

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

Mr. DORGAN. Mr. President, I ask unanimous consent to speak in morning business for as much time as I consume.

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

HEALTH CARE

Mr. DORGAN. Mr. President, as this country tries to pull itself out of a very significant economic crisis in which millions of Americans have lost their jobs, lost their homes, lost hope, there are a number of things we have to do that also threaten the future of this country, in addition to trying to restore some economic health, and those include health care to be sure—we are working on this issue of health care; the second is an energy policy that makes us less dependent on foreign oil, where we are far too vulnerable and far too dependent; and the third is the relentless march of increased Federal budget deficits. All three of these issues, in my judgment, threaten our country's future. I wish to speak about them in the coming days. Today, I wish to talk about health care specifically.

Let me again say, I do that with the understanding that first and foremost we have to pull this country out of the difficulties we are in with the general economy and try to find ways to promote economic growth and put people back to work with jobs that pay well and give them the opportunity to care for their families. That is what gets America moving again. But when we do that, when we begin to restore this economy to economic health, the vulnerabilities that will remain are health care, energy, and the Federal budget deficits far into the future. So let me talk about health care just a bit.

I know there is a lot of discussion in the committees, the two relevant committees, the Finance Committee and the so-called HELP Committee, both of which are writing pieces of the health care reform bill.

It is true that increased health care costs—the increased cost of insurance for families, businesses, and governments—are on the march. Now it consumes over 17 percent of the domestic product of this country. Of all the goods and services we produce, over 17 percent of that is consumed by health care. And the rate of increase is unsustainable. Families will not be able to pay the extra cost year after year after year. We are told that nationally it now costs about \$12,000 for a family health insurance policy.

So what do we do about this? Well, we hear a lot of discussion on the floor of the Senate, when we start talking about health care, where people will say: Well, now you are talking about a government-run health care system in which a bureaucrat is going to make decisions about how much treatment

your doctor can provide to you personally.

That is just absurd. That is not what this discussion is about. But if we can get back to some thoughtful discussion rather than thoughtless discussion on health care, maybe we can all reach an agreement of how to improve this system. I personally think this system needs improving. Let me describe some things I think we should do.

First of all, we do not have a health care system so much as we have a sick care system. We do not pay any attention in this country to the things that can keep you from being sick or getting sick; we just pay a lot of money to put you into acute-care beds once you have gotten sick. That makes no sense at all. We ought to change the entire model to say it is much, much less costly to do the preventive things than it is to pay for acute-care beds in a hospital once someone gets sick.

This is all about behavior in many respects, and nobody wants to talk much about that. But behavior is a very important part of this. We are told that two-thirds of the American people are overweight and one-third are obese. Just that alone imposes unbelievable costs on this health care system of ours.

By the way, attendant to that issue of obesity and being overweight is the march of diabetes. The incidence of diabetes in this country is unbelievable. It just ratchets up and up and up every year.

Now, you wonder about that, wonder about America's children and the number of children who are overweight and obese. Walk into a school and then find out that in a number of schools in our country, they have decided to make money by allowing the soda machines, the pop machines, from the largest manufacturers in this country to sell Coke and Pepsi and other soft drinks in the school hallways. You can buy not only a soft drink full of sugar, you can then buy, perhaps, a bag of Doritos to go with it in the middle of the afternoon at school. So what kind of message is that in a country in which a substantial number of the people—especially children—are vastly overweight and in which we, by the way, minimize physical fitness in our schools because we have become very obsessed—and necessarily so—we care now more about math and sciences and getting out of our school system more engineers, more people steeped in the maths and sciences. But should that be at the expense of physical fitness? What kind of a brain is walking around without a physical being to propel it? How about some physical fitness in our schools? How about moving soda machines or the soft drink machines and the Doritos and Cheetos out of the school hallways? Those things are just common sense. It is about personal behavior, and it is about what we do in this country.

By the way, the reason those machines are there is, if they can put ma-

chines in the hallways of schools, the companies will provide money to the schools. So that is how we are going to fund our school system these days—through soft drinks and chips? It does not make much sense to me.

With respect to this issue of personal responsibility and behavior, let me describe a meeting we held about a week and a half ago with the CEO of Safeway corporation. I know he has met with groups of Republicans and Democrats here in the Congress. He said something very interesting, and I am using numbers that I think approximate what he said. They may not be precise, but I believe he told us there are between 40,000 and 50,000 employees at Safeway corporation who are non-union. He began a project with those 40,000 and 50,000 people in health care, and now he is beginning to try to move that into the union contracts.

Here is the project. That company says to its employees: I want responsibility for four areas in exchange for lower cost health insurance. We believe behavior is an important part of controlling health care costs. No. 1, if you have high blood pressure, we want you taking medicine to control your high blood pressure. No. 2, if you have high cholesterol, we want you taking medicine to control your high cholesterol. And I believe he said the company is paying for that. No. 3, if you are smoking, you have to have stopped or be on a program to stop. No. 4, if you are overweight, you have to be on a program to deal with that issue.

Cholesterol, high blood pressure, weight, and smoking—in each case, from a baseline of the cost of health insurance policies, those who are engaged in behavior that addresses these four issues have gradations of lesser costs for their health insurance premiums. In other words, it is about personal behavior and taking responsibility for addressing the things that can keep you healthy.

He indicated to us that they have had flat costs for 5 years in that body of employees dealing with this criteria in health care. That is a success. If that is the model he is using, saying: You have a responsibility.

By the way, even in their cafeteria, where they have partially subsidized company food during the lunch hours, just as an example, he said: We still serve unhealthy things. But we charge much, much more for it—once again trying to induce the behavior to take a healthy alternative.

So I think what Steve Burd, the CEO of Safeway, has suggested represents something we need to consider as we write our health care legislation.

There is another element that was brought to my attention recently and I think has been brought to the President's attention and Members of the Congress, and that is a New Yorker article written by Atul Gawande, a doctor from Harvard. He visited McAllen, TX, and El Paso, TX, and wondered why in one city you have the highest

costs per capita for health care and why the other city is just average. What caused this? He has a lot of conclusions, and I think very interesting conclusions, about overutilization in health care, and the movement of doctors' ownership with respect to the business side of health care. The doctors' ownership in a cancer clinic, ownership in a new heart clinic, those kinds of things that he suggests promote substantial overutilization.

The fact is, in our part of the country, where it is reasonably sparsely populated—the northern Great Plains—almost every hospital of any size wants to have a cardiac surgical unit so they can do open-heart surgery. They do not all need to do that. In fact, it duplicates services, which then ends up costing more because you are duplicating services. But every hospital wants it. So many of our States have more than is necessary of cardiac surgical suites.

This weekend, I was reading about two hospital groups merging, and one of them indicated that one of the advantages would be they would be able to then perform perhaps procedures they do not now perform, citing especially heart transplants. Why would we want duplication of a lot of facilities doing heart transplants? It does not seem to make sense to me. There are not so many done in the United States that we should not at least try to suggest that you do not need too many heart transplant centers.

Some say: Well, then who should tell them they cannot do that?

Well, if you just decide that overutilization is all right; whatever it costs, it costs; whatever it pays, it pays, I think I can tell you that you cannot solve this issue. Again, I am not suggesting government-run health care, but I am saying we ought to be reasonably smart about what we are doing, and that has not always been the case.

I wish to talk about one of the fastest rising areas of health care costs for a moment; that is, the issue of prescription drugs.

By the way, maybe they ought to tone down some of this advertising or knock it off. You get up in the morning and brush your teeth. If you have a television set near and have it on just for listening purposes, you are no doubt going to hear a commercial that says: Do you know what, you should go ask your doctor whether the purple pill is right for you. I do not know what a purple pill is, but they have described a purple pill that is going to do something for you, and they ask you to go ask your doctor if you should be taking the purple pill because you cannot get it unless a doctor thinks you need it.

We have massive amounts of advertising on prescription drugs in this country. In fact, some have indicated that the promotion and advertising and marketing of prescription drugs exceed research and development by the companies that manufacture prescription drugs. Frankly, for anything that is

prescribed only by a doctor and capable of being prescribed only by a doctor, why do you have direct-to-consumer advertising? Most nations like ours do not allow it. I believe there is only one other of the industrialized nations that does—something to consider about perhaps reducing health care costs.

But I want to talk about the other side of prescription drugs.

Mr. President, if I might by unanimous consent show these two bottles.

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

Mr. DORGAN. Lipitor is one of the most popular prescription drugs in the United States, I believe, for lowering cholesterol. These bottles are identical. One is blue and one is red. They look identical because they are produced by the same company. It is produced in Ireland. Lipitor is produced in Ireland and shipped around the world. The difference between these two bottles is not the medicine inside. It is the same pill, made by the same company, in the same place. The difference is it is shipped to different places. This one is shipped to Canada, and this one is shipped to the United States. The U.S. consumer has the pleasure of paying twice the cost as the Canadian consumer. But it is not just Canadian. It is French. It is Italian. It is British. It is that almost every other industrialized country pays a fraction of the price we do. Why should the American consumer be charged the highest price in the world for this prescription drug? Because those who apply the price have the ability to do it.

Some of us—Senator MCCAIN, myself, Senator KENNEDY, Senator GRASSLEY—Republicans and Democrats—Senator SNOWE, especially, my cosponsor on the importation of prescription drug legislation—some of us believe the American people ought to have the ability and the advantage of the world marketplace to purchase that identical prescription drug—FDA approved, produced in an FDA-inspected plant—to be able to purchase it from anywhere in the world at a fraction of the price.

We put together legislation that dramatically improves the safety of our domestic prescription drug supply and the drugs coming in.

By the way, a lot of the prescription drugs we take are imported. Lipitor is imported into this country. The pharmaceutical industry—which has always opposed our legislation because they want to charge the highest prices in the world to the U.S. consumers—they say: Well, if you do this, if you allow Americans to import FDA-approved drugs, there is a greater possibility of counterfeiting. Our legislation actually will dramatically improve safety because we require pedigree—we do all kinds of safety mechanisms that do not now exist with respect to our prescription drug supply.

So my point is, this is not rocket science. Do you want to reduce health care costs? I would say to the Finance

Committee, and the HELP Committee, make sure you put this piece in your legislation because some of the fastest rising costs in this country are prescription drugs, and we know how to solve that. If we pass the legislation Senator SNOWE and I have introduced, with broad bipartisan support, that allows the importation of FDA-approved prescription drugs by American consumers, it will require the pharmaceutical industry to reprice their drugs and allow our consumers to have fair prices for the prescription drugs they take.

By the way, our legislation is actually a winner. It is \$50 billion dollars in cost savings and deficit reduction, according to the CBO evaluation.

So the fact is, there are a lot of things we can do and a lot of things that represent common sense. I know some will want to put together a health care proposal that would look like a Rubik's Cube with all kinds of moving pieces. It need not be that complicated. I just described some of the things we can do that represent common sense.

Let me make one more point. Medicare has been a very successful program. When Medicare was started, the fact is, they established a base funding for Medicare that represented the cost for health care delivery at that time from that place. The result is, those areas with the highest costs got the biggest reimbursements. And it is still true today that some of the States—including my State—measured with some of the highest quality of health care in this country get the lowest reimbursement because they are the most efficient. That is preposterous. Whatever we do on health care, it has to address that issue. Let us at least, after nearly 40 years, begin to decide we will not reward inefficiency and we will not reward higher costs.

I am not suggesting this is unbelievably simple; it is not. In many ways, I kind of wish we could hearken back to the old days, but in the old days we didn't have the medical miracles and the medicine we have now. In my hometown of 300 people—a small town—we did have a doctor. He came as a young man and stayed until he died, and he provided health care. There was no Medicare. He provided health care to anybody who needed it, and if they couldn't pay him, he would take some chickens or a hog or a side of beef. If he was out on a ranch or a farm and delivered a baby and they didn't have any money, and somebody else had money, he would charge a little extra to make up for the people who couldn't pay, so he administered his own health care system.

Then we couldn't look inside the human body. We didn't have the miracle medicines through the NIH and PhRMA and others that allow us to stay out of an acute care bed. We didn't have all of those things. So now health care has become much more complicated. According to the New Yorker

magazine article, which I recommend to everybody, when we have decided to make health care a “business proposition” where you can get several doctors together and open a cancer center, that becomes something in which you promote overutilization. And it is happening in parts of our country. We need to be concerned about that and try to evaluate what can we do together to deal with it.

One final point. Some of my colleagues march to the floor every single day and allege that a bill that doesn’t yet exist is going to be a government takeover of health care. Well, apparently they are clairvoyant, because we don’t yet have a bill. When that bill exists, they have every right to come to the floor and describe the facts about the bill. One would hope in this debate we could stick to those facts, but there is not yet a fact that allows somebody to say there is a government takeover of health care, because there is not yet a bill out of either of our committees. There have been some introductions of topics and legislative proposals, but that is far different than a bill from a committee. We will have undoubtedly a robust debate on this, and we should. Health care is a very important element in this country’s economy. It is growing, and growing too fast, and we need to deal with it to make sure all Americans have access to health care. A sick child should not have to wonder whether they get to see a doctor depending on how much money their parents have in their wallet or their bank account. That is not what health care ought to be in this country. So we can and will do much better.

I indicated I wish to talk about the future threats to this country, one of which is the march of health care costs. The second, in my judgment, is our unbelievable vulnerability on foreign oil and energy. The third is deficits. I will talk about the following two in the coming days as well.

Mr. President, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Texas.

Mr. CORNYN. Mr. President, the Presiding Officer wishes to speak for 5 minutes. I would be glad to speak after that. I ask unanimous consent that following the Senator from Virginia being recognized to speak for up to 5 minutes, then I be recognized to speak.

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

The Senator from Virginia is recognized.

Mr. WARNER. Mr. President, I am not sure whether we are in a quorum call.

The PRESIDING OFFICER. We are not.

TARP RECIPIENT OWNERSHIP TRUST ACT

Mr. WARNER. Mr. President, I rise today to discuss bipartisan legislation that I am cosponsoring with my col-

league Senator CORKER concerning the Federal Government’s recently acquired ownership stake in a number of private companies.

I think we all know the taxpayers have been on a roller coaster ride for the past 9 months, and from their perspective, each twist and turn has left us more deeply invested in troubled markets and oftentimes troubled companies. Americans are concerned about getting their money back and want to keep politics out of how we manage these investments we have had to make over the last few months.

Last week, Senator CORKER and I introduced S. 1280, the TARP Recipient Ownership Trust Act. What will this bill do? Three very simple things. First, it will remove politics from our management of taxpayer investments in private companies. Second, it will ensure these investments are managed in order to maximize taxpayer returns. Third, it will allow us to plan for removing the government from the private sector by setting a date certain for selling these investments.

To achieve these goals, Senator CORKER and I are proposing that if the government owns more than 20 percent of a private company we place that ownership stake in an independent trust. This trust would be run with a fiduciary duty for taxpayers by three independent directors appointed by the President. These directors would agree to perform this work for free as a service to the country and in doing so would give the American taxpayers what they deserve: the upside of the massive investments they have provided over the past 9 months. The trust wouldn’t be an open-ended ownership in these companies; the trust would have to sell all of these assets by the end of 2011, though they could ask for a brief extension if it were, again, in the interest of the taxpayers’ return. In this way, taxpayers can know we won’t own stock in these companies for the next 20 years. In practice, this means that taxpayer ownership of AIG, Citigroup, and General Motors would be managed in order to maximize the return on these taxpayer investments.

We have all seen how political and contentious the TARP program is becoming. I know back when we voted on this matter earlier this year how controversial it was. I still think it was unfortunate that we got into this circumstance but fortunately the right thing to do. While there are a lot of challenges about how we got into this program, if we did look around—actually, Steven Pearlstein of the Washington Post pointed out in an article recently that if 9 months ago, if 6 months ago, or even 3 months ago, back in the middle of March when the stock market was at its all-time low in terms of reacting to this crisis, any economist would have said by the end of June, would you be willing to look at a circumstance where the market was up 25, 30 percent—although it was a little bit down today—if many of the

banks we had invested TARP funds in were actually trying to repay those TARP funds, and if we had seen the housing market, at least in many communities, start to stabilize, would we view that as a good outcome. Well, that is basically where we are. While we have enormous problems, we are seeing some progress. But one needs only to look at the number of TARP-related amendments that have been filed in the Senate in these past months. As a matter of fact, the leader was speaking today about the number of TARP amendments that could potentially be on the travel bill that we will have before us to know that this has become a lightning rod.

Some of the reasons for this concern are truly relevant and they are because the American people don’t know when and how the TARP program is supposed to end. The American people, unfortunately, who invested in individual companies—some of the companies that now we have invested in—don’t know how much we as the public will get back, or whether we, as the public investment, will politically interfere with the management of these companies. That is, again, why we need to implement this legislation Senator CORKER and I have laid out that will put these ownership shares in this independent fiduciary trust.

I don’t support cutting off TARP right now or limiting the tools it currently provides the administration, including the limited reuse of money that is repaid to the government. TARP already has a sunset date after which more funds cannot be spent, and since markets are not back to normal, even though there is improvement, we shouldn’t prevent the use of the tools we currently have. But we do need to set parameters for managing our investments and winding them down in order to take the politics out of this program.

American taxpayers deserve to have their investments managed in order to maximize their returns. That is what the trust will do, and I hope we will consider using this model for other investments as well.

This trust will also help us take some of the politics out of the TARP program, and that is why I am proud of this legislation as bipartisan and led by my friend from Tennessee, Senator CORKER. I hope my colleagues will join in supporting this bipartisan legislation, S. 1280, the TARP Recipient Ownership Trust Act. While this measure won’t resolve all of our concerns surrounding TARP, I hope it can serve as a model to maximize the taxpayer returns on their investment.

Let me also take one additional moment to speak about another investment-related matter. Under the leadership of Senator JACK REED from Rhode Island, when the initial investments and the initial TARP plan were put together, Senator REED, I think appropriately, said if we invest in banks in addition to getting a traditional return, we, the public, who are taking