when they got their insurance. There would be no copays for preventive care, all the kinds of things that Richard talks about that were lacking in his health care plan when he had insurance are dealt with and will simply not happen in the health insurance bill passed out of our committee.

Next is Marcia from Cuyahoga County, which is Cleveland. Cleveland has become a center for alternative energy in our State. In the next couple years, there will likely be a field of wind turbines in Lake Erie, the first time that has been done anywhere in the world in freshwater. There are a lot of things going on in Cleveland that work for our State and country.

Marcia writes:

I am a 56 year old continuously insured professional female, but currently unemployed.

Since my last job, each year my health insurance has skyrocketed.

With each of these premium increases, the coverage decreases, while co-pays and more deductibles go higher and higher.

It is a slippery slope.

Last year my health insurance had a triple increase in three months, which is equal to almost 1 week of my extended unemployment.

I was on a COBRA for 18 months. Then I had to find my own private health insurance.

That allows one to buy insurance after they lose their job. But they have to pay their own premiums and they have to pay their employer premium which very few people can afford once they have lost their jobs.

Marcia continues:

I applied to 5 companies and was rejected by 4 of them.

One rejection occurred before I even filled out the application.

The application forms are so complex and time consuming to recount one's entire life's medical care.

The one company that accepted me charged a 50 percent markup due to my prior conditions. Note, I had no major diseases but a few treated conditions.

I now realize that anyone with an illness is uninsurable.

One of the most important things to realize about this health insurance legislation is not just that it provides insurance for those who are uninsured or that it will assist those who are underinsured get better insurance. It also helps those who now have insurance. It allows them to keep the insurance they have, if they are satisfied. It also says we will have consumer protections built in so insurance companies no longer are allowed to deny you care because of preexisting conditions or allowed to game the community rating system, no longer allowed to deny care for a whole host of reasons that insurance companies do now. These consumer protections will help people who are newly insured and people who are now underinsured, as we provide more insurance, and it will help those people—these consumer protections will be built into existing insurance policies that people have today—who are generally satisfied with their insurance. They are satisfied now until they have a major claim where the insurance companies might discontinue their care and might cut them off. Under our plan, the insurance companies would not be able to do that.

My last letter is from Justin from Cincinnati. That is in southwest Ohio along the Ohio River.

Justin writes:

I am a 25-year-old software tester with a wife and two daughters that rely on my income.

I've seen my health insurance costs more than double over the last year.

This is more than my mortgage, and it is absolutely crippling.

I've been living on advances trying to make ends meet.

Please fight for me; all I can do is plead and hope that you listen.

If that doesn't remind us how important this work on providing health insurance reform is to the people of this Nation.

Justin continues:

It drives me crazy that I pay so much a month to a company that takes my money and then uses it to try to defeat legislation that will help ease my financial burden.

He has read in the paper or seen on the Internet or heard on the radio or watched on channel 9 or channel 12, he has heard about lobbyists spending $1 million a day to lobby the House and the Senate, pharmaceutical company lobbyists, health insurance lobbyists, to weaken this bill. He resents that he is paying these companies for his insurance and prescription drugs to pay the lobbyists to lobby Congress to weaken what we ought to be doing right for Justin and so many others.

Justin concludes:

Please take a stand for me and Americans that say we need a public option. This is literally a matter of life and death for many people.

It can't fail this time, we can't afford for it to.

Justin referred to the public option. There have been a lot of things said about the public option, most of them not true. The public option is a program that will be a government option, a government insurance policy, a choice provided by the Federal Government giving people the option. You can choose Aetna, a mutual company such as Medical Mutual in Ohio or Blue Cross or you can choose to go on the public option. The public option will have lower administrative costs. The public option will keep the insurance companies honest because we know what insurance companies do when they discontinue care, when they discriminate against people because of preexisting conditions. The public option also will save money because of competition. The public option simply makes sense.

I support strongly a public option. Senator WHITEHOUSE and I wrote the public option in the HELP Committee bill that passed. We wrote that public option because we believe in good old-fashioned American competition. I want the insurance companies to compete. I want the public option to compete. We are going to get a better public option because of private competition, and we will get better private insurance because of public option competition. It is as simple as that. It is not a big government program. It simply says: Let's inject competition into the system so we get better health insurance.

There are a lot of accusations and untruths thrown around by opponents, the same people who tried to stop the creation of Medicare years ago and the same people who tried to privatize Medicare a few years ago. We know this bill protects what works and will fix what is wrong. We will all be better off as a result.

I yield the floor and 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. 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.

MORNING BUSINESS

Mr. BROWN. 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.

Mr. KYL. Mr. President, I ask unanimous consent that an article by Martin Feldstein, ''Obama's Plan Isn't the Answer'' printed in the Washington Post, Tuesday, July 28, 2009, printed in the RECORD.

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

[From the Washington Post, July 28, 2009]

OBAMA'S PLAN ISN'T THE ANSWER

(By Martin Feldstein)

For the 85 percent of Americans who already have health insurance, the Obama health plan is bad news. It means higher taxes, less health care and no protection if they lose their current insurance because of unemployment or early retirement.

President Obama's primary goal is to extend formal health insurance to those low-income individuals who are currently uninsured despite the nearly $300-billion-a-year Medicaid program. Doing so the Obama way would cost more than $1 trillion over the next 10 years. There surely must be better and less costly ways to improve the health and health care of that low-income group.

Although the president claims he can finance the enormous increase in costs by raising taxes only on high-income individuals, tax experts know that this won't work. Experience shows that raising the top income-tax rate from 35 percent today to more than 45 percent—the effect of adding the proposed health surcharge to the increase resulting from letting the Bush tax cuts expire for high-income taxpayers—would change the behavior of high-income individuals in ways that would shrink their taxable incomes and therefore produce less revenue. The result would be larger deficits and higher taxes on the middle class. Because of the

unprecedented deficits forecast for the next decade, this is definitely not a time to start a major new spending program.

A second key goal of the Obama health plan is to slow the growth of health-care spending. The president's budget calls explicitly for cutting Medicare to help pay for the expanded benefits for low-income individuals. But the administration's goal is bigger than that. It is to cut dramatically the amount of health care that we all consume.

A recent report by the White House Council of Economic Advisers claims that the government can cut the projected level of health spending by 15 percent over the next decade and by 30 percent over the next 20 years. Although the reduced spending would result from fewer services rather than lower payments to providers, we are told that this can be done without lowering the quality of care or diminishing our health. I don't believe it.

To support their claim that costs can be radically reduced without adverse effects, the health planners point to the fact that about half of all hospital costs are for patients in the last year of life. I don't find that persuasive. Do doctors really know which of their very ill patients will benefit from expensive care and which will die regardless of the care they receive? In a world of uncertainty, many of us will want to hope that care will help.

We are also often told that patients in Minnesota receive many fewer dollars of care per capita than patients in New York and California without adverse health effects. When I hear that, I wonder whether we should cut back on care, as these experts advocate, move to Minnesota, or wish we had the genetic stock of Minnesotans.

The administration's health planners believe that the new ''cost effectiveness research'' will allow officials to eliminate wasteful spending by defining the ''appropriate'' care that will be paid for by the government and by private insurance. Such a constrained, one-size-fits-all form of medicine may be necessary in some European health programs in which the government pays all the bills. But Americans have shown that we prefer to retain a diversity of options and the ability to choose among doctors, hospitals and standards of care.

At a time when medical science offers the hope of major improvements in the treatment of a wide range of dread diseases, should Washington be limiting the available care and, in the process, discouraging medical researchers from developing new procedures and products? Although health care is much more expensive than it was 30 years ago, who today would settle for the health care of the 1970s?

Obama has said that he would favor a British-style ''single payer'' system in which the government owns the hospitals and the doctors are salaried but that he recognizes that such a shift would be too disruptive to the health-care industry. The Obama plan to have a government insurance provider that can undercut the premiums charged by private insurers would undoubtedly speed the arrival of such a single-payer plan. It is hard to think of any other reason for the administration to want a government insurer when there is already a very competitive private insurance market that could be made more so by removing government restrictions on interstate competition.

There is much that can be done to improve our health-care system, but the Obama plan is not the way to do it. One helpful change that could be made right away is fixing the COBRA system so that middle-income households that lose their insurance because of early retirement or a permanent layoff are not deterred by the cost of continuing their previous coverage.

Now that congressional leaders have made it clear that Obama will not see health legislation until at least the end of the year, the president should look beyond health policy and turn his attention to the problems that are impeding our economic recovery.

FURTHER CHANGES TO S. CON. RES. 13

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 June 25, 2009, the Senate Appropriations Committee reported H.R. 2847, the Commerce, Justice, Science, and Related Agencies Appropriations Act, 2010, with an amendment in the nature of a substitute. The reported legislation contains $126 million in funding that has been designated for overseas deployments and other activities pursuant to section 401(c)(4). The Congressional Budget Office estimates that the $126 million in budget authority will result in $104 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), $379 million has been designated so far for overseas deployments and other activities for 2010.

In addition, section 401(c)(2)(B) of the 2010 budget resolution permits the chairman 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 year 2010 that both appropriates $7.1 billion and provides an additional appropriation of up to $890 million to the Internal Revenue Service for enhanced tax enforcement to address the tax gap, the difference between the amount of taxes owed and the amount of taxes paid.

On July 9, 2009, the Senate Appropriations Committee reported S. 1432, the financial services and general government appropriations Bill, 2010. The reported bill contains $890 million in funding that satisfies the conditions of section 401(c)(2)(B). The Congressional Budget Office estimates that the $890 million in budget authority will result in $837 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 combining the effects of the two adjustments, I am revising today both the discretionary spending limits and the allocation to the Senate Committee on Appropriations by a total of $1,016 million for budget authority and $941 million for outlays.

I ask unanimous consent to have the following revisions to S. Con. Res. 13 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 SECTIONS 401(c)(4) AND 401(c)(2)(B) 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	1,086,269	1,016	1,087,285
FY 2010 Discretionary Outlays	1,306,259	941	1,307,200

WASP CONGRESSIONAL GOLD MEDAL

Mr. DODD. Mr. President, as chairman of the Committee on Banking, Housing, and Urban Affairs, it is the responsibility of my committee colleagues and I to oversee and consider legislation to award Congressional Gold Medals to prospective candidates deemed worthy of the honor. Indeed, it is the highest honor that Congress can bestow on an individual or group, and as such, my committee has to ensure that these bills garner broad bipartisan support in the form of two-thirds cosponsorship in the Senate before they can receive full consideration. This year, I am pleased that a bill to award a Congressional Gold Medal to the Women Airforce Service Pilots, or