

Her personal freedom was not enough for her because she recognized there was injustice in this country, and she wanted to be involved. As the joint resolution that passed the Senate 12 years ago said:

... Harriet Tubman—whose courageous and dedicated pursuit of the promise of American ideals and common principles of humanity continues to serve and inspire all people who cherish freedom. . . .

A major part of learning and understanding the significance of history is being able to experience the places where that history occurred.

From Fort McHenry in Baltimore, MD, to the Lincoln Memorial here in the Nation's capital, we have preserved our history for future generations. Millions of visitors and schoolchildren visit these iconic places in American history.

The Harriet Tubman National Historical Park and the Harriet Tubman Underground Railroad National Historical Park is legislation I have filed so we can preserve the history of Harriet Tubman with these historic places for future generations.

I am joined in this effort by Senator MIKULSKI, Senator SCHUMER, and Senator GILLIBRAND. The natural landscape on the eastern shore that existed during Harriet Tubman's day exists today. Her homestead, where her father was born, Ben Ross, exists today. Stewart's Canal, where her father worked, exists today. The Brodess Farm, where Harriet Tubman worked as a slave, exists today. Right adjacent to it, and including part of that property, is the Blackwater National Wildlife Refuge. So we have the landscape in which the Underground Railroad was operating to free slaves in the 19th century. It exists today on the eastern shore of Maryland.

In Auburn, NY, the home in which Harriet Tubman lived still exists, the home for the aged that she started still remains. The Thompson Memorial AME Zion Episcopal Church is still there, and the Fort Hill Cemetery, where she is buried. They are all intact, and all are available for preservation.

The legislation we have filed will preserve these places in American history under our National Park System for future generations. I urge my colleagues to support this legislation, to honor a great American, and to preserve our heritage for future generations.

ASTHMA AND THE IMPACT OF HEALTH DISPARITIES

Mr. CARDIN. Mr. President, I rise to speak about asthma and the impact of health disparities. I have pointed out on the floor before that race and ethnic health disparities exist in America. I have talked on the floor before about sickle cell disease. Well, the same thing is true with the chronic inflammatory diseases of the body's airways that impede breathing, such as asthma.

As I pointed out before, the Affordable Care Act includes a provision I

helped write that establishes the Institute for Minority Health and Health Disparities at NIH. The purpose for including this information about asthma in the RECORD is to point out that we still have challenges that need to be met. I look forward to working with my colleagues on that issue.

Asthma is a chronic inflammatory disease of the body's airways that impairs breathing and affects more than 20 million Americans. People with this condition have overly reactive airways that constrict in response to allergens, temperature changes, physical exercise, and stress. During asthma attacks, the airways spasm and prevent oxygen from getting to the lungs. This leads to chest tightness, shortage of breath, wheezing, and mucus production. Severe attacks can require intubation and even result in death. Of the 20 million Americans affected by asthma, about 7 million are children. In fact, about 10 percent of all American children have asthma.

Genetics play a significant role in the development of asthma in children and adults, but asthma is also influenced by environmental factors and racial, ethnic, and socioeconomic factors. Asthma is consistently found to be more prevalent among certain minority groups, particularly among Blacks, Native Americans, and Puerto Ricans. To be more precise, research indicates that asthma is 30 percent more prevalent in Blacks than in Whites; American Indians and Alaska Natives are 20 percent more likely to have asthma than Whites; Asian/Pacific Islander children are three times more likely to have asthma than White children; and Puerto Rican Americans have twice the asthma rate as the Latino American population overall.

In addition to occurring more often, asthma is also more severe in minority populations, and this leads to higher mortality rates for Black Americans. Asthma accounts for more than 4,000 deaths in the United States each year. Blacks are 2.5 times more likely to die from asthma-related causes than Whites. Among children, this ratio is even more staggering—Black children are 7 times more likely to die from asthma-related causes than White children. Interestingly, although Latino Americans and American Indian/Alaskan Natives are more likely than Whites to have asthma, they have a 50 percent lower mortality rate.

As I noted earlier, the gap in asthma outcomes is also influenced by several socioeconomic factors. Health disparities can be attributed to differences in education level, independent of race or ethnicity. Research shows that children whose mothers have not completed high school are twice as likely to develop asthma as children whose mothers have a high school diploma, and this difference remains significant even when controlling for race and ethnicity.

Economic status also influences the incidence of asthma. Studies have

shown that unemployment is correlated with increased incidence, and that people with incomes below the Federal poverty level are 30 percent more likely to develop asthma as those who are above the Federal poverty level.

One reason is that income level is correlated with quality of housing, and substandard housing is strongly associated with poor asthma outcomes. Substandard housing exposes residents to environmental triggers for asthma such as dust mites, roaches, mold, and rodents.

A study in the journal *Pediatrics* showed that eliminating these indoor pollutants could prevent 39 percent of asthma cases in children. Other studies have shown that substandard housing accounts for up to a 50-percent increase in asthma cases.

In addition to indoor triggers, outdoor pollutants are also contributing factors. Researchers have shown that among people living within 50 yards of major car traffic, people living near a road traveled by 30,000 vehicles per day are three times more likely to develop asthma than those who live near a road traveled by 10,000 vehicles per day. To put these figures into perspective, the average segment of I-495, our Capital Beltway, carries about 200,000 cars per day.

The built environment comprising roads, factories, and other human-made surroundings is a substantial risk factor for asthma. Many people are stuck in unhealthy living conditions because they can't afford to move elsewhere, particularly in the case of public housing projects, which are often situated in the most polluted locations. Initiatives such as the Healthy Homes Program run by the U.S. Department of Housing and Urban Development are encouraging, but greater effort must be devoted to raising the quality of the home environment for people living in poverty.

Whether due to one or more of these factors, the impact of disparities in asthma is profound because asthma is such a crippling condition. Untreated or inappropriately treated, asthma makes it difficult to concentrate at school and work, limits physical activity, and often results in absenteeism. It also reaches beyond the patient to family members, as parents are often required to miss work to care for sick children. The Nation's 20 million asthma patients account for more than 100 million days each year in lost productivity due to absence from school and work, according to the American Academy of Allergy, Asthma, and Immunology. Yearly, asthma patients account for more than 11 million office visits and 500,000 hospitalizations. That is an annual cost of more than \$6 billion in direct and indirect medical expenditures. Much of this expense could be avoided with proper asthma management.

Patients who are diagnosed at an early age and whose conditions are well

managed by a primary care physician and an asthma specialist can avoid many of the complications associated with the condition. The ability to secure medications, such as an albuterol inhaler to alleviate attacks and steroids to suppress inflammation, can allow patients to play sports and live normal lives.

But patients who lack access to specialists or can't afford needed medicines will frequently miss school, must forgo physical activity, and are often hospitalized. So the effect of access to affordable, comprehensive care is apparent.

Even so, coverage is not enough. Asthma disparities have multiple interrelated causes, as I have outlined. We often view health disparities through the narrow lenses of genetic differences and differences in medical care. But upstream determinants such as social inequalities and neighborhood conditions can have a significant impact on health outcomes as well.

Even though we know this, national policies have not effectively addressed the problem of health disparities pertaining to asthma. National asthma guidelines that are supported by the National Institutes of Health recommend preventive services and asthma care by a specialist. These guidelines have been found to save money and improve quality of life. But data still show that patients covered by Medicaid are offered less preventive care and fewer referrals to asthma specialists compared to patients in the private insurance market. This matters when it comes to outcomes because specialists are more likely to prescribe controller medications than primary care providers, regardless of the patient's racial or ethnic background. Decreased access to specialists has been associated with higher rates of hospitalization, emergency room use, and mortality. The bottom line is that Medicaid patients have been receiving lower quality treatment for asthma, despite the guidelines put forth by NIH and the American College of Allergy, Asthma, and Immunology.

I am encouraged that there are significant efforts taking place to close the gaps at the local level. In Maryland, the University of Maryland Medical Center has developed an innovative approach to bringing specialized care to children who otherwise would not have access to it. Their BreathMobile program, led by Dr. Mary Beth Bollinger, is an asthma clinic on wheels. It is staffed by a pediatric allergist, a pediatric nurse practitioner, a registered nurse, and a driver who regularly travels to over two dozen schools in Baltimore City. The BreathMobile has provided ongoing care to more than 800 students.

At Johns Hopkins University, the Harriet Lane Clinic provides a comprehensive medical home for asthma patients. Over 90 percent of Harriet Lane's caseload are Medicaid patients, and they are provided with pulmonary

specialists, social workers, and case managers who help them secure healthy housing, and seek help from other programs for which they may be eligible.

With the passage of the Affordable Care Act, we have additional tools to address the problem of health disparities at a national level. I helped write into that law the new Institute for Minority Health and Health Disparities at NIH as well as the Offices of Minority Health at CMS and the Agency for Healthcare Research and Quality.

These offices are charged with evaluating, coordinating, and advocating for efforts to eliminate disparities, and they can do much to close the gaps with respect to asthma.

The new Institute will be instrumental in overseeing the coordination of asthma research at the National Heart, Lung, and Blood Institute and ensuring that the focus of biomedical research sufficiently addresses health disparities. We must encourage participation in clinical trials, particularly for underrepresented populations, so that we can speed the discovery of the most effective treatments. Provisions to encourage physicians to practice in underserved areas can improve access to care. The Office at AHRQ can help translate these findings into practice, and the Office at CMS can be instrumental in ensuring that eligible CHIP and Medicaid beneficiaries are enrolled in these programs and that they can receive the best possible care. With the Affordable Care Act, we have the momentum and the tools needed to make a difference in asthma health disparities.

I look forward to returning to the floor soon to explore the issue of health disparities further by focusing on another condition that disproportionately affects minorities.

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

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

TOXIC TEA

Mr. LAUTENBERG. Mr. President, everyone is aware of how deeply concerned the American people are about staying in their homes, about having adequate health care, and about providing education and a better path for the lives of their children. But everyone also knows there is a group calling themselves the tea party, and they are busy trying to eliminate those opportunities.

In Wisconsin, a tea party Governor is trying to take away workers' collective bargaining rights to be represented. It is like going into a courtroom without a lawyer.

In Florida, another tea party Governor has killed the critical high-speed rail project by rejecting Federal grants of \$2.4 billion to move it along. He threw it away, threw it back—\$2.4 billion. Here in Congress, tea party activists have seized control of the Republican side of the aisle. But it is far from a tea party for lots of jobless people and those qualified to study in college but unable to pay the freight. Now that they are in power, we see them brewing a toxic tea—a dangerous concoction that will create pain for our children and ultimately bring shame to our country.

We know cutting critical programs now brings sky-high prices later—in more illnesses and a less educated society. So we look at the future, we say we have to invest in our children, our environment, and medical research. But every time they hear something we need, they say no. They insist on saying no to 200,000 little kids who now go to Head Start Programs that help them in the earliest stages of life, when learning is fun and curiosity abounds. Look here. We see a young child's face through the window. They are holding back 218,000 Head Start kids from learning to learn. They ought to visit these schoolrooms and be upfront with these children and their parents and say, Sorry, America can't help you.

That is not all. Look at what they want to do to higher education. We say we must invest in Pell grants which make the dream of college a reality for millions of disadvantaged Americans. They say, Sorry, your country can't help you. They say no to future employers. Too bad we don't have enough qualified workers, so maybe the employers then can appropriately say, Oh, well, ship the jobs overseas. That is the alternative. Is that what we want America to do? They say no, even though the unemployment rate is twice as large for those who lack a bachelor's degree as for college graduates.

They are unable to look at a simple chart such as this one: There we can see the way the arrow is pointed, with the year 2000 over here and the year 2009 over here, and we see rising tuitions. That is what is happening. Therefore, it tells us how difficult it is for those who don't have the money, the family support financially, and won't able to take advantage of the Pell grants, because they want to slash them. They want to get them off the record as much as they can.

The chart shows between a \$10,000 and \$15,000 tuition rate in 2001. In 2008 and 2009, we are somewhere close to \$20,000 a year. Do we want to force middle-class citizens to take on more debt in order to attend college or slam shut the campus doors on them altogether?

I know the value of government investment in college education firsthand. I came from a poor working-class family. I was a teenager when I enlisted in the Army. My father was on his deathbed. He died and left a 37-year-old widow, myself, and my 12-