was diagnosed with Guillain-Barré Syndrome, a disease that paralyzes the nerves and muscles. Over a period of weeks I became completely paralyzed, unable to breathe on my own or move a muscle. I was put on a respirator for 75 days, and was eventually given general absolution when it was not clear that I would survive.

Three of my doctors in St. Mary's hospital in Minneapolis, Minnesota, were Notre Dame graduates, including chief of staff Pat Barrett, who was the football team's doctor on the road. They helped me survive and recuperate. But no one was more important than my mother, who traveled to Minneapolis from a suburb of Chicago and sat at my bedside, holding my hand, for 50 of my first 100 days in the intensive care unit. And then there was Sister Margaret Francis Schilling, a nun who had survived Guillain-Barré 25 years earlier, and who was celebrating her 50th anniversary as a nun in 1979, who talked to me every day, who prayed with me every night, and who helped save my life and renew my faith.

You can probably understand why, when given the opportunity to be transferred to the Mayo Clinic, I told my parents that I wanted to stay at St. Mary's. Sometimes the appearance of near-mystical serendipity trumps all other considerations.

The experience taught me many things, most notably how vulnerable each of us is, and how dependent we are on each other. I had been a young hot-shot on a fast track congressional career. I thought I could do anything. As long as I worked hard and never gave up, I would not need anybody. I learned the hard way how wrong I was. I learned first-hand how quickly our lives and health can take a turn. I came out of that experience with a renewed commitment to public service, and with a sense of how interdependent different vocations—like Sister Margaret's, my doctors', and mine—could be.

After I finished my physical rehabilitation, and recovered my physical and mental stamina, I began interviewing for jobs. My parents, Senator Brooke, and Senator Durenberger were all advocating that I join a law firm and begin a more traditional way of life.

In the middle of my deliberations, John Sears, a Notre Dame grad, a lawyer, and the former campaign manager for Ronald Reagan, gave me contrary advice. He told me that I could join a law firm at any time. But the Nation in 1981 was about to begin a historic debate about civil rights, social justice, and the role of the Federal Government. He told me that if I had an opportunity to have a leadership position, I should seize the moment. He told me how important it was to be on ''the front lines of history.'' Only then could you make a dramatic difference for your family, your community, and your country.

And that is the opportunity and the challenge that we all face at this moment.

The great Irish poet Seamus Heaney has written:

History says, Don't hope
On this side of the grave.
But then, once in a lifetime
The longed-for tidal wave
Of justice can rise up,
And hope and history rhyme.

We all have a chance, working together, to make hope and history rhyme.

Regardless of where you stand on the health care issues before us, I urge you to get involved. This is a time for all of us—of whatever vocation—to come together. We must all be willing to sacrifice for an accomplishment that would address a great moral failing, that would strengthen our Nation's economy as well as its social fabric, that could point the way toward dealing constructively with other systemic challenges ahead.

I hope you will support the principles of the National Coalition on Health Care. But the most important thing, in the words of Oliver Wendell Holmes, is to ''share the passion and action'' of one's time.

Please do not sit on the sidelines. Immerse yourself, passionately, in this historic moment.

Please know how much it has meant to me to be here. I am profoundly grateful for the opportunity to be with you tonight.

Thank you.●

HAYES NOMINATION

● Ms. MURKOWSKI. Mr. President, I ask that my letter to Senator MCCONNELL, dated May 4, 2009, with its attachment, be printed in the RECORD.

The material follows.

U.S. SENATE, COMMITTEE ON ENERGY AND NATURAL RESOURCES,
Washington, DC, May 4, 2009.

Senator MITCH MCCONNELL,
Republican Leader, U.S. Senate, Washington, DC.

DEAR SENATOR MCCONNELL, Under the provisions of the Honest Leadership and Open Government Act of 2007 (section 512 of P.L. 110–81), attached please find a notice of my intent to object to proceedings on the nomination of David Hayes, Calendar number 31, reported by the Committee on Energy and Natural Resources on March 18, 2009. The reasons for my objection are included in the notice.

Sincerely,

LISA A. MURKOWSKI,
Ranking Republican Member.

NOTICE OF INTENT TO OBJECT

Under the provisions of the Honest Leadership and Open Government Act of 2007 (section 512 of P.L. 110–81), I, Senator Lisa A. Murkowski, intend to object to proceedings on the nomination of David Hayes, Calendar number 31, reported by the Committee on Energy and Natural Resources on March 18, 2009, for the following reasons:

During conversations with the nominees at meetings and hearings, they have generally expressed very reasonable views, including an affirmation of the need for continued energy production in the United States.

However, actions speak louder than words, and I am disappointed and troubled by the lack of connection between the rhetoric from the Administration and its nominees, and the reality of the Administration's actions. Rarely a week goes by that the Department of the Interior doesn't issue a pronouncement, that, taken together, add up to a wholesale assault on domestic natural resource development. A few examples are: Cancellation of the Utah leases; 180-day delay of the 5-year plan; delay of the new round of oil shale research, demonstration, and development leases; listing of the yellow billed loon; Monday's determination that the mountaintop coal mining rule is ''legally defective,'' and, most recently, the potential application of Endangered Species Act consultation requirements to all activities that may increase carbon output.

Further, I have not been satisfied with the responses to questions we have submitted on these matters to nominees that have previously come before this Committee.

Therefore, I will add my name to the list of those who intend to object to the confirmation of Deputy Secretary-nominee David Hayes, until we can get some assurance that we will see the actions of the Department of the Interior comport with the transparency and process and policy that they have promised.

I will soon be sending a letter to the Department of the Interior with detailed questions regarding my concerns.

These are questions of huge significance to not only American energy security, but to our ability to maintain our Nation's entire infrastructure, and grow our economy.●

ADDITIONAL STATEMENTS

TRIBUTE TO COMMANDANT CHARLES BALDWIN

● Mr. CARPER. Mr. President, this spring, the fourth class will graduate from the Delaware Military Academy, and I would like to take this opportunity to recognize Commandant Charles W. Baldwin for his years of dedicated service to the school.

The Delaware Military Academy, DMA, is a unique public charter school affiliated with the Red Clay School District. Cofounded in 2003 by Commandant Baldwin and opened that year with only grades 9 and 10, the DMA has quickly found success.

Today, in addition to being a Middle States fully accredited school, the academy has grown to enroll 525 students in grades 9 though 12 and has a waiting list of more than 200 applicants. Since 2006, DMA has earned a superior rating every year from the Delaware Department of Education. In 2008, the school was named a Superstars in Education Award Winner by the Delaware Chamber of Commerce.

Designated by the United States Navy as a Distinguished Unit with Academic Honors, the academy has the unique privilege and responsibility of naming nine nominations among the Naval Academy, Air Force Academy and West Point Military Academy.

The unique school offers students a tuition-free, 4-year high school program. The entire school is incorporated within the Navy Junior Reserve Officer Training Corps, and as the first school of this nature, has become the model high school for this Navy Training Corps.

The Delaware Military Academy's college preparatory academic curriculum is supplemented with courses that include naval operations, navigation, leadership, seamanship and oceanography. With its cadet hierarchy, students are placed in leadership positions and given responsibilities rarely found in a civilian high school. As a result, they emerge from the academy better prepared to meet the demanding challenges of the adult world.

In just 6 short years, the academy, under the leadership of Commandant Baldwin, has done what takes some schools more than 20 years to accomplish. It has built and maintained a successful system that instills values and responsibility into our children while providing them an excellent education. Moreover, the commitment of DMA and its student body to community service is widely known and appreciated in the State of Delaware.

While success in such a short period is certainly a credit to the faculty and students of the academy, Commandant Baldwin has indeed played a critical leading role.

A 24-year Navy veteran himself, Commandant Baldwin has dedicated his life to training, teaching and recruiting, including a tour of duty as principal of the George V. Kirk Middle School in Delaware's Christiana School District. Before cofounding the Delaware Military Academy, Commandant Baldwin established NJROTC programs in Delaware's Seaford and Christiana School Districts. During this time, he has received both military and civilian awards for excellence, including the Meritorious Service Medal, the Military Order of the Purple Heart, Christiana Teacher of the Year and the Christiana School District Citizenship Award. In addition, he twice received Presidential awards for management excellence.

On a personal note, I have known and admired Commandant Baldwin for more than a decade. My sincere hope is that as he steps down from his leadership role at the Delaware Military Academy, he will consider leading an effort to establish other public charter schools in the state that are based on the DMA's unique model.

I want to personally thank Commandant Baldwin for his commitment to Delaware, to the education of its young people, and to preparing them for lives of service. I warmly wish him the best.●

DRAFT LIST OF SITES, LOCATIONS, FACILITIES, AND ACTIVITIES IN THE UNITED STATES FOR DECLARATION TO THE INTERNATIONAL ATOMIC ENERGY AGENCY (IAEA), UNDER (THE ''U.S.-IAEA ADDITIONAL PROTOCOL''), AND CONSTITUTES A REPORT THEREON, AS REQUIRED BY SECTION 271 OF PUBLIC LAW 109–401—PM 15

The PRESIDING OFFICER laid before the Senate the following message from the President of the United States, together with an accompanying report; which was referred to the Committee on Foreign Relations:

To the Congress of the United States:

I transmit herewith a list of the sites, locations, facilities, and activities in the United States that I intend to declare to the International Atomic Energy Agency (IAEA), under the Protocol Additional to the Agreement between the United States of America and the International Atomic Energy Agency for the Application of Safeguards in the United States of America, with Annexes, signed at Vienna on June 12, 1998 (the ''U.S.-IAEA Additional Protocol''), and constitutes a report thereon, as required by section 271 of Public Law 109–401. In accordance with section 273 of Public Law 109–401, I hereby certify that:

(1) each site, location, facility, and activity included in the list has been examined by each department and agency with national security equities with respect to such site, location, facility, or activity; and

(2) appropriate measures have been taken to ensure that information of direct national security significance will