Whereas the Penguins beat the Washington Capitals in the Eastern Conference Semifinals and the Detroit Red Wings in the Stanley Cup Championship after losing the first 2 games in both series, making the Penguins the only team in league history to rally from 2-to-0 series deficits twice in the same year;

Whereas Mario Lemieux is to be honored for his commitment to keeping the Penguins in Pittsburgh and passing along his legacy to a new generation of players and fans;

Whereas, in February 2009, the Penguins hired Head Coach Dan Bylsma from the Penguins' minor league franchise in Wilkes-Barre, Pennsylvania, making Bylsma the first coach in the history of the National Hockey League to begin a season coaching in the American Hockey League and finish a Stanley Cup champion;

Whereas Sidney Crosby, the youngest team captain to ever win the Stanley Cup, was third in scoring during the regular season, had a league-leading 15 playoff goals, and demonstrated leadership by taking the Penguins to the Stanley Cup Finals in 2 consecutive seasons;

Whereas, over the course of the playoffs, Evgeni Malkin led all players in scoring with 36 points, including 14 goals and 22 assists, and won the Conn Smythe trophy for most valuable player in the playoffs;

Whereas Max Talbot is to be commended for scoring the only 2 Penguins goals in the Game 7 victory over the Detroit Red Wings;

Whereas thousands of Penguins fans supported the team throughout the postseason, donning white t-shirts to create a ''whiteout'' effect at home games or gathering to watch the game on a big screen television outside Mellon Arena;

Whereas the Red Wings are to be commended for a terrific season, committment to sportsmanship, and excellence on and off the ice; and

Whereas nearly 400,000 fans packed the streets of Pittsburgh, Pennsylvania, on June 15, 2009, to honor the Penguins in a parade along Grant Street and the Boulevard of the Allies: Now, therefore, be it

Resolved, That the Senate—

(1) congratulates—

(A) the Pittsburgh Penguins for winning the 2009 Stanley Cup Championship;

(B) Mario Lemieux and the coaching staff of the Penguins and support staff and recognizes their commitment to keeping the team in Pittsburgh;

(C) all Penguins fans who supported the team throughout the season; and

(D) the Detroit Red Wings on an outstanding season; and

(2) directs the Secretary of the Senate to transmit an enrolled copy of this resolution to—

(A) co-owners Mario Lemieux and Ron Burkle;

(B) vice president and general manager Ray Shero; and

(C) head coach Dan Bylsma.

Mr. CASEY. Mr. President, I wish to say, first, how much I appreciate the action on that resolution. I could spend a lot of time talking about our Penguins; we are so grateful they were successful in a very hard-fought series against the Detroit Red Wings, who have a strong organization and were difficult to defeat.

As a Pennsylvanian, I was especially proud that it now marks three champions in the last year: the Philadelphia Phillies in baseball, the Pittsburgh Steelers in football, and now the Pittsburgh Penguins in hockey.

We are very fortunate in our State to have three champions this year. We let the Lakers have basketball for this year. We will try to get that next year.

HEALTH CARE

Mr. CASEY. Mr. President, I rise this afternoon, at the end of a week where—and the Presiding Officer knows this in his work representing the State of Oregon and in his work as a member of our Health, Education, Labor, and Pensions Committee—we have spent a lot of time on health care, as we did the week before and several weeks leading up to this time. But now we are at the point where in our committee we are actually voting—voting on amendments.

We know this is a challenge that has faced America for decades: the challenge of covering people in our country who do not have coverage and making sure those who do have coverage have quality health care coverage that is affordable. So all these challenges are presented to us now.

We have a situation in the country today—and Chairman DODD mentioned this this morning in a hearing—that about 14,000 people a day lose their health care coverage. It is hard to comprehend that every single day that number of Americans are losing their health care coverage. Candidly, if the number was half that, it would be unacceptable—or even less than that—but that is, in a very real way, the status quo, where we are now. Thousands and thousands of people losing coverage every day, 14,000 by one count; people who might have coverage but it is hard for them to afford it or to continue to afford it, and sometimes people have coverage and it is not of the kind of quality that would ensure the best health care for them and for their families.

We are at a point now where we are beginning to see a basic choice that the Congress has to make and the American people have to make. It is the status quo or change. It is the status quo—where we are now—which, in my judgment, is unacceptable—or reform. It is coming down to a basic, fundamental choice.

The status quo right now is the enemy of change. The status quo is the impediment in front of us, the tree across the road or whatever image you want to illustrate. So we have to get to work making sure that the status quo doesn't stay in place.

There are so many ways to tell this story. Every Member of the Senate and every Member of the House and, frankly, virtually every American could tell a story about someone they know or someone they have read about and the challenges they face. In Pennsylvania, we have a lot of examples about people who are living the reality of a lack of coverage or bad quality coverage or coverage they cannot afford. One letter I got stood out for me, among many. It was written back in February of this year by Trisha Urban from Berks County, PA, the eastern side of Pennsylvania. I will read portions of her letter which I think tell the story about as well as anyone could; unfortunately, in this case, in a tragic circumstance. She wrote, talking about her husband Andrew, that he had to leave his job for 1 year to complete an internship requirement that he had to get his doctorate in psychology. The internship was unpaid and they could not afford COBRA coverage—extended health care coverage. Now I am quoting from the middle of the letter. Trisha Urban says:

Because of the preexisting conditions, neither my husband's health issues——

He had some heart trouble——

neither my husband's health issues nor my pregnancy would be covered under private insurance.

Now I am quoting again:

I worked 4 part-time jobs and was not eligible for any health care benefits. We ended up with a second rate health insurance plan through my husband's university. When medical bills started to add up, the insurance company decided to drop our coverage, stating that the internship did not qualify us for the benefits. We were left with close to $100,000 worth of medical bills. Concerned with the upcoming financial responsibility of the birth of our daughter and the burden of current medical expenses, my husband missed his last doctor's appointment less than one month ago.

Trisha Urban's letter goes on. She talks about what happened at one particular moment after summarizing their health care situation. She says, describing her pregnancy:

My water had broke the night before. We were anxiously awaiting the birth of our first child. A half-hour later, two ambulances were in my driveway. As the paramedics were assessing the health of my baby and me, the paramedic from the other ambulance told me that my husband could not be revived.

She concludes her letter this way. Again, I am quoting Trisha Urban from Berks County, PA:

I am a working class American and do not have the money or the insight to legally fight the health insurance company. We had no life insurance. I will probably lose my home and my car. Everything we worked so hard to accumulate in our life will be gone in an instant. If my story is heard, if legislation can be changed to help other uninsured Americans in a similar situation, I am willing to pay the price of losing everything.

Trisha Urban is telling us through that poignant but tragic story about her own circumstances and the circumstances surrounding the birth of her daughter and the death of her husband, all we need to know about this debate.

Then, posing that question—or that challenge, I should say—to all of us, especially those of us who have a vote in the Senate:

I am willing to pay the price of losing everything if my story can be told and legislation can be enacted to deal with health care.

That is the basic challenge that Trisha Urban has put before the Senate and the Congress and the administration. It is the challenge we must respond to. We cannot pretend it is not

there. We cannot pretend that the status quo I talked about a moment ago—14,000 people losing their health insurance every day; so many other people worried about the coverage they have—we cannot pretend that is not there. We cannot say to Trisha Urban that we are sorry about the circumstances of your story, but Congress can't get it done this year.

We have to get it done. We have to pass a bill in our committee. We have to get a bill through the Finance Committee, and we have to make sure the Senate votes on this legislation this year—frankly, this summer; not late in the fall, not in the winter, not in 2010. Right now is the time for action.

President Obama has led us in this effort. He has attached the same sense of urgency to this issue that I know the American people feel.

What is it about? Well, it is about an act that a lot of Americans are just hearing about, which goes by a very simple name: the Affordable Health Choices Act. That is the act that is presently before our committee. It does a couple of things. It focuses on some fundamentals to get at that change that should come to the status quo. First, it reduces costs by way of prevention. It is very important. We know that can reduce costs substantially. It also reduces costs by better quality and information technology. It is still hard to believe that when other industries such as banking and insurance and other parts of our economy have moved into the new era of technology that our health care system isn't anywhere near where it has to be to reduce medical errors and to provide better quality. So by focusing on information technology, we can reduce costs. That is in the bill.

Also, the bill contemplates rooting out waste, fraud, and abuse—another area of cost reduction. We know that the big questions on costs will be dealt with in the other committee—the Finance Committee—but there are elements in this bill that, in fact, reduce costs.

Secondly, the bill preserves choice, that if you like what you have in your insurance plan and the coverage you have, you can keep it. There is no reason why that should change, and it won't change under this bill. But if you don't like the coverage you have, we want to give you options and we also want to give you an option in coverage if you obviously don't have any health insurance at all. So it does reduce costs, it does preserve choice, and, thirdly, it will ensure quality and affordable care for the American people.

I believe, and I think most people in the Senate believe, that one ought to have the option of not just any health care but quality care that is affordable, that you can actually make work in your own budget. So we are going to build on the system we have. We are not going to throw the old system out; we are going to build on the system we have and make it better.

We are also going to make sure that in this legislation, we protect the patient-doctor relationship. There is no reason why anyone should get in between those two, and this bill will not do that.

Finally—this is a quick summary, I know—we are going to make sure that at long last, a preexisting condition does not prevent you from getting the kind of quality health care you have a right to expect in America today.

As we move forward on this legislation, I want to make sure we highlight the fundamental obligation we have, not just in the bill—but especially in the bill—but even beyond this legislation, and that is the obligation we have to get this right for the American people, and to get it right especially for our children. The Presiding Officer knows of the great progress we made this year on children's health insurance. Thank goodness we got that done. Instead of having 6 million kids in America covered by the children's health insurance program, by way of the legislation we passed this year we are going to extend that to almost 11 million kids. That was wonderful. That is a big success and we should all be proud, but it is not enough. We should make sure that the other 5 million children out there who don't have coverage today will get it but especially a child who happens to be in a poor family, a low-income family, or a child with special needs.

Here is what the rule ought to be. This is what should happen throughout this process while enacting health care reform, but certainly at the end of the road, so to speak, ideally this fall when we will have a bill the President can sign: The rule ought to be no child worse off, and especially no child who is poor or who has special needs or is disabled. The great line from the Scriptures that talks about a faithful friend—we have heard this over many years in the context of friendship, in the context of sometimes a reading at weddings, but I would like for us today to think about it in the context of our children. This is what the Scripture said: ''A faithful friend is a sturdy shelter''—a great image about what friendship means. There are a lot of us day in and day out, year in and year out, who talk about how important children are to us, that we are advocates for children—and we should be—that we have solidarity with our children, we are going to do everything we can to protect them. In essence, we are saying we are their friend, that those of us who are elected to public office have an obligation to be a friend of and an advocate for our children. Going back to that line from the Scriptures, if we are going to be a faithful friend to children, we better make sure that we provide a sturdy shelter; not just in the context of the obvious in health care. What is more fundamental than that, other than making sure that a child has enough to eat and making sure that child has an opportunity to learn? Other than those two, health care is essential in the life of a child, especially a vulnerable child, whether they are poor or have special needs or both. So if we are faithful friends in the Senate to our children, we better provide that sturdy shelter. We better make sure that at the end of the day, these children are not worse off because of our legislation.

I wish to conclude with a thought from an expert—not someone who is just interested in children but someone who has an area of expertise which is probably unmatched. I am speaking of someone who testified last week—a week ago today, it was—in front of our committee. Her name is Dr. Judith Palfrey. She is a pediatrician, a child advocate, and happens to be president-elect of the American Academy of Pediatrics. She provided compelling testimony. I won't go through all of her testimony, but here is something she said which I think has relevance and resonance for the debate we are having on health care. She says—and I quote Dr. Palfrey's testimony:

> Sometimes we as childhood advocates find it hard to understand why children's needs are such an afterthought; and why, because children are little. Because children are little, policymakers and insurers think that it should take less effort and resources to provide them health care.

Because children are little, we think that somehow less effort is required or less resources, less in the way of hard work. Well, none of us believes that, do we? We don't believe that. The health care we provide to our children, the protection, the shelter we provide them should be every bit as significant, every bit as fully resourced as the protection we give to adults. We might disagree about a lot of the details in the health care bill, but I think we all in this Chamber believe that children may be little but in God's eyes they are 7 feet tall and we must treat them accordingly, especially on legislation so significant as legislation on health care reform.

So the rule ought to be no child worse off. It is that simple. I believe we can get it right. I believe we can enact health care reform that preserves choice, reduces costs, and enhances quality and affordable coverage for the American people, and that we can make sure every child is no worse off.

This is a great challenge. We understand the difficulty of it. This is a great challenge, but it is a challenge worthy of a great nation. It is a challenge that will help us in our continuing struggle, our journey to make this a more perfect Union.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Ohio is recognized.

Mr. BROWN. Mr. President, I will make a couple of comments on Senator CASEY's comments. We sit next to each other in the HELP Committee, and Senator CASEY reminds us almost every day, as we work on this health care bill, that ''no child should be

worse off.'' That is something that, frankly, we all need to hear and every Member of this body and in the House of Representatives needs to hear. I appreciate Senator CASEY's work. It is really our mission to do this right and to see that no child is left worse off.

We spend more than $2 trillion a year on health care in this country, which is more than double any other industrial nation. Americans account for more than 35 million hospital visits and more than 900 million office visits every year. More than 64 million surgical procedures are performed and more than 3.5 billion prescriptions are written. Health care is, in dollar terms, one-sixth of our national economy, and it is growing. Think about that—one-sixth of our economy and hundreds of billions of dollars. Yet millions of Americans are one illness away from bankruptcy.

What we cannot forget as we debate health care reform are the millions of Americans who are depending on us to do the right thing. We cannot forget their stories. Chairman DODD, in the HELP Committee today, reminded us that 14,000 Americans lose their health insurance every single day. So as our committee meets—and some people seem to be slowing this down a little, and they certainly have the right to offer amendments, but they get carried away and talk some of these amendments to death. Every day that we don't pass this health care bill, 14,000 Americans are losing their insurance. I will tell you some of the stories I hear.

Christopher, from Cincinnati, tells us that he and his wife are retired but are not yet 65, not yet Medicare-eligible. Without health care reform, they cannot afford health care insurance because of preexisting health conditions. Their 401(k)—their retirement—is bleeding. Their small pensions don't keep up with rising premiums. Chris puts off going to the doctor to save money. The annual premium increases will raise their out-of-pocket expenses by 45 percent.

Our Nation spends in excess of $2 trillion annually in health care. Yet too many people are only a hospital visit away from financial disaster. We cannot afford to squander this opportunity for reform, nor settle for marginal improvements. Instead, we must fight for substantial reforms that will significantly improve our health care system.

First of all, whatever plan you are in, if you are happy with it, you can keep your insurance. We want to fix what is broken and protect what works. That is why I am making a case for giving Americans a public health insurance option, not controlled by the health insurance industry.

So many of us have had fights—even the President, when he was talking about his mother as she was dying of cancer during the campaign last year, about how while she was sick she had to fight insurance companies to be reimbursed and get payment for her illness. The public health insurance option is important, in part, because it is not controlled by the health insurance industry. It is a competitor. It can compete with private insurance plans. We must preserve access, but that is clearly not enough for what we do in health care. Giving Americans a choice to go with a private or public health insurance plan is good policy and good common sense.

A public insurance option will make health care available and affordable for Americans like Michelle of Willoughby, OH, east of Cleveland. When she was first diagnosed with breast cancer, she had excellent coverage through her husband's insurance. But when her husband lost his job, she lost her insurance. Not yet eligible for Medicare, she started a consulting business and found an insurance plan—exorbitant as it was. With the economic downturn, Michelle writes that the ''sum of her work is to pay for insurance.''

At a time when too many Americans struggle to pay health care costs, the public health insurance option will make health insurance more affordable.

A public health insurance option would make insurance affordable for Americans like Gary from Toledo. Gary was laid off last year and couldn't afford the more than $800 a month COBRA costs. After obtaining health insurance from a company that promised equivalent payments of Medicare for surgeries, Gary's wife underwent surgery. After a week of recovery, they received a hospital bill of $210,000, with a hospital letter saying they lacked insurance. Gary talked to his provider, who agreed to pay only $400 out of $210,000. Fortunately for his family, the hospital absorbed the remaining costs. But that should not happen, either, because of what that means to the local hospital. With Gary and his wife still 3 years away from age 65, they deserve health reform that works for them now.

A public health insurance option will also expand access to affordable health care in rural areas that are often ignored by a private insurance market that tends to target big cities with a more dense population and more consumers.

Too often, as Randall of West Liberty, OH—a small town in our State—can explain, rural communities have a difficult time attracting even basic care. Randall oversees Ohio's only rural training track in family medicine. While his program has received awards for training excellence, he struggles to attract enough doctors for their rural residents. He wrote to me explaining the disincentives and misperceptions he has to overcome to attract the care needed to serve rural Ohio.

A public health insurance option will not neglect rural areas. Insurance companies bail out in rural areas or the insurance companies that stay are so small in number that there is no real competition and they can charge rates that are too high. Instead, the public option would be consistently available in all markets, including rural eastern Oregon and rural western and southeastern Ohio.

I stand ready to work with my colleagues to design a public insurance option as part of overall health care reform. The stories of millions of Americans behind spiraling costs of health care will no longer go unheard. The stories of Chris, Gary, Michelle, and Randall will guide this administration, this Congress, and this Nation to protect and provide health care for all Americans.

I yield the floor and 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. Mr. President, we are now embarked in the Senate on one of the most important challenges that our country faces—we will begin to reform our tragically flawed and broken health care system to bring down its skyrocketing costs, to cover its tens of millions of Americans left uninsured, and to improve its way-below-average results so that high-quality health care comes within reach for every American family. The stakes are high.

This week, in a speech before the American Medical Association, President Obama said:

> The cost of our health care is a threat to our economy. It is an escalating burden on our families and businesses. It is a ticking time bomb for the Federal budget. And it is unsustainable for the United States of America.

The President said:

> Health care reform is the single most important thing we can do for America's long-term fiscal health.

Savings in waste, confusion, unnecessary or defective care, and illness prevention could eventually well exceed $700 billion a year. It is not going to happen instantly, but it is a goal we can shoot for.

I applaud President Obama's commitment and leadership, and I commend my Senate colleagues for their tireless efforts in the pursuit of meaningful, comprehensive reform. The new energy and focus we have seen in this debate isn't limited to us here in Washington. In recent months, doctors and hospitals, patients and insurance companies, labor unions and drug companies have all come together in support of the need for a restructure of our system.

Amidst all this, it has been my great honor to join the Presiding Officer, the Senator from Oregon, on the HELP Committee, where he serves with such distinction and where much of the legislation to repair our broken health care system is being debated, written,

and refined. In that capacity, I was recently invited to the White House to meet with President Obama, his health care team, and all of our colleagues on the HELP and Finance Committees. We discussed our priorities for reform, and we reported on the progress each committee has made in the past several weeks.

In the coming weeks, we will hear a lot about the details of health care reform legislation, and those details are very important. But even more important are the hundreds of millions of American families in each of our States all over the country who have experienced real anguish—coverage lost or denied, hospital stays extended due to complications or errors, prescription drug bills rising and rising, with no end in sight, even losing everything because a loved one fell ill.

A few months ago, I launched a page on my Web site for Rhode Islanders to share their personal experiences with our broken health care system, and hundreds of people have written in from all over the State.

Anita is a social worker and mental health professional in Providence. She shared what she describes as the ''sad and rude awakening'' she experienced after opening her own practice last year. As a provider, like all providers, she takes great pride in the quality of care and attention she gives to her patients. Yet she often found herself burdened with an endless trail of paperwork and the time-consuming task of battling insurance companies and tracking down claims. Like so many of her colleagues, Anita is frustrated that she must spend so much time fighting administrative hurdles and navigating bureaucratic red tape. After years of training to become a health professional, Anita wishes she had more time to do just that—provide care to her patients. She writes:

> I would much rather spend the time seeing clients than negotiating automated telephone systems and waiting to speak to a person several hours per week. It is a total waste of human time and talent.

I heard from Melissa, a self-employed writer from Newport, whose unpredictable income leaves her unable to afford health insurance. Without coverage, Melissa knows that she risks being one serious illness away from what she calls the ''brink of disaster.'' Through the stress and fear of not having insurance—through that brink of disaster that she lives on—Melissa waits and hopes that she doesn't get sick because that is the only option she has in this, our great country.

Rhonda is a mother in Coventry. She told me about her struggle to get health care coverage for her family. As if raising her two sons wasn't enough work, this single mother works two jobs to make ends meet. Although her employer offered health coverage at an affordable price, Rhonda's limited income could not be stretched to cover the additional cost of coverage for her children. So her sons went without insurance for 3 years. Rhonda, like so many hard-working Americans, was caught between a rock and a hard place—making slightly more than the eligible income to qualify for health coverage through State assistance plans, but not making enough money to afford health care coverage on her own. She prayed every day her children would be spared from sickness or injury.

I also received a story from Richard, in Providence, who told me about his father—a hard-working man who left work for 6 months to concentrate on fighting a battle against cancer. Sadly, just when Richard's father needed the support the most, his company dropped him from their health plan. Without coverage and unable to pay the costs out of pocket, his father was forced off his chemotherapy treatment. Richard's father was very lucky. The doctors cleared him of cancer. However, the medical bills were so high that Richard's parents lost their home. Remarkably, after all his family has been through, Richard feels fortunate that at least his father was covered for part of his treatment, but he urged us to fix ''this old and broken system.''

For these Rhode Islanders and for millions of more Americans silently suffering through their own personal catastrophes all over the country, we now have to be a voice. We must improve the quality of our health care, we must develop our Nation's health information infrastructure, and we must invest in preventing disease.

We must protect existing coverage where it is good and improve it when it is not. As the President said, if you like your health plan, you get to keep it. We must dial down the paperwork wars, and dial up better information for American health care consumers. We must speak for the 46 million Americans, 9 million of whom are children, who right now as I stand here on the Senate floor have no health insurance at all.

As Families USA reports, 47 million actually understates the problem because during the course of this year nearly 90 million Americans will, at one point or another, go without health insurance.

We look around at dark and tumultuous economic times. Yet looking beyond the immediate economic perils we face, a $35 trillion unfunded liability for Medicare—not a penny set against it—is bearing down on us. As the President told the AMA earlier this week:

> . . . if we fail to act, Federal spending on Medicaid and Medicare will grow, over the coming decades, by an amount almost equal to the amount our government currently spends on our Nation's defense. In fact, it will eventually grow larger than what our government spends on anything else today. It's a scenario that will swamp our Federal and State budgets and impose a vicious choice of either unprecedented tax hikes, overwhelming deficits, or drastic cuts in our Federal and State budgets.

We can only avoid that vicious choice by reforming the health care system. We are committed to making sure every American has health insurance coverage, but meaningful reform will take more than that. Think of it this way. If you had a boat out in the ocean and people overboard around it in danger of drowning, surely you would try to bring them all into the boat. But if the boat itself was sinking, if the boat itself was on fire, you would have to do more than just bring them on board. You have to repair the boat. You have to get it floating and moving forward.

That is what we have to do with our health care system. It is not enough just to provide coverage for all Americans, we also have to right this ship. This means improving the quality of health care and investing in prevention, especially in those areas where improved quality of care and investment in prevention means lower cost so that, for instance, 100,000 Americans will no longer die each and every year because of entirely avoidable medical errors. This also means reforming how we pay for health care so what we pay for is what we want from health care.

Government must act. At last, government must act. The problems of health care in America are rooted in market failures. We cannot wait for the market to cure a problem rooted in market failure. It is nonsense. We have to change the rules of the game.

We also can't pay for one thing and expect another. We have to change the incentives. We do not expect Americans to go out and build our highway infrastructure for us. We do that through government. We can't sit around and wait for our health information infrastructure to build itself either. We cannot expect quality improvement and prevention of illness to flourish when we make it a money-losing proposition for the people who have to make it work. We have to change those incentives too.

Opponents of reform are arguing that this process is going too quickly, that we need to slow down, wait, pause. They are loading down this bill with hundreds of amendments—170 amendments alone on the section that deals with preventive care. But haven't we waited long enough? Slow is what we have done for years, even decades. When I hear from Rhode Islanders with the stories I reported here, such as Richard and Rhonda and Melissa and Anita, I think not that we are going too fast, I think we are irresponsibly, even frighteningly late in getting after this problem and taking up this charge.

If we wait much longer, we may be too late to avoid that tidal wave of costs that threatens to swamp our ship of state. To those who say slow down, I say keep up.

Opponents of reform want people to believe that a system that costs too much, that lets insurance company bureaucrats make decisions about our health care; that is riddled with error, duplication, and waste; that leaves nearly 50 million Americans without any health insurance, is acceptable.

Everyone says they want reform, but unless we get moving, all we will end up with is more of the same. As President Obama said this week: The status quo is unsustainable.

Some opponents want to slow this down because they know if they slow it down they can kill it. We cannot let that happen. The stakes are way too high.

The anguish out there, as you know in Oregon, as I see in Rhode Island, as all our colleagues see across the country, is real and it is everywhere. At last we can do something about it. Now is the time. This is the moment. Let us make this work. Let us, together, find a way to make this work.

I yield the floor.

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

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

Mr. ROBERTS. I ask unanimous consent I may proceed as if in morning business for approximately 15 minutes.

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

Mr. ROBERTS. Mr. President, and to all present in terms of staff, this is Friday, and here we are at 1:25. I apologize to the doorkeepers, I apologize to the elevator operators, I don't want to keep you here for a long time, so I will quit apologizing, but there have been some things happening with regard to health care.

The distinguished Senator from Rhode Island indicated the need to move forward on health care. Everybody agrees to that. The pace of it, what is going on, is a real concern, so I do have some remarks to make. I will try to make this as quickly and succinctly as possible so everybody can go about their business. I see smiles from the pages, in regards if I can just hurry up and get through my comments.

Yesterday, in the HELP Committee's markup of the Kennedy-Dodd health care reform bill, we had a very good discussion about the proper use and the objectives of something called government-conducted comparative effectiveness research.

I know that is getting into the weeds in regard to health care language and health care acronyms. It is called CER; remember that term, ''CER.'' It is going to be around for a long time because it has become quite controversial in regard to our health care discussion and what eventually passes. CER is research that compares the relative outcomes of two medical treatments for the same condition to determine which one is better. That is a good thing. It is a good thing to disseminate and to inform doctors and everybody in the health care delivery system—nurses, health care providers, pharmacists, et cetera—it is a good thing. But the first problem with CER is that not every patient is the same. What is better for one patient may not be better, or could actually be worse, for another. For this reason doctors and patients must be able to deviate from the results of something called CER, or a master plan or a master evaluation that could come out of Washington from an outfit called CMS, under the Department of Health and Human Services.

The situation is patients must be able to deviate from the results and make treatment decisions on a case-by-case individualized basis. That is what we all want in terms of our treatment with our doctors.

The other major problem, I submit, is that CER has been used by other governments, such as the United Kingdom, to base treatment decisions not just on relative effectiveness but on relative cost. There is the rub. If CER is going to inform doctors and everybody in the medical community that this kind of treatment or this kind of best practice is the arena in which you should operate or pasture you should operate in, that is OK. But if it is used to control costs as opposed to care, then we have a problem.

By giving priority to the relative costs of the treatments being compared, the government can deny access to health care based on what I would call pseudoscience, under the guise of CER. That brings me back to yesterday's discussion on CER on the health care markup. The Kennedy-Dodd bill includes a section that establishes a new Center for Health Outcomes Research and Evaluation. This outfit is to conduct and support comparative effectiveness research.

Section 219(h)(1)—if that isn't getting into the weeds, I don't know what is—includes the following language relating to the practical effect of CER, or comparative effectiveness research. That would, again, be conducted by the center.

> Center reports and recommendations shall not be construed as mandates for payment, coverage and treatment.

That language was in there to get at this problem for those of us who worry that CER will be used by CMS—that is another acronym. That is the outfit that runs Medicaid and Medicare, in terms of services. These are the people who count the beans, these are the people who want to turn the red beans into black beans. These are the people into cost containment. These are the people who many times drive board members in small hospitals crazy.

At any rate, to take away the worry, that language was put in there: Senate reports and recommendations shall not be construed as mandates for payments, coverage and treatment. They thought that was enough to protect us in regard to CER dictating medical care and stepping in between you and your doctor.

Let's go back to those words ''shall not be construed as mandates.'' What does that mean? ''Mandate'' means to force, compel, bind. This language says the CER shall not be interpreted as forcing CMS, Veterans' Administration or the Department of Defense to restrict payments to doctors based on its results.

Senator MIKULSKI and I and Dr. COBURN as well had a very lively discussion about the intent of this language. Senator MIKULSKI said the intent of the language was to keep the right to make treatment decisions with the doctor and the patient, not with the government. I certainly agree with that.

Senator MIKULSKI has worked long and hard on this bill, and I respect her for that. She is a good colleague and a good friend. I agree with this intent.

But as I pointed out to the Senator, the language in the Kennedy-Dodd bill does not accomplish our common intent of saying the government is not mandated or forced to use the results of this comparative effectiveness research to make payment decisions. Whether you are paid or not in regard to Medicare or, for that matter, Medicaid is not the same thing as prohibiting or preventing CMS from doing so.

In order to vigorously protect the rights of patients and doctors to make treatment decisions against the danger that the government will interfere in that process, I believe the bill must prohibit the government from using the results of CER in making payment, coverage, or treatment decisions. Sorry, you cannot have that, you have got to have this treatment, because it is a best medicine practice, regardless of the fact that maybe you and your doctor have had that treatment before and the doctor thinks that treatment is the best treatment for you.

I offered new language, and the new language would have placed a clear, bright-line firewall between the conduct of CER—which, by the way, I think is essential to advancing medical science; it is a good thing—and the use of its results to restrict your doctor from using his or her best judgment when treating you.

My language, which I further modified at the suggestion of Senator MIKULSKI, read: ''Center reports and recommendations are prohibited from being used by any government entity for payment, coverage, or treatment decisions.''

Senator MIKULSKI agreed to consider my suggestion over last night, along with Senator DODD. I appreciate that. But today when the HELP Committee reconvened in our markup, Senator MIKULSKI and the majority refused to accept my language and offered counter-language that would basically put us back to square one and, in my view, would do nothing to protect patients and doctors from CMS or any other government agency interfering in their treatment decisions.

When I asked why my language was unacceptable, which I thought was acceptable for everybody when we left yesterday, I was told that the decision

to say my language was not acceptable was based on concerns by ''Washington policy experts.''

I said: Who is that? Which Washington policy expert said my language was not acceptable?

When pressed on which policy experts, we learned that the directive came straight down from the White House. Why would the White House be so concerned about prohibiting the Federal Government from using CER to restrict payments to doctors or to direct doctors to follow specific treatment orders? Why would the White House do this on this in-the-weeds proposal, which is not an in-the-weeds proposal at all, it is about what the government is going to do or tell doctors and patients what they can expect.

It is clear from statements made by this administration that they see CER as the golden ring for cost containment. The President said when asked, how on Earth are you going to pay for the health care bill, We are going to cut Medicare payments.

How are you going to do that?

Well, if you have a CER golden ring that comes down from CMS or the National Institutes of Health for cost containment, you can see: This research says that you should follow these practices, not those practices and those practices, or, these practices would certainly cost less.

I do not think that is a good thing. From OMB Director Peter Orszag, to the NIH Director, going on to the National Economic Council Director, Larry Summers, and indications from our new Secretary of Health and Human Services, Kathleen Sebelius, a good friend, former Governor of Kansas, all have pointed to the huge potential of CER to be used to contain costs, not to recommend procedures best for patients and the doctors as determined by the patient and the doctor, but by CER to control costs.

That is why the White House does not want to prohibit CMS or any government agency from using the results of CER to deny you and your doctor the right to choose the treatment that is best for you.

After all of that was said and done, and a lot was said and not much done, I got quite a lecture this morning in regard to my use of the word ''rationing'' to describe what this could lead to. This lecture was referred to as a scare tactic. They indicated that I was using the word ''rationing'' out there as a scare tactic to scare people to say we do not want health care reform.

I find that rather condescending. I find that demeaning. And it is certainly not accurate. You tell me, when Medicare refuses to pay your doctor if he or she decides you need a particular course of treatment that deviates from the government standard, what would you call it? I would call it rationing.

That is the danger. It is not a scare tactic. Health care rationing is happening right now in this country. We may not have explicit rationing such as in the United Kingdom where the government refuses to give elderly people drugs to treat their macular degeneration until they have already gone blind in one eye—not making that up—or refuses kidney cancer drugs for terminal patients because it is not worth the money to extend their life by 6 months. That is rationing.

But we do have de facto rationing, because Medicare and Medicaid refuse to pay doctors anything close to what their costs are. By the way, it's the same thing for pharmacists, the same thing for home health care, and for all of the providers who provide our health care treatment. This means those doctors cannot afford to take Medicare and Medicaid patients—they make the decision then—and it means that those individuals do not have access to care. That is rationing I am talking about.

I am talking about a doctor who makes a decision: I am only getting paid about 70 cents in terms of the dollar in regard to my cost in regard to Medicare patients. I have to hire extra people to keep up with paperwork and regulations. Those people do not exist in the rural health care system. We have to try to find them. So it is a lot easier if I drop the Medicare Program.

That comes as a sudden jolt and a sudden decision that is not fair in regard to the patients who were being treated by that doctor in terms of Medicare. That is what we call rationing right now in regard to the United States of America.

We know the administration wants to use CER to contain costs. We know CMS has a history of denying full payment based on cost. I am not going to take the time on the Senate floor right now to go into all of the problems that CMS has posed for the health care delivery system. Again, these are folks who have a difficult task. They are trying to change the red beans into black beans so that health care does not cost so much. But in terms of their decisions here in Washington in regard to what care is going to be paid for and what is not, they are an absolute nightmare to every hospital administrator, every hospital board member in the 350 or so hospitals I have in Kansas, and the 83 critical access hospitals I have in Kansas.

We do not have a very good relationship with CMS. What we have is a meaningful dialog, most of the time, when yet another regulation comes down the pike to contain cost, most of which the doctors have never heard of, not to mention everybody else in the health care delivery system. I can go into quite a rant, as you can expect from my comments in regard to CMS and what they do and what they do not do.

Why is the majority, why are the Democrats, resisting any language to protect patients and their doctors, you and your doctor, and your right to make the right treatment decision for you? Why are they trying to muzzle my warnings that this could lead to the rationing of health care? It boils down to the fact that they do not want the American people to know what their true plans could actually be. That is why they are shoving this massive health care reform bill through Congress at warp speed, having markups before we even have complete language or cost estimates.

We heard from the distinguished Senator from Rhode Island about the need for health care reform, and the fact that he was complaining about over 100 amendments in the HELP Committee. My goodness. Almost every major bill I have been associated with, you have literally hundreds of amendments. Many fall by the wayside, many are withdrawn. We have dealt with 17, 18 of them as of today.

Senator MIKULSKI and Senator DODD did a very good job in that respect, along with our ranking member, Senator ENZI from Wyoming. But it would be helpful, if we are going to move forward with the health care reform, if we had the bill. We do not have the bill in the HELP Committee. We have one section of the bill, and then we have a Congressional Budget Office score on one-sixth of the bill that is $1 trillion. And, boy, did that shock everybody. Say $1 trillion for one-sixth of the bill. What is the whole bill going to cost? That estimate is somewhere in the neighborhood of $4 trillion. How on Earth are you going to pay, in the Finance Committee, the pay-for committee, $4 trillion for health care reform, and take it out of the health care delivery system?

I do not think you can do it. But we do not know, because we have not seen the legislation. We are being asked to go on a deadline schedule to produce amendments on things such as CER that worry people in regard to possible rationing by a date certain or a time certain, and we have not even seen the bill we are amending.

I have never been through a situation like that. Not to mention the specific cost estimates by CBO. This is not right. That is why Chairman BAUCUS in the Finance Committee had at least the good sense to postpone the markup of his bill until we could work this out. That is why slowing down does not necessarily mean that everybody is opposed to health care reform. It means we ought to get it right.

We at least ought to have a bill to read, to know what we are dealing with. I think it is because they know that if Americans knew what they were doing, they would never stand for it. I think we need to get this out to the public, and the public will hopefully fully understand it. I am not going to allow this. Personally, I am going to continue to shout it from the rooftops and beware of what lurks under the banner of ''reform'' to tell every doctor, every hospital administrator, every hospital board member, anybody who has anything to do with the health care delivery system, watch out in regard to CER.

It could be the golden ring of cost containment, and it could put you out of business. It could put you out of business. We have examples of CMS doing exactly that. So do not wake up one day and realize that the government has taken over your health care the same way they have taken over the banks and the auto industry. Do not let them ration your health care. Rationing is not what we need. It can be terribly counterproductive, and I hope we can do a better job in the future.

I yield the floor and 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.

The PRESIDING OFFICER. In my capacity as a Senator from the State of Oregon, I ask unanimous consent that the order for the quorum call be rescinded.

Without objection, it is so ordered.

RECESS SUBJECT TO THE CALL OF THE CHAIR

The PRESIDING OFFICER. In my capacity as a Senator from the State of Oregon, I move that the Senate stand in recess subject to the call of the Chair.

The motion was agreed to, and at 2:30 p.m. the Senate recessed subject to the call of the Chair and reassembled at 2:34 p.m., when called to order by the Presiding Officer (Mr. MERKLEY).

The PRESIDING OFFICER. In my capacity as a Senator from the State of Oregon, I suggest the absence of a quorum.

The clerk will call the roll.

The legislative clerk proceeded to call the roll.

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

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

TRAVEL PROMOTION ACT OF 2009

Mr. REID. Mr. President, we have worked several days this week trying to move forward on the tourism bill. It is an extremely important piece of legislation. It is important to every State in the Union. That is why it is so heavily bipartisan.

We have almost 50 cosponsors of this legislation. Lots of Republicans cosponsored this legislation—BOND, BROWNBACK, ENZI, GRAHAM, MARTINEZ, THUNE, WICKER, ALEXANDER, COCHRAN, ENSIGN, VITTER—and I am sure there are others. It is a bipartisan bill.

We have already wasted so much time. We had to file cloture on a motion to proceed to this heavily bipartisan bill. Once we were on the bill, I spoke to the Republican leader. We thought we had a pathway to having civility here, so the Republicans would try to help us. But, of course, we learned yesterday the GOP is still saying no; Democrats need to know when they bring bills up, we are going to extend debate as long as we can, even if we cannot win.

We said: OK. You offer—you, the Republicans—four amendments. And they did. They picked all the amendments they wanted to offer—not germane to this bill.

I said: OK. They were all involving TARP or the money that we all know about by now. So I said, and I told the Senator from Vermont, Mr. SANDERS: If the Republicans want to offer nongermane amendments, I will be happy to have you offer your amendment.

His is a fairly simple amendment. We see what is happening in the world today as it relates to oil. Again, we are seeing speculation. We know it was there before, we are seeing it again. We have a large inventory, with no reason for the price to spike. But we have those people, these commodity traders, who are rolling the dice as if they were coming to Las Vegas to roll the dice on the oil because they think the price is going to go up.

What Sanders wanted to do is basically nothing unique. He wanted to make sure the entity that is responsible for making sure there are no shenanigans being conducted by these traders, that we pass some legislation saying: You have to do better than what you have done, in effect. I am paraphrasing the picture of that legislation. It was fairly noncontroversial. But the Republicans said no. Whom are they trying to protect?

So we were generous in our offer. What was the other amendment they wanted to offer? They still had another amendment. I said: Fine, go ahead. The Senate should take hard votes. I am not concerned about my folks having to take difficult votes.

The Presiding officer knows, in the short time he has been here, that we have taken some hard votes. That is what we are elected to do. We are not elected to run from issues. To be clear, some of the amendments which my Republican colleagues wanted to include would have been votes that have nothing to do with this bill. I said: Let's do it anyway.

But the standard for a Democrat offering an amendment that is not germane, I guess, is different. You can have four. I said: We do not even need the same number of amendments. I guess what is good for us is not good for them.

I am disappointed this has not been worked out. I was going to propound an agreement which was agreed upon that would permit the process of legislating on this most important tourism bill, but I am not able to do so because we do not have a Republican here to object. I certainly am not going to take advantage of anyone because no one is here to object.

But I do want the RECORD to reflect that the majority is ready to move forward with amendments now or Monday. I hope that on Monday, when our managers are here, Senators DORGAN and MARTINEZ, we may still be able to reach an agreement to begin the process of working through this legislation. If we cannot, we are going to vote at 5:30 on Monday on cloture on this bill.

A decision is going to have to be made. I have not tried to jam anybody. We have not tried to jam anybody. We have been as reasonable as anybody can be. But we are going to have to make a decision on this legislation.

The State of Oregon, the home of the Presiding Officer, a couple years ago I took my family to Oregon. Every summer we take all 5 children and all 16 grandchildren and try to go someplace. We went to Oregon. We rented a home on the beautiful coast that was stark. For 8 days the Sun did not shine. But I loved it. Being from the desert, I loved that rain a little bit. It was wonderful.

I would love to go back. There were so many things to do around there. We drove 20 miles to see a waterfall. The water fell some 300 or 400 feet. It was not a lot of falling, but it dropped a long way.

The only point I am making is there is so much for people to see. Years ago, UNLV had a great basketball team. Yours was good, but theirs was great—the Tarkanian years. So I flew into Portland with my wife. We drove over to the coast, down the coast, and went to—I think it was called Salem, the University of Oregon, I think, or Oregon State, whatever university it was where they had this tournament.

I watched UNLV play. The reason I mention it, driving down that coast was so beautiful. But every State, every State I have ever been to—I have been to most of them. I think I have been to all of them—have beautiful things for people to come and see. That is what this legislation is all about.

The No. 1, 2 or 3 most important driver of the economy in every State is tourism, every State. It is the same in Oregon, where unemployment now is over 12 percent. We can get more people to come to Oregon or Nevada. It would be tremendous for those economies. That is what this legislation does. It sets up a public-private partnership in the model, frankly, of what the Las Vegas Convention Center did, which has been so successful. That is what this legislation is all about.

It is bipartisan legislation. Because we could not work anything on amendments, I hope we will get cloture on this bill. But whether we do or not, I am happy to work with my Republican colleagues to move forward on this.

CONCLUSION OF MORNING BUSINESS

Mr. REID. Mr. President, I ask unanimous consent that we close morning business.

The PRESIDING OFFICER. Without objection, it is so ordered. Morning business is closed.