I would also note that DHS Secretary Janet Napolitano has been pleading with the Senate to confirm Dr. O'Toole. Secretary Napolitano has said that Dr. O'Toole's biosecurity and epidemiology expertise are critical to DHS and to her, personally. The Secretary's urgency is heightened because of the critical roles Dr. O'Toole will play in both defending our Nation against bioterrorism and in the continuing preparations for the H1N1 flu pandemic.

Let's consider the tough job Dr. O'Toole has been asked to take on and then consider the qualifications she brings to it.

The Science and Technology Directorate is charged with managing our Nation's investments in homeland security research and development projects with the goal of providing its customers within and without the DHS the kinds of state-of-the-art technologies they need to achieve their missions.

The S&T Directorate got off to a rocky start and struggled in its early years to clarify and execute its primary mission. Former Under Secretary Jay M. Cohen resolved to build a leaner and more tightly managed organization that focused on better serving its customers and being transparent with Congress. He implemented internal controls to monitor S&T finances and track the progress of S&T investments. He established a structured strategic planning process that is designed to produce specific objectives and annual performance measures.

But despite this progress, big challenges await the new undersecretary, including expanding investments in innovative R&D for homeland security—like the advanced spectroscopic portal, ASP, and the secure border initiative—and insuring the reliability of the a testing and evaluation that DHS relies on for large acquisition programs.

Programs like these can be force multipliers for DHS's customers within and without the department.

Now let's consider the resume Dr. O'Toole brings to the job—both as a medical professional and as a manager.

Let's start with Dr. O'Toole's solid and impressive educational background: a bachelor's degree from Vassar College, a medical degree from George Washington University, and a master of public health degree from Johns Hopkins University.

Now let's consider her management skills: From 1989 to 1993 she served as a senior analyst and project director with the Congressional Office of Technology Assessment; from 1993 to 1997, she served as the Assistant Secretary for Environment, Safety and Health at the Department of Energy.

From 1999 to 2003, she managed the Johns Hopkins Center for Civilian Biodefense Strategies. For the last 6 years, she has served as the Director and Chief Executive Officer of the Center for Biosecurity at the University of Pittsburgh.

On top of all this, Dr. O'Toole is also an accomplished author.

She has published her research on anthrax, smallpox, the plague, biological attacks, containment of contagious disease epidemics, biodefense, and hospital preparedness. She is coeditor in chief of the Journal of Biosecurity and Bioterrorism.

And she took all this knowledge she has gained over these many years and used it to help create the 2001 bio-terror attack simulation known as ''Operation Dark Winter'' that helped open our eyes to our many vulnerabilities.

Dr. O'Toole is also a former chair of the board of the Federation of American Scientists and she has participated in major studies or advisory panels at the request of the National Science Foundation, the Department of Defense, the Department of Health and Human Services and the Department of Homeland Security.

Besides these many qualifications, another important measure of her fitness for this post is the bipartisan respect she has earned across the government and scientific communities that monitor homeland security and bioterrorism challenges.

Among her many supporters are: Former Senators Bob Graham and Jim Talent, Chairman and Cochairman of the Commission on the Prevention of WMD Proliferation and Terrorism; former DHS Secretary Tom Ridge; former Senator and defense expert Sam Nunn; former National Security Adviser to Presidents Gerald Ford and George H.W. Bush, Brent Scowcroft, as well as Dr. Robert P. Kadlec, former Special Assistant for Biodefense Policy at the Homeland Security Council under President Bush; Dr. D.A. Henderson, who led the World Health Organization's efforts to rid the world of smallpox, and the Federation of American Scientists.

Dr. O'Toole brings a remarkable breadth of experience to this job that is so crucial to our nation's security and I say again she is an inspired choice and I urge my 3 colleagues to take up her nomination and confirm her to this position where our nation so desperately needs her talents.

The PRESIDING OFFICER. The question is, Will the Senate advise and consent to the nomination of Tara Jeanne O'Toole, of Maryland, to be Under Secretary for Science and Technology, Department of Homeland Security?

The nomination was confirmed.

The PRESIDING OFFICER. Under the previous order, the motion to reconsider is laid upon the table, and the President will be immediately notified of the Senate's action.

LEGISLATIVE SESSION

The PRESIDING OFFICER. Under the previous order, the Senate will now return to legislative session.

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

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

MORNING BUSINESS

Mr. WHITEHOUSE. Mr. President, I ask unanimous consent that there now be a period for the transaction of morning business.

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

ORDER OF PROCEDURE

Mr. WHITEHOUSE. Mr. President, I ask unanimous consent that the next hour be controlled by the Democratic side; that colloquies be allowed among the speakers; and that the speakers be recognized, first, the Senator from New Jersey, Mr. LAUTENBERG, then the Senator from Oregon, Mr. MERKLEY, and then as recognition may be sought on the Democratic side after that.

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

Mr. WHITEHOUSE. One further unanimous consent request, Mr. President. I ask unanimous consent that Senator STABENOW follow Senator MERKLEY after Senator LAUTENBERG has spoken.

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

The Senator from New Jersey is recognized.

HEALTH CARE REFORM

Mr. LAUTENBERG. Mr. President, I thank my colleagues for giving me an opportunity to talk for a few minutes about health care as we try to understand what brings us to this point with a shred of rage, trying to maintain the dignity of our society.

We are on the verge of fixing our health care system once and for all, but there is one major obstacle in our way. The obstacle I talk about is the health insurance companies, their lobbyists, CEOs, and their friends on the other side of the aisle. We can call this group the status quo caucus. They are spending unlimited funds on TV commercials and bogus studies to kill health reform. That is their mission. Think about it. They define their goal, their objective, as articulated by our colleague from South Carolina, as saying: If we can stop this health care reform from continuing, it can be the end of the Obama Presidency, it can be his Waterloo.

What kind of an objective is that, that we put politics at the top end as we ignore millions of people, over 40 million people who do not have any insurance, and many of the others who do

have insurance do not have a complete picture about what their policies permit or what they might lose by way of restrictions.

This is an outrage. The public is manifesting their concern. They are not sure about what they hear, the derogatory material they see—don't do this, don't do that, no public option, and let's take our country back. I don't know whom they are talking about. Whose country? It is our country. It is everybody's country. There is no monopoly here for participation in American society.

We hear the worst kinds of assertions about what we are trying to do—turning this country into a Socialist country. What has happened would be almost humorous if it were not so tragic; that is, for people who are on Medicare to be concerned about government interfering with their lives. Medicare is a government program, one of the most successful ever put into the structure of our country.

While this group of obstructionists goes about their business, ''don't let it happen'' is their mission. I just told you how it is demonstrated in the words of the Senator from South Carolina.

The insurance companies are spending millions on TV commercials and bogus studies to kill health care reform. Quenching their thirst for profits has led to some of the worst predatory practices imaginable. This is an industry that will knowingly strip children of their health care coverage when a parent loses a job. This is an industry that demeans women by treating pregnancy and domestic violence as preexisting conditions—anything to escape their obligations under their insurance policies, for which they charge a lot of money. This is an industry that squeezes small businesses by charging them 18 percent more than they do large firms for the same health insurance policies.

The priority of the health industry is not patients, it is profits. In the richest Nation in the world, decent health care should be a basic tenet of life for everyone in our society. But that is not the way it is going and that is not the way the health insurance companies look at it. Their single-minded drive for profits is at the expense of their policyholders—policyholders who depend on them for care when they are sick or injured and when they need medical or health professional assistance.

We have a chart that demonstrates the massive profit increases at some of our largest health insurance companies for the years 2000 to 2008. These are the profit increases at health insurance companies. This is 2000 and this is 2008. How can we forget 2008, when our country was coming apart at the seams, deep in recession and terrible expectations in front of us, with people losing their jobs and losing their homes by the millions. Yes, 2008 was that kind of a year. It was a disaster year, except for the guys who were in the health insurance business.

In 2000, the profit for WellPoint, one of the best-known companies, was $226 million. Eight years later, their profit was $2.5 billion. Note this: $226 million and $2.5 billion, for a 1000-percent increase. For Aetna, $127 million in 2000; in 2008, $1.4 billion. Think about it—$127 million to $1.4 billion, for a 990-percent increase. Humana, in 2000, had a $90 million profit year, but by 2008 they were up to $647 million, for a 619-percent increase. United Health had $736 million worth of profit in the year 2000, and in 2008 these guys made $3 billion, for a 340-percent increase. That is $736 million compared to $3 billion, for a 304-percent increase.

I can assure you working people were not looking at these kinds of increased percentages in their incomes. As a matter of fact, their purchasing power declined. Even though salaries may have stayed the same or have been increased by some factor, their purchasing power decreased.

Humana, we recently learned, achieved these profits largely by cheating taxpayers, by taking funds that were supposed to be subsidies for lower rates for their policyholders but, in fact, they went into the company's profits.

Just like the industry's profits have risen, so has CEO compensation. Over the last 20 years, compensation for health insurance company CEOs has grown steadily while workers' pay has barely moved. The average compensation package for each of the top five health insurance company executives between 2006 and 2008 was almost $15 million a year.

I ran a fairly large company before I came to the Senate, and I think earning a profit is good. I think it is appropriate to keep your books honestly, tell the company to be transparent, tell the country exactly what your profits are, how it was earned, what your expenses were, what your revenues were. The company I ran is a company called ADP. I started it with two other fellows. They, like I, came from poor, working-class families who worked in the mills in Paterson, NJ. We worked very hard. That company today has 46,000 employees in 26 countries across the world. We started in Paterson, NJ, in a dumpy hotel building where we could rent space. So I know something about balance sheets, financial statements, and profitability. I think that profit is a good thing.

But it is one thing if you are manufacturing lawnmowers and another thing if you are providing health care and the squeeze on the profit side comes out of people's lives; comes out of creating suffering and fear of loss of coverage.

The average salary for these insurance company executives was almost $15 million each year—each CEO—while a year's pay for the average worker during that same time was about $44,000. Imagine, these people are working in the shops, moving things along, doing their clerical work, doing what they have to do, and the top guy is earning $15 million a year, while the average person working there is earning $44,000, and $44,000 today doesn't carry a family very far.

A single health insurance CEO earns approximately 335 times the average worker. It is scandalous. But it doesn't end there. At the same time health insurers and CEOs have made out like bandits, the industry has increased its premiums relentlessly. According to a new report from the Kaiser Family Foundation, insurance premiums for families more than doubled since 1999. Ten years ago, premiums averaged less than $6,000 a year. Today, they have grown to an average of more than $13,000 a year—the highest amount on record. These are for middle-class people earning very modest incomes trying to get along and watch their health insurance.

I have had people walk up to me, people I see in positions of labor, saying: Mr. Senator, please, my rent is going up, my taxes for real estate are going up, I can't afford more. My health care is the one thing that worries me so much. I can't afford to pay the premium, Mr. Senator. Please, help us.

As the following chart shows, over the past 10 years, insurance premiums have gone up three times faster than wage increases—in a period of just 10 years. So we see what is happening to a family's ability to afford to cover their needs. If today's CEOs cared as much about the public health as their financial wealth, our system wouldn't look this way. What happens is we are trading the well-being of the needy for unconscionable gains by the greedy.

It is so funny, the times we live in. I read there was a boat show that just took place in Miami, FL, and the most active part of the sales of boats was for boats that were 100 feet or longer. We are talking about millions of dollars for these boats. I don't begrudge those people. I don't, really. But look at basic America and see what it is that keeps our country going.

The health care field is one of the great abominations. We have to end this poisonous prescription for management of health care companies and change the way these health insurance companies operate. There is one way to do it and that is to make sure there is competition within the industry that is serious. The legislation we are putting forward will reshape health insurance and end the industry's choke hold on ordinary Americans.

Under our proposal, it will be against the law for insurance companies to discriminate against women. It will be against the law for them to deny coverage because of a preexisting condition. It will be against the law for them to end insurance coverage just because policyholders become sick. That is what they are supposed to take care of. On top of that, we are going to stop insurance companies from charging immense amounts of out-of-pocket expenses.

We will also make it so insurance providers have to cover routine checkups and preventive care, so lifesaving mammograms will no longer be out of reach for millions of women. I know a world-renowned research clinician in New York who says mammograms are the gold standard for dealing with anticipation of breast cancer.

These changes will make health insurance companies more honest, more transparent and more accountable and they will still make enough money to take care of the wages and the profits they seek. They may not be as great as they are, but they shouldn't be as great as they are.

Our Republican colleagues are chasing a different goal. They are looking for political victories on the backs of the working people of our country. They are fixated on stopping the Congress and President Obama no matter what the consequences are for our country and for the people who work hard to keep their families together. But I want to remind these obstructionists that health insurance companies have shown their utter disregard for the well-being of all Americans from all walks of life. They do not care if the policyholder is a Democrat, a Republican or an Independent. I remind anybody who hears what we are saying or looks at what we are doing that fixing health care is not a choice; it is a necessity.

I know this on a personal basis, though I am fortunate. I have a grandson who is 16 years old. He has asthma. When my daughter takes him to play sports—he is a good athlete—she first checks to see where the nearest emergency clinic is in case he starts to wheeze. I have a granddaughter, 11 years old, and she has diabetes. When she was here in Washington on a visit, I looked at her, and I didn't like the way she looked. I said to my daughter—they live in Florida—you have to find out what is wrong with Maddie. There is something there. It worried me. She was pale, she didn't have any energy, and she looked terribly slim. When I went down to Florida 3 days later, after they left Washington, I went to the hospital where she had entered and I saw her. She looked like a new person because the diabetes was treated and she had insulin. She looked like a new person.

Those things mean so much. There is nothing more important to any of us—and I say this about my Republican friends as well—nothing more important than our children, our grandchildren. That is what we all live for. They have a right to live and be healthy. For the future of our children and grandchildren, every American—we have to meet our obligations. I plead with my friends on the other side, get out of the way. Don't stand there unless you are willing to come in here and say: I don't want people to have health insurance. I don't care whether a child has health insurance. Say it out loud instead of skulking behind the walls and hiding the truth about what your mission is.

It is my hope that history will record a moment of success, success for the people of our country. We have never quite been this close to achieving fundamental health care reform. We may never have this opportunity again.

Once more, step forward, colleagues, Senators, sent here by people who trust you, who have confidence in you. Take care of them. Be honest with them. If you don't want to give them health care insurance, say so. Say: I don't want to give you health insurance. Or say: We don't want your condition to determine whether we cover you, we want to decide. This is an opportunity we have to seize.

I yield the floor.

The PRESIDING OFFICER. The Senator from Oregon is recognized.

Mr. LEVIN. Will the Senator yield for a unanimous consent request?

Mr. MERKLEY. I will.

Mr. LEVIN. I ask unanimous consent that after the Senator from Oregon is recognized and the Senator from Michigan is recognized, under the existing unanimous consent agreement I then be recognized.

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

Mr. MERKLEY. Mr. President, I thank the senior Senator from New Jersey for his remarks, for his reminder that health care is not about profits, it is not about salaries of the CEOs, it is about health care for Americans so that all citizens have access to affordable and quality health care. That is what this debate is about.

One component of that debate is extending the opportunity for health care to those who do not have that opportunity right now. Another part of this debate is about improving the way insurance works for those who already have insurance. That is what I want to address tonight.

There are common practices in our insurance industry, our health care system, and that includes exclusion of preexisting conditions, gender discrimination, arbitrary annual spending limits or lifetime spending limits, and dumping—the practice of kicking people off policies when they get sick. They go against the very idea of insurance. What people expect is that their health insurance will be there if they need it. What they often find is it is not there.

For example, many people do not realize their insurer has placed an arbitrary limit on how much care they can get in a single year or over the course of their lifetime. A person may be paying monthly premiums, perhaps $500 a month in premiums, every month for years, adding up to tens of thousands of dollars. That person may be going forth in that fashion, needing not so much as a checkup, but then they are struck by a serious illness or a serious accident and they need regular and sometimes expensive care. Suddenly they find out that the thousands of dollars in premiums they have paid do not actually guarantee they will get the care they need.

I will give an example from my home State of Oregon. Alaya Wyndham-Price is a healthy 27-year-old from Lake Oswego, OR. She had insurance but had no reason to think she would actually need it, given that she was healthy and she was young. Imagine her surprise when she was diagnosed with a tumor the size of a golf ball just below her brain. Then imagine her further shock when she found out that her insurance policy caps treatment at $20,000 a year.

It took $30,000 of tests—and it doesn't take a whole lot of testing to run up that kind of bill—to determine the best treatment for her tumor. The surgery to remove that tumor is going to cost $50,000, but because of Alaya's limit, she has to put off the surgery until next year. That means further hardship on her, for her family—emotionally, physically, and financially.

As she told me this story a couple of weeks ago, I kept pondering, what will that delay do to her ultimate health outcome? How much opportunity is that delay affording to a tumor that doesn't have her health in mind as it grows?

These caps are not right. It is not right to tell someone who is gravely ill that they can only have so much health care in a given year. It is not right to ration treatments on the ability to pay. It is not right to collect premiums year after year and then in the fine print put in an annual cap that denies care when it is desperately needed. Alaya has insurance but she has already amassed a massive amount of debt. Hopefully, she will be able to continue paying her bills and not have this critical health care issue also drive her into a critical financial situation, into bankruptcy. Indeed, that is what happens to many Americans who have health insurance. Half the people who declare bankruptcy do so because of medical bills, and three-fourths of those who declare bankruptcy because of medical bills had insurance.

Insurance at the least is supposed to be the way to keep yourself financially solvent in the case of a disaster, but that is not what is happening for millions of Americans. It is not working for many Americans.

Insurance failed Kathryn Peper of Tigard, OR. Katherine had trouble getting any insurance because she had high cholesterol, a common condition but enough to allow the insurers to deny her application because of this preexisting condition. She did finally find a policy—$550 a month. She paid that premium and one would think insurance at that price would pay some of her medical expenses, but she found out it did not. Her insurer routinely refused to pay for even simple doctor appointments. So she was paying a huge amount for insurance and getting no coverage as a result, when she needed it to go to the doctor. She finally canceled her policy, and she now pays out

of pocket for each visit, and she hopes she does not have a debilitating condition come up or an accident.

There are other practices. I mentioned dumping. This is egregious. Imagine you pay your premium year after year, month after month, stretching over 10, 15 years, and then you have that accident or that disease that lands you in the hospital and you need a lot of care. You get a letter from your insurance company saying: We don't think you are a good insurance risk anymore so we are canceling your insurance.

At the end of that year you are suddenly stuck with massive bills and no insurance coverage to pay for the ongoing treatments you need. That is not right.

We have built our health care system around private insurance and private insurance remains an integral part of health care reform. But things have to change. We can't continue to have our citizens pay millions to insurers and see so little in return. It is not good for the health of the American people or our Nation. We need an insurance policyholder bill of rights. It needs to have guaranteed issue, no blocks as a result of preexisting conditions, no rejection because of preexisting conditions. It needs to have no arbitrary annual or lifetime limits. It needs to say no dumping, and it needs to say no gender discrimination.

Each and every one of these concepts was debated in the Health, Education, Labor and Pensions Committee and incorporated into the bill that came out of that committee. These are principles I want to see carried straight through until we put this health care reform on the President's desk.

It is time to act for the citizens of this Nation. It is time to have a health care system that works for working Americans.

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Ms. STABENOW. Mr. President, first I thank my friend and colleague from Oregon, Senator MERKLEY, for those wonderful comments and his passion and commitment on this issue; also, Senator LAUTENBERG from New Jersey and my friend and partner from Michigan, Senator LEVIN, who will be speaking, and the great Senator from Rhode Island, as well, who has been a wonderful leader on this issue and so many other issues as well. We all come today because we are committed. We are absolutely committed to seeing reforms in our insurance system so families get what they are paying for and we can bring costs down and we can save lives.

We are here because we want to share the voices and stories from people in our States who have paid into a system and too often not gotten what they have paid for, not been able to benefit from the health care system that we have in this country.

It is important that insurance industry reforms be a part of health care reform. We know we are still in the process of bringing a bill to the floor. At this point we are talking about our goals and our commitment to the common shared values and goals that we have going forward because we know we need to make sure this is addressed.

When we started this debate earlier this year, I set up an online health care people's lobby for the people of Michigan to be able to share with me their thoughts, concerns, and stories as they relate to health care, not having health insurance, what is happening to their families. My sense was we can step outside this Chamber and meet at any moment with insurance company lobbyists and prescription drug lobbyists and others who are here representing special interests. It is very important that voices be heard from people who just want health care for their families and either cannot find it, cannot afford it, or they have it and the costs are going through the roof and then they find that what they have paid for or what they thought they were paying for is not what they are actually getting for their families.

That is specifically what we want to talk about today, the fact that there are abuses, bad practices occurring right now. People who have insurance have a stake in health care reform. We are not changing their ability to have insurance. Everyone can keep what they have. But we want to make sure they are getting what they are paying for.

That is a very important part of health care reform. It is important as we look at the fact that since 2000, insurance company profits have gone up 428 percent. People in my State would take a quarter of that. We are seeing insurance premiums during that same period go up 120 percent. Even though profits have gone up 428 percent, we still have seen premiums going up 120 percent, and now even higher. We are seeing more and more announcements of premiums going up despite the high profits in the industry.

What is most concerning is, for average people wages are either going down, they are losing their job, or if they have a job their wages certainly are growing much more slowly. In fact, over the 8-year period we have seen wages going up about 29 percent at best, if you are fortunate enough to have a job in this bad economy. That means every day insurance companies are taking a bigger chunk out of budgets of our families and businesses, and it is not fair.

The status quo is not working anymore for anybody other than those who are making profits off the system. It is hurting families, it is hurting businesses, and it is costing us jobs. In fact, health care reform is about jobs. It is about saving jobs, it is about making sure if you lose your job you do not loose your health care. It is about making sure that small businesses that want to provide insurance for employees can do that or not have to lay off people because premiums are going up. So it is very much about jobs.

It is very much about jobs, and that is why we need a health care reform bill now. It is time to put an end to the insurance company abuses. The goals we share in this process are to stop the process of denying coverage because of preexisting conditions; to stop the process of annual and lifetime caps on benefits; to stop the process where someone can get charged more or dropped from coverage if they get sick.

I have seen too many situations where somebody pays in, pays in, and pays the higher premiums and so on, and then somebody in the family gets sick and, based on technicalities, they are dropped or they are not covered. That is wrong. We are committed to fixing that.

We also want to make sure on the positive end that we are focusing on prevention and on checkups and making sure you can do that without the cost of copays and deductibles. We are encouraging people to get healthy, to get those early checkups, to be able to get the care on the front end that they need.

It is also extremely important as we move forward we crack down on discrimination by insurance companies. Right now women can pay twice as much for insurance as men and, in fact, get less coverage. In eight States and the District of Columbia, being a victim of domestic violence can count as a preexisting condition. I was stunned when I first heard that, and then said, well, that cannot be. We doubled back and, yes, in fact, that is true for men and women who need help for getting the insurance care they need right when they need it.

In many places, being pregnant, having ever been pregnant, even wanting to be pregnant, can be qualified as a preexisting condition. We had a report in the Washington Post about insurance companies that even denied coverage to men who were expectant fathers. I am not sure what kind of family values those are. But we need insurance reform that addresses some pretty basic things.

Right now 60 percent of the plans in the individual and small business markets do not cover vital maternity and prenatal care for pregnant women. That needs to change with health care reform. It is not an accident that we have an infant mortality rate of 29th in the world, below some Third World countries, children and babies who do not make it through their first year of life.

We look at the fact that too many insurance plans do not cover prenatal care and care for mom and baby during the first year of the baby's life. We are committed to changing that.

I wish to share a story I received that goes right to the heart of why insurance reform is so important to families in Michigan and all across the country. It comes from a constituent of mine in Michigan, Lynn, from Marshall, MI.

A few years ago she got the kind of news that every parent fears. Her son

Justin was diagnosed with leukemia. To date, his medical bills have totalled over $450,000. Thankfully they have insurance and his leukemia has a very high cure rate.

Justin is 21 now and a senior in college. He is doing fine, thankfully, but Lynn worries about what is going to happen when he graduates from college and can no longer stay on her insurance. With leukemia as a preexisting condition, his insurance premiums will go through the roof. And for a young man who is just starting his career, those kinds of costs would simply be unaffordable.

If Justin wants to start his own business, which is so central to the American dream, he would never be able to afford to pay for his own insurance with that kind of preexisting condition. How many other Justins are out there, who would be the innovators and the entrepreneurs we need to revitalize our economy in America? Who would make the difference if only they could afford to go out on their own and start their own company and know they could get affordable insurance without preexisting conditions and other barriers that have been in their way from insurance companies?

That is why we need health care reform. We need health insurance reform as a part of health care reform. We are committed to that. We are committed to stop abuses in the health insurance industry. Those who have insurance now who will be able to keep their insurance need to know they are getting what they are paying for in the health care system today for their families. That is why we need reform now, and we are committed to getting it done.

I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan is recognized.

Mr. LEVIN. Mr. President, it should be crystal clear to all of us why the health insurance industry opposes reform so strenuously: because the status quo is so profitable.

As my colleagues have pointed out, the massive profit announced this week by Humana, Inc. illustrates this vividly. Humana's third-quarter profit of $301 million was a 65-percent increase over the same period a year ago. And Humana executives made no secret of the reason for this ballooning profit. The company's president and CEO said, ''Our government segment continued to perform well in the third quarter particularly in our Medicare business.''

It is no coincidence that Humana is one of the biggest providers of Medicare Advantage plans. These plans, in which private insurers contract with the government to provide coverage to Medicare beneficiaries, were supposed to unleash the power of private-sector competition, lowering costs, improving service, and increasing benefits to our seniors.

It has not often worked out that way. While some Medicare Advantage plans have performed well, Medicare pays, on average, 14 percent more for Medicare Advantage beneficiaries than for those in traditional Medicare, and despite this increase in payments to Medicare Advantage plans, the Government Accountability Office has found that seniors often face higher out-of-pocket costs in Medicare Advantage plans.

In fact, when the GAO studied the costs and performance of these plans, it found that in 2005, those plans spent significantly less for health care for seniors than they projected to pay. That lower spending on medical care for seniors led directly to windfall profits, $1.1 billion more in profits than the insurance companies had told the government they expected to earn. That $1.1 billion is taxpayer money that should be providing treatment to our seniors, and instead is boosting insurance company profits.

Indeed, health insurance companies need no taxpayer help in reaping big profits. From 2002 to 2006, profits at publicly traded insurance providers increased more than tenfold. At the same time these companies are making massive profits, working Americans and their employers have endured year after year of much higher premiums, reduced benefits, and denials of treatment.

Our citizens need a sensible health care system. We can not afford a system in which our people are denied treatment because their benefits are capped. We can not afford a system in which they are denied coverage because they have a preexisting condition. Our Nation can not afford a system in which the loss of a job means the loss of coverage and debilitating health costs. Our Nation can not afford a system in which even those with jobs and insurance face rapidly increasing premiums and out-of-pocket costs. Our nation certainly can not afford a system in which our tax dollars boost the ever-higher profits at insurance companies, or in which premiums and out-of-pocket costs constantly go up, while coverage constantly shrinks or disappears entirely.

The Senate needs to put the interests of the American people ahead of the interests of insurers. We need to take up a health reform plan that makes comprehensive, affordable health coverage available to every American, and helps keep insurance companies honest.

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

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

Mr. WHITEHOUSE. I ask unanimous consent that the period for speakers be extended for an additional 20 minutes.

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

Mr. WHITEHOUSE. Mr. President, I have joined my colleagues on the floor this evening to discuss the need for health insurance reform, which is a critical component of the health care reform package that the Senate will soon consider.

Our colleagues on the other side of the aisle are fond of suggesting to the American people that our current health care system is fundamentally fine, fundamentally sound, and all it needs is some minor tweaks. But Rhode Islanders who have faced down their insurance companies over the denial of benefits they paid for will tell you that idea is dead wrong. As they and many other Americans have found to be painfully true, our current system of health care is all too often a mirage concocted by health insurance companies to extract premiums from consumers while denying coverage when it is actually needed.

Reform of this system of delusion is needed and it is needed now. As someone said the other day: Americans have all the health care they need until they need it. Then the insurance company comes and interferes.

Those profit-driven companies focus on share price and quarterly earnings and other telltales of the business world and are only too happy to diligently mail those premium notices and collect those payments when you are feeling well. But when illness strikes, they vanish, they disappear, hiding behind stacks of forms, automated 800 numbers, with no human to be found, and weeks and weeks of delay and denial.

The insurance company Humana pulled just such a stunt a few years ago. In May of 2006, a Humana policyholder was diagnosed with a rare and advanced form of liver cancer. Without treatment, he was not expected to live more than 4 years. But in September of that year, his doctor, a board-certified interventional radiologist, recommended a course of treatment for the cancer involving a new technology, expensive but proven to be effective.

The insurance company policy explicitly covered such radiological treatment. At this point, it is an inspirational story, a terminally ill patient whose persistent and caring doctor found a technological advance that could extend his life. But when the insurer Humana became involved, this patient's bureaucratic nightmare began. The treatment recommended by the doctor is widely accepted. It is FDA approved. It is reimbursed by Medicare and Medicaid, and it is covered by several large insurance plans. But Humana's medical director denied coverage. He denied it on the basis that it was ''experimental/investigational, not identified as widely used or generally accepted.''

Humana decided to deny this life-saving treatment in spite of the fact that the insurance company medical director, the same fellow who made that determination, later admitted in court that:

He has never performed [the] treatment, consulted with another physician about the treatment, or even read any literature on the topic.

Without ever having performed this treatment, without ever having consulted with another physician about this treatment, without ever having read any literature on the topic, he reached the decision that this treatment was ''experimental/investigational . . . not identified as widely used [or] generally accepted,'' leaving this man with liver cancer and a doctor telling him how to cure it hanging in bureaucratic limbo.

Since this policyholder could not pay out of pocket—it was an expensive treatment—the hospital treating him said it could not proceed with the treatment. With time running out and nowhere to turn, he hired an attorney to force Humana to stick to the terms of its health insurance policy. Thank goodness, he won.

In a blistering opinion, the trial judge found that the company could not have possibly made a well-informed decision under the provisions of the plan. Rather, the judge found, the company relied on the flimsy pretext of an internal company guideline deeming the treatment ''experimental.'' How good is that? You are the insurance company that has the decision on whether to pay. You have a rule that says you don't pay if it is experimental, and you create your own internal, independent guideline that decides, contrary to all the rest of the evidence, that it is experimental. It is like being able to grade your own exams, except that lives hang in the balance.

The basis for that conclusion was two written summaries of medical articles by a private health insurance industry consultant. That is what they based that internal guideline on. They said it was based on written summaries of medical articles by a private health insurance industry consultant. It makes you feel pretty good as a customer of the insurance company to think that they are getting recommendations from their own private health insurance industry consultants, right? The real problem was this: The summaries were wrong. Neither of the articles actually concluded that the treatment was experimental. The whole thing was a big, complex, bureaucratic chase founded in falsehood.

The court found that Humana inappropriately denied the treatment and ordered that it immediately pay for this patient's cancer treatment. What a waste—a waste of money, a waste of time, and a waste of resources. Worse than all of that, what a thing for this man to have to go through. Not enough that he has been diagnosed with a rare and fatal form of liver cancer, not enough that a doctor has told him that with the right treatment, he could extend his life, maybe long enough to see a daughter graduate, maybe long enough to see a son get married, maybe long enough to arrange his affairs for his family to do well after he has left them, on top of all that, he now had two battles to fight—one with his illness, one with his insurance company.

We have heard a lot of hysterical propaganda lately about how health reform will put the government between you and your doctor. Indeed, the recent GOP health care bill on the House side has in its opening passages that it will not intervene in the doctor-patient relationship, suggesting that other proposals would intervene in the doctor-patient relationship.

I submit that our colleagues on the other side are a lot less concerned about intervening in the doctor-patient relationship than they are about the Congress of the United States intervening in the insurer-to-insured relationship. I submit they are more concerned about leaving American insureds at the mercy of these insurance companies—the place where they actually intervene between the patient and the doctor. The worry for the real American isn't that the government is interfering between them and their doctor; the worry is that when they get sick, that insurance company intervenes between them and their doctor.

We hear it in Rhode Island, in Colorado, the State of the Presiding Officer. We hear it over and over. Indeed, one of the things they do is called rescission. Rescission is when you have paid your premiums, you have been a good customer, you think you are a customer in good standing, and something awful happens—an unexpected diagnosis, a terrible accident. Suddenly, you need to call on that insurance policy that you have paid for month after month, year after year, to see you through your time of illness or injury. Then what do they do? The first thing they do is send somebody in their administrative offices squirreling off through your file to look for something you did wrong when you filled out your form. If they can find a mistake, they yank the coverage you paid for all those years.

During a recent study by House colleagues, committee investigators found a total of 19,776 rescissions from just three large insurance companies over 5 years; 19,776 families who thought they had coverage, who paid for coverage, who were good customers, but when they got sick, the insurance company turned on them, and, once again, they had to fight two battles—one against the illness or injury and one against the insurance company. The rescissions saved those three insurance companies $300 million, a third of a billion dollars. As a prosecutor would say, there is motive.

When you look for real examples of bureaucratic interference, when you look for real examples that resemble death panels, you need look no further than the kind of story about this gentleman Humana turned on when he got his diagnosis. We are here not to encourage that, not to have the government do it, but to stop it, to put an end to it.

In stark contrast to this patient's humiliation, having to pay attorney's fees out of pocket to fight the insurance company, having to try to cope with all this nonsense while suffering from a terminal illness, Humana executives and shareholders have done quite well. The company reported this week that its third-quarter profits are up 65 percent. Its CEO, Michael McCallister, was paid $5.2 million in 2008. Nice pay. Too bad the work is so mean-spirited.

You might think the Humana story is extreme, an outlier, a rare, tragic case, but you would be wrong. The private health insurance industry torments Americans like that patient day-in and day-out, 17,000 of them just with the rescissions.

Another example: In 2005, BlueCross of California denied a patient's claim for bone marrow treatment, writing only that its decision was ''based upon the member's specific circumstances and upon peer reviewed criteria including Medical Policy.'' What is that? What does that mean? ''Based upon the member's specific circumstances and upon peer reviewed criteria including Medical Policy''—what a lot of rigmarole. The State insurance commissioner stepped in and penalized the company because it didn't describe any reasons for its denial, nor did it cite provisions of the insurance policy upon which it relied, just ''based upon the member's specific circumstances and upon peer reviewed criteria including Medical Policy.'' You could make that up about anything. In essence, the insurance company denied that claim for no reason.

That same year, the company denied another patient's claim for nutritional counseling to treat anorexia. In its notice of cancellation, the company wrote to its insured that ''nutritional counseling is only covered when the diagnosis is diabetes. Since the claim was not submitted with a diabetes diagnosis, the claim was denied.'' California's insurance regulator found that the company's reasoning directly contradicted the benefits listed under the policy which said that dietary counseling ''is covered if it is for the treatment of anorexia.'' Why do you make somebody who needs this health care go chasing through the policy to find the place where it actually says it is covered? Why make up a lie that it is not covered? There is an obvious reason: If you do that to enough people, some won't take the trouble. Some will fight back. Some will figure out that it is inaccurate. Some will go to the regulators. But some will give up. Of those who give up, you make money.

BlueCross of California is owned by WellPoint, whose CEO, Angela Braly, made $9.8 million last year.

Many years ago, Charles Dickens wrote a book called ''Bleak House.'' In ''Bleak House,'' there are a lot of story lines, but one of them is about two young people who are pursuing a case in the British courts. Jarndyce v. Jarndyce was the name of the litigation. It is described in ''Bleak House''

as a monster extending through the courts, through writs and clerks and judges. And the storyline through ''Bleak House'' is that eventually, through all this bureaucracy, through all this static, through all this nightmare, through all this hassle, the couple finally gets to the point where they achieve the inheritance that was theirs, and that was the subject of the litigation they needed to claim through this arduous ordeal. The problem: By the time they got the inheritance, it had all been eaten up, every penny and farthing, by all that process and all that delay.

Our current system of private health insurance too often leaves policyholders feeling like that poor young couple in ''Bleak House,'' surrounded by bureaucracy; surrounded by people who are out to gouge you, not to help you; surrounded by people who turn their backs on you in your hour of need; surrounded by people who sold you all the health coverage you need until you really need it. Then they are looking for loopholes and trying to deny you coverage.

We owe Americans better than that. We can build a system of health insurance about which Dickens would not be tempted to write or Franz Kafka for that matter. Let's build a system that prevents insurers from evading their promises—in which people can't be denied coverage for a preexisting condition; in which surprise annual or lifetime caps don't pitch you into bankruptcy; in which insurers compete on customer service, not on how to figure out ways to deny you coverage. That is the system we in Congress are striving to enact into law this year.

One of the ways we will do this is by adding to the bill a public option. You can chase these insurance companies around until you are blue in the face. You can sic the regulators on them all day long. But they have been doing this for years. It is a habit. It is a pattern and practice. It is a business model. It is not going to change without competition forcing it. That is yet another one of the reasons a public option is so important in this debate.

One of my fellow Rhode Islanders, Karen Ignagni, is actually the chief lobbyist for the health insurance industry. She said something the other day about the public option. She said that it would reduce payments ''to doctors and hospitals rather than driving real reforms that bring down costs and improve quality.'' I submit she has it exactly wrong, exactly backward.

First, as we have crafted a public option, it would have to compete and negotiate for price, just like the private insurance industry does, no different than the insurance companies Ms. Ignagni represents.

But more to the point, this idea that it will compete by reducing payments to doctors and not drive real reforms, I submit the exact opposite is true. It is the public option that will drive the real reforms. It is the public option that will pursue cost-effective quality improvements; that will pursue wellness and prevention for customers; that will find better ways to pay doctors for value, not for volume; that will take advantage of President Obama's investment in health information technology to transform American health care for the better.

So I will close with that observation, and I will add one more thing. I have used examples from public records, but many of us here have had this experience personally.

Someone in my family, whom I love very much—I would describe him as my best friend—got a terrible diagnosis some time ago, and his family and everybody who loves him gathered around to help him. One of the things that was recommended was that he go to the National Institutes of Health, where the best specialists for this terrible diagnosis he had can be found.

So he went to the National Institutes of Health. Actually, I went with him because it is just up the road in Maryland—he had to come down from New York—and I wanted to be a good friend and a good family member and show support and be there with him. So I know firsthand he went up to NIH, and I know he spoke to that doctor, that world's best expert on this terrible diagnosis, and I know firsthand what he was told. I know exactly what he was told to do by that doctor.

He went back home to New York with this course of treatment for his condition that had been given to him by the top specialist in the field in the country, the man recognized by the National Institutes of Health, and when he began that course of treatment, guess what his insurance company told him. ''I'm sorry, that's not the indicated treatment.'' Oh, really? Not indicated? By whom? By some person on the other end of the phone who has never even examined him? By some person on the other end of the phone who might not even have a medical degree?

Why is it that every single time the insurance companies get involved and say something is not the ''indicated treatment,'' the indicated treatment is less expensive, the treatment they want is less expensive than what the doctor wants? You would think that maybe once in a while, just to throw us off, they might say: No, no, no, wait a minute, the indicated treatment is actually more expensive and better than what your doctor said, and we want you to have that. Has that ever happened? I do not think so. Every time the private health insurance industry steps in between you and your doctor and says: No, we are not covering that treatment, we don't care that your doctor has prescribed it—in this case, we don't even care that the top specialist in the country prescribed it—it is always to push you to a cheaper treatment.

The terrible thing is that for every American like the man I love, for every American like him who fought back, who said: Nuts to that, I have been to the NIH, this is what they told me to do, this is what I am doing, some number will give up, some number will be defeated, already scared by a terrible diagnosis, already bombarded at home with forms and bills and things they do not know how to cope with, already trying to cope with issues like preparing their family for horrible news. Dealing with the difficulties of treatment, some number of them will give up, and they will let the insurance companies get away with it. For every one of them who dies a little earlier because they did not get the treatment they should have—for every one of them—we in this Congress need to get to work to make sure this kind of behavior is never permitted again.

This is not a small matter. This hits home in every one of our States every day. So I am proud to support our health care reform. I think we are going to see this legislation through to the end, and we are going to get it right, and after all the scare mongering and all the stories about death panels and all the phony defense about the government getting between you and your doctor—when what they are really protecting is the right of the insurance company to step in and get between you and your doctor; that is what they are about—after all of that, what people are going to find, coming out, when they actually see the real results, is that, in fact, the world has changed for them. What Americans will see is that we will have changed the world for the better for people who are now in the grip of these greed-driven insurance companies.

Mr. President, I thank the distinguished Presiding Officer very much, and I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. BURRIS). The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

Mr. CASEY. Mr. President, I also ask unanimous consent that after the next, I believe, 10 minutes expires on our time, that I be permitted to speak in morning business beyond that time by, oh, say 10 minutes at the most.

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

Mr. CASEY. Mr. President, I rise tonight to also speak about health care, as we have heard from some of my colleagues. I was coming in as Senator WHITEHOUSE was concluding his remarks on the floor and am grateful for his leadership and the leadership demonstrated by so many of our colleagues here on this critically important issue.

We have heard a great deal in the last couple of weeks about some of the fundamentals of health care reform. I was speaking last week about children

and some of the progress we need to make in the final bill to protect our children, to make sure that especially poor children are not only not worse off at the end of this debate but also that they are, in fact, better off because of the reforms we make. We have great programs to work with. The Children's Health Insurance Program, for example, has been tremendously successful in insuring the children of working parents. We know the kinds of early, periodic screening and diagnostic testing done in Medicaid is very important to poor children and their families. So there is much we have to do just with regard to children.

Our older citizens, of course, are a huge focus of this health care reform. We want to control costs. We want to provide better quality, ensure prevention strategies that will not only save lives but also save us a lot of money. We want to wrestle, as we have been trying to do, with the cost issue, and we will continue to do that, and I think successfully.

But one area I think we often, unfortunately, overlook is what happens to our small businesses. We know that most of the jobs in America—the foundation of our economy—are created by small businesses. These are the very businesses in States such as Pennsylvania and the Presiding Officer's home State of Illinois and States across the country—big States and small State—where businesses have been devastated by health care costs. Over and over again, we hear it.

Just in the last couple of days, we saw this headline in the New York Times: ''Small Business Faces Sharp Rise in Health Costs.'' And the subheadline or the reference to the story says: ''Up 15%, On the Average.'' ''Insurers Increase Rates as Congress Weighs Major Overhaul.'' So there are a lot of small businesses in Pennsylvania and across America that are waiting to see what the House and the Senate will do. What kind of bill will we send to President Obama for his signature?

If we do nothing, there is one thing we are sure of. If we do nothing, if we do not pass legislation this year—as I think we will—but if the Congress did nothing, we know those costs are going up all the time. The New York Times reminds us of that: ''Up 15 percent, On the Average.'' There is an increase in costs, if we do nothing, that has been escalating for years now. We have had people in the Congress, here in this Chamber, and other places saying: We have to help small businesses. We have to be conscious of what their needs are, the difficulties they have had in this recession.

Families have had a lot of difficulties, obviously. In addition to that, small businesses have. But we cannot say we really are concerned about what happens to small businesses—small business owners—in America if we do not help them on health care, if we allow this to persist, this spiraling, ever-increasing cost of health care for small businesses.

If you look at it just in terms of Pennsylvania—one way to look at this is just in terms of State numbers. These numbers, we will not have to go through. I know some of them are small. But here is the basic point: cost of health benefits to small businesses per year if there is no reform. This is just for Pennsylvania, as shown on this chart. If you look at the year 2009: 7.43—the annual spending in billions of dollars in the State of Pennsylvania. Almost $7.5 billion spent by small businesses on health care. You do not need to read every number here because a lot of them are small, but you can see the trajectory of that graph, that blue line going up and up and up. So by the time 2018 rolls around, not even a decade away—9 years away—if we do nothing, Pennsylvania's small businesses will pay more than $16 billion for health care—just in less than a decade, more than a doubling of health care costs for small businesses in one State. One can just imagine. One doesn't have to be an expert with numbers to extrapolate from that what that means for the United States of America. Small businesses already crushed in many instances by health care costs, being crushed even further. That is the cost of doing nothing. There are a lot of ways to measure that, but the cost to small business is one of them.

According to an August 2009 Small Business Majority survey of 200 Pennsylvania small businesses, the top three concerns for small businesses in Pennsylvania—and I have no doubt this is similar to the rest of the country—here are the three top concerns: No. 1, controlling costs; No. 2, having insurance that covers everyone; and, No. 3, ensuring at least high-quality standard benefits. So small businesses have the same concerns that many people here have: controlling costs, enhancing quality, and making sure we have broad coverage.

Ninety percent of small businesses in Pennsylvania want to eliminate preexisting condition rules, and 75 percent see these rules as a barrier to starting a business. So someone is making a decision, making a determination about whether they will start a small business, and they think to themselves: I may not be able to get this business off the ground because of health care costs or because of preexisting conditions.

Why have we allowed this problem—not just the cost problem but the problem that we point to all the time of preexisting conditions—why have we allowed insurance companies to do that? Well, we have allowed it over many years because we haven't taken them on and defeated them when it comes to passing legislation.

This is the year when at long last we are going to say to insurance companies: You cannot have this kind of power over people's lives, over people's business decisions by, for example—one of many examples, but the most prominent, the most egregious example—denying someone coverage because of a preexisting condition.

I know this summer, way back in the middle of July, as a member of the Health, Education, Labor and Pensions Committee, we passed our bill out of that committee and the first section of that bill dealt with the preexisting condition problem. In one sentence in that bill we set forth a determined effort to make it illegal to prevent someone from coverage because of a preexisting condition. So this is about individuals and families, as well as about small businesses. They, too, suffer from the preexisting condition problem in our health care system.

There are a lot of other numbers I could point to in a survey. I will not go through all of those, but I do wish to highlight tonight as well what we heard just yesterday, or part of what we heard yesterday in the Health, Education, Labor and Pensions Committee where we had a number of witnesses. One of those witnesses was Jonathan Gruber who is an MIT economist. He testified that small businesses—and I am paraphrasing his testimony; it is all in the record—small businesses are disproportionately hurt by the health care status quo and that health insurance reform will lower—lower—premiums and save jobs in the small business sector.

I am quoting from Dr. Gruber from MIT:

> Small business has little to fear and much to gain from health reform.

Not my words, the words of an MIT economist who has spent time not just analyzing health care reform over many years, he played a role in helping Massachusetts develop their strategy. But he is talking about reform generally on health care as it relates to small businesses.

Professor Gruber also talked about health insurance reform breaking down many of the barriers that currently are faced by small business owners or prospective small businesses. For example, unpredictable premium jumps, as we see on the chart. Whether they are predictable or not, they occur all the time. But they are especially problematic when a small business owner doesn't have any warning. Fear of starting new businesses for lack of affordable health insurance options is an impediment to starting a small business. An impediment to creating jobs is another way of saying it, in my judgment.

Professor Gruber talks about other barriers to small businesses under our current system: higher costs and limited choices due to administrative expenses and lack of bargaining power. Just imagine what it is like for a small business owner in a huge environment where they don't have the kind of bargaining power a big company has or they don't have the kind of bargaining power the Federal Government has to go into the marketplace to keep costs down. So they go in virtually unarmed

or alone into that marketplace, a small business owner, who might have 4 or 5 or 7 or 8 or 10 or 20 employees.

Tax credits would help small businesses who need it the most to help them pay for insurance. Dr. Gruber unveiled a new analysis in his testimony showing that health insurance reform will save small businesses 25 percent over the next decade. One thinks: Well, 25 percent, what does that mean? By his estimate, this 25 percent savings to small business as a result of health care reform, in his judgment, would be a $65 billion-per-year savings for small business. That is Dr. Gruber at MIT, not my words, not the words or the analysis of some Senator or House Member on one side of the debate or the other.

So the consequences of those savings would be enormous to small businesses in America. I know we need this kind of reform in Pennsylvania.

Workers in small businesses would see an increase in their take-home pay, according to Dr. Gruber, of almost $30 billion a year. That affects all of our lives in a very positive way. If a small business in our community can hire more people, can make an investment in the development of that small business because of health care savings as a result of a health care reform bill, our communities will be stronger. We will have more people working. We will have a much stronger economy right at the community level, not just in a macro or larger scale way.

Finally, on this analysis of what health care reform could mean to small businesses in terms of savings, that reform could save almost 80,000 jobs, according to Dr. Gruber—80,000 jobs in the small business sector by 2019. Dr. Gruber also dispelled the myth that health insurance reform will raise costs for small businesses. He said:

> Objective CBO analysis shows that these claims are clearly wrong. Reform will lower, not increase, nongroup insurance costs.

So says MIT economist Dr. Gruber, who has lots of experience in this area and is lending the benefit of his experience and his insight into these analyses on health insurance reform, but in particular as it relates to small businesses.

So what we want to try to do with health care reform when it comes to a State such as Pennsylvania is take this blue line of an exponential increase in health care costs for small businesses in one State—and I think this is true of the country as well, in my judgment—we want to make sure this line and this exponential increase is turned the other way or at least begin to flatten out so that the $7 billion that small businesses are paying in Pennsylvania for health insurance reform by the year 2018 might be only something a little less or a little more than $7 billion.

We cannot say with a straight face or with any degree of integrity, in my judgment, that we want to lower costs for small businesses, that we want small businesses to hire more people, and then in the next breath say: But I don't think we should pass any health care reform. It is too complicated or it is too something to get it done this year. We cannot do that.

We cannot continue to say: Oh, isn't it too bad that health care costs are so high? Isn't it too bad we couldn't do something about the health care costs of small businesses? This, in the end, is not simply about the small business owner, it is not simply about what we are going to do for small businesses to help them get through this recession. This, in the end, is about our economy. We are either going to change course, get control of costs, reform health care and be able to move our economy forward or we won't meet that challenge.

We are going to make the changes and institute reforms that will lead to lower costs, better health care outcomes, and a better bottom line for small businesses and, therefore, control long-term health care costs and long-term national debt. All of that comes from a good health care bill in the end.

We cannot fail. We cannot at long last say we didn't get the job done. We have to for our families, for children, for older citizens, as well as for small business owners. I think we can. I think we have the strategy that the American people understand fundamentally, and I think we can do it this year.

Mr. President, with that I yield the floor and note the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

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

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

MORNING BUSINESS

Mr. CASEY. Mr. President, I ask unanimous consent that the Senate proceed to a period of morning business with Senators permitted to speak for up to 10 minutes each.

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

COLD WAR PATRIOTS NATIONAL DAY OF REMEMBRANCE

Mr. BROWN. Mr. President, October 30, 2009, has been designated a national day of remembrance for hundreds of thousands of Americans who served their nation with distinction. Cold War Patriots National Day of Remembrance recognizes and commemorates former nuclear workers who built and operated our Nation's nuclear infrastructure during World War II and the Cold War.

It is an honor to recognize the thousands of Ohioans—from towns and cities across the State—whose work helped protect our Nation during five decades of ideological battles against totalitarianism. With a job to be done and a war to win, every day for more than 50 years laborers, millers, and haulers exemplified Ohio's Midwestern values of hard work and patriotism. Factory workers, metallurgists, and scientists risked exposure to hazards that are unique to the production of nuclear weapons in order to preserve our Nation's freedom and ideals to create a better world for all of us.

From the Mound laboratory in Miamisburg to the Fernald foundry near Cincinnati to the enrichment plant in Piketon to the more than 20 other sites across the State, the people of Ohio served their Nation with distinction, confronting threats that today we still don't completely understand and that their children and grandchildren continue to face. Many of the hardworking men and women of that generation sacrificed their health some lost their lives while protecting our country and our freedom.

The Cold War Patriots National Day of Remembrance recognizes these men and women for their contribution, service, and sacrifice towards the defense of our great Nation.

NATIONAL BIBLE WEEK 2009

Mr. VOINOVICH. Mr. President, I am honored to serve as the congressional cochairman of National Bible Week 2009. National Bible Week, which will be held from November 22 to 29, was created to underscore the importance of regular Bible study and scripture reading. The Bible is the word of God. I know that many of us could not face the challenges, stress, and heavy burden of serving during this critical time for our country, if it were not for the daily guidance God provides us through scripture—and for those of us in the Catholic faith, reception of the Blessed Sacrament. I believe that my colleagues and I need to pay special attention to the lessons the Bible teaches us, as we work together to make a difference for our country.

The enormity of what confronts us makes it is easy to become frustrated, discouraged and tired. Thankfully, the Bible provides us with inspiration, strength, and wisdom to motivate us. Prominently displayed in my office is a picture showing an eagle soaring high in the sky. One of my favorite Bible verses, Isaiah 40:31 adorns the frame, it reads:

> Those who hope in the Lord will renew their strength. They will soar on wings like eagles; they will run and not grow weary, they will walk and not be faint.

As I read those words so often, I am reminded that the Holy Spirit is always present and willing to inspire and help us. Isaiah reminds us that we can certainly try to tackle the big issues on our own, but that without the Holy Spirit by our side, the road will be long and arduous.

My colleagues have often heard me express my desire to address the ballooning Federal deficit, to create an economic climate that is conducive to