owe all of them our gratitude, and we will do our part to take care of them. I ask my colleagues to support this bill.

Again, I would like to thank Senators INOUYE and COCHRAN for their support putting this bill together, and I would especially like to thank Chairman JOHNSON for his leadership and the hard work of his staff: Christina Evans, Chad Schulken, and Andy Vanlandingham.●

The PRESIDING OFFICER. The Senator from South Dakota is recognized.

AMENDMENT NO. 2732 TO AMENDMENT NO. 2730

Mr. JOHNSON. Mr. President, I send an amendment to the desk on behalf of myself and Senator HUTCHISON and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from South Dakota [Mr. JOHNSON], for himself and Mrs. HUTCHISON, proposes an amendment numbered 2732 to amendment No. 2730.

Mr. JOHNSON. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

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

The amendment is as follows:

(Purpose: To make a technical amendment regarding the designation of funds)

On page 56, between lines 9 and 10, insert the following:

SEC. 401. Amounts appropriated or otherwise made available by this title are designated as being for overseas deployments and other activities pursuant to sections 401(c)(4) and 423(a)(1) of S. Con. Res. 13 (111th Congress), the concurrent resolution on the budget for fiscal year 2010.

Mr. JOHNSON. Mr. President, this amendment is a technical amendment which provides for the proper designation for title IV of the bill, Overseas Contingency Operations. This information was inadvertently left out of the bill. An amendment would correct this error.

I note the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. JOHNSON. 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 President, I ask unanimous consent that the order for the quorum call be rescinded.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. JOHNSON. Mr. President, I believe it has been cleared by both sides. I ask unanimous consent that the amendment be agreed to.

Mr. ROBERTS. Will the chairman yield?

Mr. JOHNSON. Yes.

Mr. ROBERTS. The chairman has accurately described the contents of the amendment. We have no objection and ask that it be agreed to.

The PRESIDING OFFICER. Without objection, the amendment is agreed to.

The amendment (No. 2732) was agreed to.

Mr. JOHNSON. Mr. President, 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. BROWN. 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. BROWN. Mr. President, with respect to amendment No. 2732, I move to reconsider and table the vote on adoption of the amendment.

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

Mr. CONRAD. Mr. President, section 401(c)(4) of S. Con. Res. 13, the 2010 budget resolution, permits the chairman of the Senate Budget Committee to adjust the section 401(b) discretionary spending limits, allocations pursuant to section 302(a) of the Congressional Budget Act of 1974, and aggregates for legislation making appropriations for fiscal years 2009 and 2010 for overseas deployments and other activities by the amounts provided in such legislation for those purposes and so designated pursuant to section 401(c)(4). The adjustment is limited to the total amount of budget authority specified in section 104(21) of S. Con. Res. 13. For 2009, that limitation is $90.745 billion, and for 2010, it is $130 billion.

On July 7, 2009, the Senate Appropriations Committee reported S. 1407, the Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2010. The reported bill contains $1.399 billion in funding that the Senate Appropriations Committee intends to designate for overseas deployments and other activities pursuant to section 401(c)(4). An amendment has been offered that provides a designation consistent with section 401(c)(4). The Congressional Budget Office estimates that the $1.399 billion in budget authority will result in $145 million in new outlays in 2010. As a result, I am revising both the discretionary spending limits and the allocation to the Senate Committee on Appropriations for discretionary budget authority and outlays by those amounts in 2010. When combined with previous adjustments made pursuant to section 401(c)(4), $129.999 billion has been designated so far for overseas deployments and other activities for 2010.

I ask unanimous consent that the following revisions to S. Con. Res. 13 be printed in the RECORD.

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

CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 2010—S. CON. RES. 13; FURTHER REVISIONS TO THE CONFERENCE AGREEMENT PURSUANT TO SECTION 401(c)(4) TO THE ALLOCATION OF BUDGET AUTHORITY AND OUTLAYS TO THE SENATE APPROPRIATIONS COMMITTEE AND THE SECTION 401(b) SENATE DISCRETIONARY SPENDING LIMITS

[In millions of dollars]

	Current allocation/ limit	Adjustment	Revised allocation/limit
FY 2009 Discretionary Budget Authority	1,482,201	0	1,482,201
FY 2009 Discretionary Outlays	1,247,872	0	1,247,872
FY 2010 Discretionary Budget Authority	1,218,252	1,399	1,219,651
FY 2010 Discretionary Outlays	1,376,050	145	1,376,195

HEALTH CARE REFORM

Mr. BROWN. Mr. President, I rise again this evening, as I have many days in the last couple of months, to share with my colleagues letters from people in Ohio—from Bucyrus, Lima, Springfield, and Zanesville—people who are sharing their stories with us.

As I have been in the Senate now for 3 years, it occurs to me that perhaps more often than not, we talk about policy up here, but we simply do not pay enough attention to individual problems and individual people. That is why a lot of people think their elected officials are out of touch with them. These letters really do share with us where we are, what we ought to do, and how we should respond as we move forward on the health issue.

This letter comes from Ann from Montgomery County. She writes:

Our insurance premiums have nearly tripled in the last 6 years, going from $500 per month to $1,500 per month. At the same time, none of our benefits have increased. Since we bought our policy, we have paid the insurance company $68,000 for the insurance. Anthem's total spending for my family's claims since we bought the insurance: $4,064.24. Anthem's profit from my family: $64,000. Anthem's CEO's total compensation last year alone: $10 million.

Ann from Montgomery County, Dayton, Huber Heights, Centerville, Oakwood—that area of the State, southwest Ohio. Obviously, Ann is angry and frustrated with what she has seen. She has paid so much for insurance, gotten so few benefits, and she sees Anthem's CEO taking down $10 million a year.

What we see repeatedly in the insurance industry, the average CEO salary for the biggest 11 insurance companies is $11 million a year. Insurance company profits have gone up more than 400 percent in the last 7 years.

The way they make this money is this kind of business model where they hire a huge bureaucracy, a bunch of bureaucrats to keep people from buying insurance if they are sick. They discriminate based on gender. They discriminate based on age. They discriminate based on disability. In some cases,

they use the excuse of preexisting condition to keep people from buying policies, including, believe it or not, women who have been victims of domestic violence. Some insurance companies consider that a preexisting condition. If their husband hit them once, they might hit them again, and that would be a cost to the insurance company. They cannot get insurance. Sometimes a woman who has had a C-section is a preexisting condition. She cannot get insurance because if a woman has had a C-section, she might get pregnant again and need another one. That is too expensive. They don't give her insurance. That is how Anthem and these other companies make these kinds of profits, because they hire bureaucrats to keep you from buying insurance if you have a preexisting condition.

On the other end, they hire more bureaucrats to reject your claims when you have been sick. Oftentimes the insurance company records show that about 30 percent of all claims are rejected initially. Sometimes they are appealed and then they pay these claims. But then you as the patient or you the family of a sick husband, wife, child have to spend your time on the phone fighting with the insurance company while at the same time you are trying to nurse your husband, wife, child, or mother. What kind of system is that, that we allow these insurance companies to do that.

What I found in these letters, in the last 3 months I have been doing this on the Senate floor, is a couple of things. One is, consistently people were pretty happy with their insurance, if you asked them a year or two earlier, but then they got sick and they found out their insurance wasn't what they thought it was. That frustration and anger builds from that.

Another thing I found is that people in their late fifties and sixties have lost their insurance, they have lost their jobs, their insurance is canceled or their employers cannot afford it because they are a small business, they don't have insurance, they are 58, 62 years old, and they just hope they can hang on until they are Medicare eligible or until they can get a stable public plan, such as a public option, such as Medicare.

I will share two more letters.

John from Richland County—that is my home county. I grew up in Mansfield. There is Shelby, Lexington, Butler—north central Ohio.

> Health care reform will not be achieved unless a public option is in place to compete with insurance carriers. I recently retired after 45 years as a family physician. If government-run medicine is so bad, why should insurance companies object to the competition? Cost and treatment is already controlled by the insurance providers whose only motive is profit.
>
> Allowing the insurance industry to dictate terms of cost and treatment has not worked and will not work. Please fight for a public option.

John, a physician of 45 years, absolutely gets it. He says something interesting. I hear opponents of the public option, a lot of conservatives say government cannot do anything right, they mess everything up, and then they say that if we have a public option, they will be so efficient that they will run private insurance out of business. So which is it—the government cannot do anything right or the government is so efficient, it is going to run private insurance out of business?

The point is, insurance executives' average salary is $11 million. Insurance companies' profits are up 400 percent in the last 7 or 8 years. Insurance companies don't want the public option because you know what will happen—their profits won't be quite as high. They won't go up 400 percent. Salaries won't be as high because they have competition from the public option. They know they will be in a situation where life is not going to be quite as good for insurance companies and insurance executives. That is why they don't like the public option. That is why they fight the public option. And we know that is why the public option will work. It will mean more choice for consumers.

In southwest Ohio, two companies have 85 percent of the insurance policies. A public option will provide competition, will stabilize prices, which means prices will come down and quality will be better. If you have two companies controlling 85 percent of the business in Cincinnati, Batavia, Lebanon, Hamilton, Littleton, Fairfield, or any of those counties, you have two companies controlling 85 percent of the business, you know the quality is lower and prices are too high.

Let me conclude—Senator CASEY is here. He more than any single Senator has spoken out strongly and fought successfully to make sure this health care bill works for our Nation's children, from when we passed the SCHIP back months ago to the health care bill on which my colleague from Pennsylvania has done remarkable work. Let me read one more letter and turn to him.

Cheryl from Cuyahoga County in northern Ohio, the Cleveland area, writes:

> My daughter is paying costly health care out of her own pocket to treat her depression. Despite getting a new job, she was told her condition is preexisting and would not be covered.
>
> After struggling for a year to find a good job, she doesn't need this preexisting condition to shadow her.
>
> I, too, have a preexisting condition of breast cancer. Please stop insurance companies from denying insurance due to preexisting conditions.

This letter again shows this insurance reform—our health care bill makes so much sense. I am hearing from hundreds and hundreds of them from Gallipolis, Pomeroy, along the Ohio River to Lake Erie, Lake County, to the Indiana border, Troy, Preble County—all over—that too many people are denied coverage because of a preexisting condition.

Why does it make sense that people who are sick or maybe are going to get sick cannot get insurance? Why does it make sense that they would have to pay so much, they simply cannot qualify or literally cannot get it no matter how much they pay?

One of the important things about our bill is that it will outlaw—there will be no more exclusions for preexisting conditions. Nobody will be prohibited from getting insurance because of a preexisting condition, including women who have been victims of domestic violence, women who have had C-sections, men who have had colon cancer, whatever, No. 1.

No. 2, nobody will be denied care because of discrimination, because of their disability, because of their age or their gender or their geography.

No. 3, nobody will have their insurance policy rescinded. That is what the insurance companies say when they take away your insurance. Nobody will have their policy rescinded because they got sick and it was a very expensive illness they had and the insurance companies want to cut them off.

In addition to these changes in the law that we are going to do with insurance reform, the public option will make sure these rules are enforced, that people simply can't game the system. The insurance companies will not be able to game the system the way they have.

It makes so much sense to pass this bill. It is going to mean people who have insurance and are happy with it will be able to keep their insurance and have consumer protections. Small businesses will get help with tax incentives and other things to insure their employees. And it will mean those without insurance can get insurance and have the option of going to Medical Mutual, CIGNA, BlueCross, Aetna, WellPoint, or the public option and have that choice.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Mr. BENNET). The Senator from Pennsylvania.

Mr. CASEY. Mr. President, I rise tonight to speak about the health insurance reform bill that will eventually come before the Congress. We have a process underway in the Senate that is still playing out. We don't have a bill, but I think we are cognizant of the fact that we need to talk about the challenge we face with regard to health care, as well as talk about some good ideas to confront this challenge.

I commend my colleague from Ohio, Senator BROWN, who has led the fight on making sure the public option is a priority. From day one, he not only has led this fight, but also from day one, way back in the summer when we were actually working on language in the Health, Education, Labor,and Pensions Committee, he and others sat down to actually rewrite that section. We are grateful for his leadership and for his ability to relate to us what a public option means to real people—not the concept, not only the policy of it, but what

it means to real people and real families. I commend him for that great work.

One of the areas I have tried to spend as much time as possible on is the question of what happens with regard to our children. Will children at the end of this process be better off or worse off, especially in the context of children who happen to be vulnerable because of income? We are concerned about poor children and children with special needs in particular.

I believe one of the principles—or maybe the better word is a goal—that we must meet at the end of the road, when we have a bill that gets through both Houses of Congress and goes to the President, when a bill gets to the President of the United States, President Obama, for his signature—and I believe we will get there; it is going to take some time and we are going to be continuing to work very hard in the next couple of weeks to get that done. But when that bill gets to President Obama, I believe we have to make sure in this process over these many months of work—and for some people, many years—we have to make sure that bill ensures that no child, especially those who are vulnerable, is worse off. I believe we can get there. I believe we must get there. I believe we have an obligation, especially when it comes to vulnerable children, poor children, and those with special needs.

To set forth a foundation for that, I submitted a resolution several months ago, resolution 170. I won't read it or review it tonight, but it was a resolution that focused on that basic goal of making sure no child was worse off. I was joined in that resolution by Senator DODD, then-chairman of our health care reform hearings, this summer. Senator ROCKEFELLER also was a cosponsor of this resolution, someone who has led on not just health care issues in the Finance Committee but also in a very particular way he stood up for children, as has Senator DODD—both Senators in their many years in the Senate.

We just heard from Senator BROWN. He was a cosponsor of this joint resolution for children, as well as Senator SANDERS from the State of Vermont and Senator WHITEHOUSE from Rhode Island. Those five Senators joined with me in this resolution which I believe is the foundation for what we have to do with regard to children.

The chart on my left is a summation of some of the things we just talked about. First of all, this first point with regard to our children, children are not small adults. It seems like a simple statement. It seems very much self-evident, but, unfortunately, we forget that. I think we forget it once we become adults. But even in the context of health care reform, we cannot just say this is a health care strategy or program or manner of delivering care or a treatment option or a way to cover more Americans with regard to health care, so if it applies to an adult it will work for children. Unfortunately, because they are not simply small adults, we have to have different strategies for children that differ from the way we approach the challenge in providing health care for adults.

The second bullet: Children have different health care needs than do adults. I think that is a basic fundamental principle; that children have to be approached in a different way. The treatment is different, the prevention strategies are different, and sometimes the outcome of a health care treatment or strategy is different.

It is also critical that all children, particularly those who are most disadvantaged, get the highest quality care throughout childhood. And that is the foundation of that resolution.

When it comes to health care reform generally, but in particular with regard to our children, we have to get this right. We can't just say: Well, we tried, and we tinkered with some details or some programs, and we did our best. When it comes to health care for children, not only for that child or his or her family or the community they live in—and we tend to forget this—but also our long-term economic strength is predicated in large measure, in my judgment, on how we care for our children, and especially the kind of health care our children will receive. So we have to get this right for our kids, for their families, and for our economy long term.

Fortunately, we have made great strides over the last 15 years. Really even less, maybe the last 12 years we have made great strides on children's health insurance. President Clinton signed a law passed by Congress in 1997 creating a nationwide Children's Health Insurance Program—the so-called CHIP program. In that case, we had something that had its origin in the States.

My home State of Pennsylvania started one of the largest, if not the largest, children's health insurance efforts in the Nation, and that was built upon by way of Federal legislation so that we now have had a program in existence since about 1997 nationally where millions of children have health care because we made them a priority.

In Pennsylvania, for example, we have had, fortunately, a diminution, a decreasing number of children who are uninsured, to the point where last year, when there was a survey done for the State of Pennsylvania, the uninsured rate for children was 5 percent. That is still too high, but it is lower than it used to be. We want to bring that, obviously, to zero, but we have a 5-percent rate of uninsured children in Pennsylvania and 12 percent uninsured for people between the ages of 19 and 64.

For children and for citizens over the age of 64—65 and up—we have had strategies for both those age groups; children more recently, with regard to children's health insurance, as well as Medicaid for low-income children, and also, we have had Medicare for our older citizens. But the problem is that age category in the middle, that vast middle age group of 19 to 64. We haven't had a strategy recently, or over many decades, and that is one of the many reasons we are talking about health insurance reform for everyone but especially for those who are in that age category.

With regard to children, we have to make sure what we know works stays in place. We have plenty of data to show that children with health care coverage do better than children without health care coverage. That is irrefutable. It is absolutely indisputable now. I don't think anyone would dispute that as a matter of public policy. Children with insurance are more likely to have access to preventive care.

A major part of our reform effort—and the major part of the HELP bill we passed this summer—is all about prevention. Children in public programs are 1½ times more likely to obtain well-child care than uninsured children. What does that mean? Well, it is simple. The experts tell us children enrolled in the CHIP program—or SCHIP, as we sometimes call it—in their first year of life have six well-child visits to the doctor. That is fundamentally important. It can alter in a positive sense that child's destiny. Their future can be determined in the first couple of weeks and months, and certainly the first year of life. It is good for that child in the first year of life to go to the doctor at least six times for a well-child visit, as they do in the CHIP program. It is important that we have prevention strategies in place for that child in the very early months of that child's life, but certainly in the first year.

Here is another chilling statistic. Uninsured children are 10 times more likely to have an unmet health care need than insured children—not double or triple but 10 times more likely to have an unmet health care need.

We hear some people in this debate say: Well, that is about someone else. That is about some other family, someone else's child. That is not our problem.

Well, it actually is your problem. Even if you have no compassion, even if someone out there says: Well, that is not my problem; that is someone else's problem.

It is your problem because for every child who has no insurance, and as a result has no well-child visits to the doctor or does not get to the dentist or does not get preventive care, there is, in some way, an adverse impact on our economy. Think about it long term. If you are running a company, who do you think will be a stronger employee for you or a more productive employee, someone who got good health care in the dawn of their life—as Hubert Humphrey used to say—or someone who didn't get that kind of health care or nutrition or early learning?

All these things we talk about have ramifications for our long-term economy because of our workforce. To have a high-skilled workforce, you have to have access to health care. So that number of 10 times more likely to have an unmet health care need for the uninsured child versus the child with insurance is chilling. It is one of those numbers that alone should compel us, should motivate us to pass this bill.

Insured children are better equipped to do well in school. Uninsured children, with poorly controlled chronic diseases, such as asthma, can suffer poor academic performance if their health care condition causes them to miss many days of school. We know that. This is not news, but, unfortunately, we have allowed conditions to persist in our system where a child doesn't get the kind of care they need, and that allows their asthma or other condition to be made worse. Insurance improves children's access to the medications and treatments they need to control chronic diseases, allowing them to miss fewer days of school. We know that is the case.

The chart on my left gives a brief overview of a Johns Hopkins University study published in the New York Times on October 30, just a few days ago, which states that hospitalized children without insurance are more likely to die. So this isn't just about a child getting a slower start in life because they didn't have health care or a child not having a B average in school because they didn't get health care or missing days from school. All of that is terrible for that child and for that family, but this is a lot worse than that. This is literally about the life and death of a child, according to this study and others as well.

Mr. President, I ask unanimous consent to have printed in the RECORD an article dated October 30, 2009, in the New York Times with the headline: ''Hospitalized Children Without Insurance Are More Likely to Die, a Study Finds.''

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

(See Exhibit 1.)

Mr. CASEY. This is what the article says:

Researchers at Johns Hopkins Children's Center analyzed data from more than 23 million children's hospitalizations in 37 states from 1988 to 2005.

This wasn't a quick survey, Mr. President. This was a detailed study of millions of records over that long a time period. Continuing the quote:

Compared with insured children, uninsured children faced a 60 percent increased risk of dying, the researchers found.

So this research showed a 60-percent increased risk of dying. That is what we are talking about. This isn't theoretical. This isn't some public policy argument we have pulled down from a public policy report. This is about life and death for children. We are either going to stay on the course we have been on with regard to children, making improvements, strengthening a program like CHIP, or we are not. I think it is vitally important that we continue to make progress as it relates to children's health insurance.

So this is fundamental to this discussion about health care reform, and sometimes a study or a chart or a public policy report doesn't tell us nearly enough. Sometimes the life of a person says it best.

Senator BROWN has been highlighting letters that he has received from people in the State of Ohio, and people in Pennsylvania have written to me or sent an e-mail or appeared in my office and relayed their own stories. In this case, when it comes to real families and real children, it is especially important to highlight them.

I just have one example to share tonight. I received a letter from a Pennsylvania resident named Denise Lewis. Denise has four children who are now older, but when she contacted us, she was recalling what she went through with her four children in terms of health care. All through their childhood, Denise and her husband struggled with being either uninsured or underinsured. What health insurance they have had has always been employer-based but often was limited and only covered hospitalizations. Her family couldn't afford the premiums on more expensive coverage, and much of this, unfortunately, was before the Children's Health Insurance Program was in effect. Her family never qualified for any other kind of assistance.

She said she would work a second job part time as a waitress so they could afford food and to pay off medical bills. Today, even though her youngest is 19 years old—her youngest child of the four is 19 years old today—she is still sending monthly checks to her pediatrician to pay for all the care her children received.

Imagine that, all these years later, because of the system we have. Goodness knows there are great parts to our system that we should celebrate and be proud of, but there are a lot of parts of our health care system which simply don't work for too many Americans and is hurting families, hurting businesses, and killing our ability to grow our economy long term, and this is one example.

Why should Denise Lewis or anyone have to worry like this, have to choose between food and getting medical care or paying for a hospital visit? Why should anyone have to pay off medical bills years and years later for children who are already grown?

At times, Denise said the medical care her children needed would actually determine what food the family ate that week. They managed to make ends meet but never had any money for extras of any kind.

Listen to this in terms of what Denise said, and these are her words:

Wondering whether you should go to the doctor is completely different from wondering whether your kids should go to the doctor.

That is the nightmare that too many families are living through. There are those who say: Well, let's just think about it for another 6 months. Some are saying: Let's not pass a bill. Let's slow it down. It's too complicated. We can't do this.

For those who are saying that, I would ask them if they have ever had to face that decision—the question of what kind of care their child would get. Had they ever faced the dilemma of how much your family can eat in a particular week or can you pay for a doctor's visit?

Denise Lewis, one of her children had frequent ear infections as a baby, and more than once she would call the pediatrician and ask if she could get a prescription without coming to the office so she wouldn't have to pay for the office visit.

Why have we tolerated this, year after year and decade after decade, of people telling stories such as this? The Congress of the United States, year after year, has said we will get to that later; it is too complicated. Why should any parent, mother or father, single parent—why should any parent have to make those choices or say to a pediatrician can I get a prescription without coming to the office because I can't afford the office visit?

We are the greatest country in the world. We have all the benefits of the wonders of technology and great doctors and dedicated and skilled nurses, great hospitals and hospital systems, all this brainpower and talent and ability—ability to cure disease. Yet on the other side of our system we tell people you have to pay more for a doctor visit for your child. Why did we allow this to happen? Year after year, we have just allowed the problem to persist.

Our system has said to women, you should engage in some preventive strategy. With regard to breast cancer, you should get a mammogram. Then we say you have to pay for all or most of it. Why do we do that? Why should we allow that to continue?

I want to move to two more charts. I know I am over my time a little bit. Let me go to the next chart. I really believe, when we describe some of these challenges, we are talking about, really, a national tragedy, that the children in our country should be reduced to having the emergency room as their primary care physician or their doctor's office.

When we were growing up, we knew what it was like to go to the doctor, but for too many children the emergency room is the doctor's office. That is not good for the child because that usually means they are further down the road for a condition or problem; they are sicker and have more complications. It is also bad for how we pay for health care.

We also know the emergency room care by uninsured Americans with no place to go but an emergency room is one of the biggest drivers of the out-of-

control costs we often see in our system. That is why we need health care reform now.

We now cover about 7 million children in CHIP. Thankfully, fortunately, we reauthorized it in 2009. It kind of went by people pretty quickly, but that was a major achievement. That bill went through and the President, President Obama, signed it into law. By virtue of that one signature and the work that led up to that, those 7 million who are covered now by CHIP will double by 2013 to 14 million children who will be covered by that program.

But even with that reauthorization, there are still things that will challenge us with regard to the Children's Health Insurance Program. One of them is a failure that could take place over time where we do not strengthen the Children's Health Insurance Program.

I meant to highlight this chart as well: ''Uninsured low-income children are four times as likely to rely on an emergency department or have no regular source of care.'' That is the point I wanted to make about emergency room visits.

Finally, let me move to the fourth chart. Not only is this program, the Children's Health Insurance Program, a major success across the country, but it has reduced the rate of uninsured children by more than one-third. As we can see by this chart on my left, insuring children is something people across America strongly support. Prior to the amendments and the markup process in the Finance Committee this fall, there was a proposal to move the Children's Health Insurance Program into the health insurance exchange as part of the Finance Committee bill. Many members of that committee, and others like me and others, didn't think that was a good idea. Senator JAY ROCKEFELLER was another and, fortunately, he was on the Finance Committee. His amendment in that committee fortunately removed the Children's Health Insurance Program from the exchange.

Why was that important? The data is overwhelming that placing families that are covered by the Children's Health Insurance Program into that newly created insurance exchange would, in fact, increase their costs and decrease their benefits. There was a debate about it, but I think the Finance Committee did the right thing. By keeping the Children's Health Insurance Program as a stand-alone program that we know works—all the data shows it. It is not an experiment. It is not a new program. We have had more than a decade of evidence that shows that it works. We have to keep that in the final bill. We have to keep that as a stand-alone program, and we have some work to do to make sure that happens.

When you see the numbers here, an overwhelming three to one majority, 62 percent to 21 percent of Americans, would oppose the elimination of the Children's Health Insurance Program if they learned that a new health insurance exchange ''may be more costly for families and provide fewer benefits for children.'' We have to make sure when we get to the point of having a final bill worked out that we keep that in mind.

We know for now that we have a stand-alone program. Thank goodness that change was made. We know it works. But we have to do everything we can to strengthen the Children's Health Insurance Program, because in the coming years there will be recommendations to change it. There will be others who will make suggestions about how the Children's Health Insurance Program fits into our health care system, and we have to be very careful about how we do that.

But for now I want to emphasize two points and I will conclude. A commitment to that basic goal that no child at the end of this is worse off, especially vulnerable children who happen to be poor or have one or more special needs—we have to make sure that happens. We also have to reaffirm what I think is self-evident and irrefutable. The Children's Health Insurance Program works. We have to keep it as a stand-alone program, and we have to continue to strengthen it because there are some changes we can make to strengthen it.

I look forward to working with our colleagues in the Senate to meet those goals. I know the Presiding Officer has a concern about this as well. He has been a great leader on health care in his first year in the Senate. I thank him for his work.

I will conclude with this. In the Scriptures it tells us ''A faithful friend is a sturdy shelter.'' We have heard that line from Scripture. We have heard it other places as well. We think of a friendship as a kind of shelter when things get difficult, when life gets difficult. One of the questions we have to ask ourselves in this debate is, Will the Congress of the United States really be a friend to children? Will we be that faithful friend who acts as a sturdy shelter? Because children can't do it on their own; we have to help them. I believe by getting this right we can be that faithful friend and we can be that sturdy shelter for our children.

Let it be said of us many years from now, when people reflect upon how this debate took place and what we passed, in terms of health care reform—let it be said of us, when our work is done, that we, all of us as Members of the Senate and Members of the Congress overall, that we created at this time, at this place, a sturdy shelter for our children and that we can say that with confidence and with integrity.

[From the New York Times, Oct. 30, 2009]

EXHIBIT 1.

HOSPITALIZED CHILDREN WITHOUT INSURANCE ARE MORE LIKELY TO DIE, A STUDY FINDS

(By Roni Caryn Rabin)

Nicole Bengiveno/The New York Times Researchers analyzed data from more than 23 million children's hospitalizations from 1988 to 2005.

Uninsured children who wind up in the hospital are much more likely to die than children covered by either private or government insurance plans, according to one of the first studies to assess the impact of insurance coverage on hospitalized children.

Researchers at Johns Hopkins Children's Center analyzed data from more than 23 million children's hospitalizations in 37 states from 1988 to 2005. Compared with insured children, uninsured children faced a 60 percent increased risk of dying, the researchers found.

The authors estimated that at least 1,000 hospitalized children died each year simply because they lacked insurance, accounting for 16,787 of some 38,649 children's deaths nationwide during the period analyzed.

''If you take two kids from the same demographic background—the same race, same gender, same neighborhood income level and same number of co-morbidities or other illnesses—the kid without insurance is 60 percent more likely to die in the hospital than the kid in the bed right next to him or her who is insured,'' said David C. Chang, co-director of the pediatric surgery outcomes group at the children's center and an author of the study, which appeared today in The Journal of Public Health.

Although the research was not set up to identify why uninsured children were more likely to die, it found that they were more likely to gain access to care through the emergency room, suggesting they might have more advanced disease by the time they were hospitalized.

In addition, uninsured children were in the hospital, on average, for less than a day when they died, compared with a full day for insured children. Children without insurance incurred lower hospital charges—$8,058 on average, compared with $20,951 for insured children.

In children who survived hospitalization, the length of stay and charges did not vary with insurance status.

The paper's lead author, Dr. Fizan Abdullah, assistant professor of surgery at Johns Hopkins, dismissed the possibility that providers gave less care or denied procedures to the uninsured. ''The children who were uninsured literally died before the hospital could provide them more care,'' Dr. Abdullah said.

Furthermore, Dr. Abdullah said, indications are that the uninsured children ''are further along in their course of illness.''

The results are all the more striking because children's deaths are so rare that they could be examined only by a very large study, said Dr. Peter J. Pronovost, a professor of surgery at Johns Hopkins and an author of the new study.

''The striking thing is that children don't often die,'' Dr. Pronovost said. ''This study provides further evidence that the need to insure everyone is a moral issue, not just an economic one.''

An estimated seven million children are uninsured in the United States, despite recent efforts to extend coverage under the federal Children's Health Insurance Program.

Advocates for children said they were saddened by the findings but not surprised.

''We know from studies of adults that lack of insurance contributes to worse outcomes, and this study provides evidence that there are similar consequences for children,'' said Alison Buist, director of child health at the Children's Defense Fund, a nonprofit advocacy organization. ''If you wait until a child gets care at a hospital, you have missed an opportunity to get them the types of screening and preventive services that prevent them from getting to that level of severity to begin with.''

The most common reasons for children being hospitalized were complications from birth, pneumonia and asthma. The study found that the reasons did not differ depending on insurance status.

Earlier studies have found that uninsured children are more likely than insured children to have unmet medical needs, like untreated asthma or diabetes, and are more likely to go for two years without seeing a doctor.

Following a recent expansion, 14 million children will be covered by the CHIP program by 2013, according to the Congressional Budget Office. Advocates for children are concerned that efforts to overhaul the health care system may actually reverse the progress made toward covering more children if CHIP is phased out and many families remain unable to afford health insurance.

''You can't just dump 14 million vulnerable children into a new system without evidence that the benefits and the affordability provisions are better than they are now,'' Dr. Buist said. ''That's not health reform.''

Mr. CASEY. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

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

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

UNANIMOUS CONSENT AGREEMENT—EXECUTIVE CALENDAR

Mr. CASEY. Mr. President, as in executive session, I ask unanimous consent that at 4:30 p.m. on Monday, November 9, the Senate proceed to executive session to consider Calendar No. 185, the nomination of Andre M. Davis to be a U.S. Circuit Judge for the Fourth Circuit; that there be 60 minutes of debate with respect to the nominations, with the time equally divided and controlled between Senators LEAHY and SESSIONS or their designees; that at 5:30 p.m. the Senate proceed to vote on confirmation of the nomination; that upon confirmation, the motion to reconsider be made and laid on the table, the President be immediately notified of the Senate's action, and the Senate then resume legislative session.

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

Mr. CASEY. For the information of the Senate, if Members wish to speak with respect to this nomination on Friday, they are encouraged to do so.

EXECUTIVE SESSION

EXECUTIVE CALENDAR

Mr. CASEY. Mr. President, I ask unanimous consent the Senate proceed to executive session to consider en bloc Calendar Nos. 314, 495, 496, 502, 503, 515, 516, 517, 518, 523, 524, 525, 528, and 529; that the nominations be confirmed; that the motions to reconsider be laid on the table en bloc; that no further motions be in order; that any statements relating to the nominations be printed in the RECORD; that the President be immediately notified of the Senate's action, and that the Senate resume legislative session.

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

The nominations considered and agreed to are as follows:

DEPARTMENT OF STATE

Arturo A. Valenzuela, of the District of Columbia, to be an Assistant Secretary of State (Western Hemisphere Affairs).

NATIONAL FOUNDATION ON THE ARTS AND THE HUMANITIES

Rolena Klahn Adorno, of Connecticut, to be a Member of the National Council on the Humanities for a term expiring January 26, 2014.

Marvin Krislov, of Ohio, to be a Member of the National Council on the Humanities for a term expiring January 26, 2014.

DEPARTMENT OF JUSTICE

Laurie O. Robinson, of the District of Columbia, to be an Assistant Attorney General.

Benjamin B. Wagner, of California, to be United States Attorney for the Eastern District of California for the term of four years.

FEDERAL MOTOR CARRIER SAFETY ADMINISTRATION

Anne S. Ferro, of Maryland, to be Administrator of the Federal Motor Carrier Safety Administration.

DEPARTMENT OF TRANSPORTATION

Cynthia L. Quarterman, of Georgia, to be Administrator of the Pipeline and Hazardous Materials Safety Administration, Department of Transportation.

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

Elizabeth M. Robinson, of Virginia, to be Chief Financial Officer, National Aeronautics and Space Administration.

DEPARTMENT OF COMMERCE

Patrick Gallagher, of Maryland, to be Director of the National Institute of Standards and Technology.

MERIT SYSTEMS PROTECTION BOARD

Susan Tsui Grundmann, of Virginia, to be Chairman of the Merit Systems Protection Board.

Susan Tsui Grundmann, of Virginia, to be a Member of the Merit Systems Protection Board for the term of seven years expiring March 1, 2016.

Anne Marie Wagner, of Virginia, to be a Member of the Merit Systems Protection Board for the term of seven years expiring March 1, 2014.

DEPARTMENT OF JUSTICE

Carmen Milagros Ortiz, of Massachusetts, to be United States Attorney for the District of Massachusetts for the term of four years.

Edward J. Tarver, of Georgia, to be United States Attorney for the Southern District of Georgia for the term of four years.

LEGISLATIVE SESSION

The PRESIDING OFFICER. The Senate resumes legislative session.

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.

GLOBAL CHILD SURVIVAL ACT OF 2009

Mr. DURBIN. Mr. President, I rise before you today to speak about a population that is all too often forgotten in the poorest corners of our world; women and children. A woman's pregnancy should be a joyous time in her life. Sadly, in many developing countries countless women suffer from pregnancy-related injuries, infections, diseases, and disabilities often with lifelong consequences. Too often their children die or struggle from a lack of basic childhood medical care.

Over the years I have traveled to some of the poorest corners of the world, from Congo to Haiti. I have seen those who struggle to find food and water, battle AIDS, TB and malaria, and fight every day to eke out a living against great odds.

Yet one of the most fundamental struggles I have witnessed is that of a mother and child surviving pregnancy and childbirth. It is heartbreaking to hear stories of women who have been in labor for days before being able to reach a hospital, of those who die giving birth because of a lack of basic medical facilities, of the thousands of children who could be saved with low cost vitamin A supplements, or of the thousands of children left as orphans.

What could be a more fundamental need in our world than making sure women and children survive childbirth?

Reducing child mortality and improving maternal health make up two of the eight United Nations Millennium Development Goals. While progress has been made in many countries, an effort to reduce under-five mortality by two-thirds and improve maternal mortality to achieve MDG targets has made the least progress than any of the other MDG's.

That is why Senators DODD, CORKER and I introduced the Global Child Survival Act of 2009.

This legislation is about strengthening the U.S. Government's role in saving the lives of children and mothers in poor countries. The act would require the U.S. Government to develop a strategy for supporting the improvement of newborns, children, and mothers.

Across the developing world, mothers are dying giving birth from complications such as hemorrhaging, sepsis, hypertensive disorders, and obstructed labor. Each year, more than half a million women die from causes related to pregnancy and childbirth.

The sad reality is that most of these complications have easy and preventable solutions. In fact, if women had access to basic maternal health services, an estimated 80 percent of maternal deaths could be prevented.

Key interventions, such as adequate nutrition, antenatal care, skilled attendance at birth and access to emergency obstetric care when necessary,