

to become the fine Senator he is. He is filling that role now as chairman of the Foreign Relations Committee. He has worked so hard on doing something on a bipartisan basis to move forward on this most important legislation. With what he has done in reaching out to Republicans—I say that in the plural—we have had one brave Republican step forward to work with him, LINDSEY GRAHAM. I first saw LINDSEY GRAHAM in action when we had the impeachment trial of President Clinton. He was one of the impeachment officers from the House. He was very good. I learned at that time what an outstanding trial lawyer he had been in South Carolina. I recognized that from the presentation he made right in the well of this Senate.

As we learned with the work we completed dealing with unemployment insurance, net operating loss, first-time home buyers, it only takes one person to break from the pack, for lack of a better description, to develop bipartisanship. That was done along with Senator ISAKSON from Georgia. On this most important issue dealing with climate change, it is LINDSEY GRAHAM from South Carolina. He is bravely stepping forward.

What Senators KERRY and GRAHAM have done is quite remarkable. They have reached out to the coal interests. We have a number of coal Senators who have said: No way will we ever agree to anything, and they are working toward having them as part of the agreement. Nuclear power, which when this all started, I think it is fair to say, people on this side of the aisle wanted no part of that—most people on this side. Now that will be part of the mix. The production of oil in our country—people say, does that mean you have given up on all these great things we believe in? Legislation is the art of compromise. We need to have legislation that is bipartisan. I believe what LINDSEY GRAHAM and JOHN KERRY have done will allow us to move forward on this legislation. It is important that we do things on a bipartisan basis.

I compliment and applaud and recognize the good work these two brave men are doing in setting an example for the rest of us in moving forward on legislation that will be dramatic not only for our country but for the world.

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#### RECOGNITION OF THE MINORITY LEADER

The ACTING PRESIDENT pro tempore. The minority leader is recognized.

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#### HEALTH CARE REFORM

Mr. McCONNELL. Mr. President, the last 2 years haven't been easy ones for the American people. Millions have lost jobs and homes, and many have had the bitter experience of watching years of savings disappear. Unemployment stands at a 25-year high, and in many States it is worse. Just to take

one example, in Kentucky unemployment rose in all 120 counties from June 2008 to June 2009. A lot of Americans are hurting. A lot of them have been struggling for a long time. And despite the occasional piece of good news, the situation doesn't seem to be getting a whole lot better for most people.

This is the situation now, and this was the situation when the White House announced its plan to undertake health care reform. Throughout this debate, the need to do something about the economy has never been far from our minds.

Indeed, from the very outset of this debate, the administration has rested its case for reform on the need to do something about the economy. The economy was in bad shape, the argument went. And reforming health care would make it better.

All of us agree that health care costs are unsustainably high, and alleviating the burden of these costs on American families and businesses is something we should work together to do. But somewhere along the way, the administration got off track. The original purpose of reform was obscured. And now we are hearing from one independent analysis after another that a bill which was meant to alleviate economic burdens will actually make these burdens worse. And the most significant finding is this: A reform that was meant to lower costs will actually drive them up.

Americans are scratching their heads about all this, and rightly so. Business owners can't believe a reform that was meant to help them survive will end up costing them more in higher taxes. Seniors can't believe a bill that was meant to improve their care will lead to nearly half a trillion dollars in cuts to their Medicare. And families can't believe that they are going to have to pay higher health care premiums and taxes at a time when so many of them are already struggling to make ends meet.

Higher taxes, higher premiums, cuts to Medicare. These are three of the major blows this legislation would deal to the American people. And any one of them would be bad enough on its own. But let's just look at one of the unexpected consequences of the Democrat health care plan for a moment—let's look at the tax hikes.

The Senate bill we've seen targets individuals and businesses with a raft of new taxes, fees, and penalties. It imposes a 40-percent tax on high value insurance plans for individuals and families. It imposes billions in fees on health plans that will inevitably be passed along to consumers. It imposes fees on the costs of medical devices and life-saving drugs, fees that would be paid by consumers.

Millions of taxpayers managing chronic conditions and facing extraordinary medical expenses will be faced with even higher out of pocket costs because the bill makes it more difficult to deduct these expenses. And small

businesses with as few as 50 employees would be required to buy insurance for all workers whether they could afford it or not, or pay a substantial tax for each of them.

Taken together, the health care plan we have seen would impose roughly half a trillion dollars in new taxes, fees, and penalties at a time when Americans are already struggling to dig themselves out of a recession. What's worse, an independent analysis by the Joint Committee on Taxation suggests that nearly 80 percent of the burden would fall on middle-class Americans.

So a reform that was meant to make life easier is now expected to make life harder. If you have insurance, you get taxed. If you don't have insurance, you get taxed. If you're a struggling business owner who can't afford insurance for your employees, you get taxed. If you use medical devices, you get taxed.

This is not the reform Americans were asking for, Mr. President. And that's precisely why more Americans now oppose this health care plan than support it.

The administration didn't listen to the American people when it put this plan together, but it can listen now, and the message it is going to hear is this: Put away the plan to raise premiums, raise taxes, and cut Medicare. Get back to the drawing board and come up with a commonsense, step-by-step set of reforms. That is what people want, and that is what they should get.

Mr. President, I yield the floor.

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#### RESERVATION OF LEADER TIME

The ACTING PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

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#### MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Under the previous order, there will now be a period of morning business for 2 hours, with Senators permitted to speak therein for up to 10 minutes each, with the time equally divided and controlled between the two leaders or their designees, with the majority controlling the first half and the Republicans controlling the final half.

The Senator from North Carolina.

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#### HEALTH CARE REFORM

Mrs. HAGAN. Mr. President, the United States spends \$2.3 trillion each year on health care—the most per capita of all industrialized nations. Yet we still have higher infant mortality and lower life expectancy than many of the other industrialized nations. Moreover, medical errors kill 100,000 patients per year and cost the system tens of billions of dollars, and \$700 billion is spent each year on treatments that do not lead to improved patient health.

Today, my freshman Senate colleagues and I are going to speak about

the need to reform our health care delivery systems. You will hear from all of us about innovative initiatives that are successfully bringing down the cost of health care and at the same time improving the quality of care.

Mr. President, I would like to yield 5 minutes to my colleague from Colorado, Senator MARK UDALL, to discuss accountable care organizations.

The ACTING PRESIDENT pro tempore. Without objection, the Senator from Colorado is recognized.

Mr. UDALL of Colorado. Mr. President, I thank my colleague from North Carolina, Senator HAGAN, for convening this important session this morning where we will talk about the urgent need to reform health care in our country.

The unsustainable growth in health care costs and lack of stable, affordable coverage for millions of Americans continue to jeopardize not only our Nation's fiscal well-being but also the physical well-being of our families and neighbors. One of the key ways we can help put our health care system and our economy on the right track is by encouraging value in the delivery of health care.

I have cited these numbers before—I know many of us have—but I want to emphasize them again. As a nation, we spend over \$2 trillion per year on health care—that is nearly one-fifth of our economy. Yet between 30 and 50 percent of these dollars are not contributing to better patient health. That is not a good deal for the American people.

Health reform is designed to address this staggering amount of waste in a number of ways. One way is to encourage providers to focus on the quality of care they provide and not just on the volume. And we can start with Medicare.

I think the American people would agree that taxpayer dollars are better spent rewarding doctors for keeping patients healthy and not for performing more tests or more procedures. Health reform legislation can move us in this direction through the development of what are known as accountable care organizations, or ACOs. These organizations would encourage groups of health care professionals to team up and provide more coordinated, streamlined care to Medicare patients. The idea is to have these ACOs take responsibility for improving patient care while lowering cost and then sharing the savings that accrue. Research indicates that this idea of shared savings would help eliminate waste and spur changes in our health care delivery system to emphasize patient outcomes and value.

The idea for ACOs no doubt came from the great work being done by a patchwork of physician groups. Groups such as the Physician Health Partners, or PHP, in my home State of Colorado, and others across the country focused on care coordination and quality.

For example, PHP has seen great success in improving care for kids suf-

fering from asthma—the No. 1 cause of child hospitalization and school absence. They developed treatment guidelines and promoted collaboration among doctors, the Children's Hospital in Denver, and the Colorado Allergy and Asthma Centers. As a result, they have reduced emergency room visits and improved families' ability to manage asthma on their own.

PHP also has the Practice Health Project. This comprehensive effort brings doctors together to share best practices and encourage the adoption of commonsense guidelines to improve quality and efficiency. The goal of this team effort is to raise the standard and value of care and allow these physician groups to act as a model for Denver's physician community as a whole.

I would also like to tout the PHP's Transitions of Care Program in collaboration with Denver's St. Anthony Hospital and other local care providers. The program dispatches nurse coaches to help Medicare patients make the transition from the hospital to their homes. The period immediately following a hospital stay is a very confusing time, particularly for our seniors. Having someone help with this transition is crucial. PHP has had tremendous early success with this program, showing the potential to reduce costly hospital readmissions by 40 to 50 percent. At the same time, this program keeps patients healthy and it saves money.

The successes of groups such as Physician Health Partners demonstrate that we already have the will and the know-how to change our system for the better. But under our existing system there is no incentive for programs like PHP to even exist. Under the status quo, a hospital stands to lose money if it decreases its admission rates. Primary care doctors would be at a financial disadvantage if they spent time in the development and implementation of effective treatment plans for their asthmatic patients.

This is why health reform includes commonsense proposals such as encouraging groups such as Physician Health Partners to form accountable care organizations and paying them to coordinate care for Medicare patients. Promoting ACOs and other creative pro-consumer ideas will increase quality for patients and value for the taxpayer.

Only by reshaping the way we do business in our health care system can we truly change health care delivery in our country. I look forward to working with my colleagues here today and other Senators in the coming weeks to promote the many ways we can accomplish that goal.

I thank Senator HAGAN, and I yield the floor.

Mrs. HAGAN. I thank Senator UDALL. Accountable care organizations are extremely important in health care reform.

Mr. President, I would like to yield 5 minutes to my colleague from Dela-

ware, Senator TED KAUFMAN, to discuss Delaware's health information network.

The ACTING PRESIDENT pro tempore. The Senator from Delaware.

Mr. KAUFMAN. First, Mr. President, I want to thank Senator HAGAN not just for putting this on but for her leadership all along on health care reform, and I look forward to working with her because of her great leadership. I appreciate the opportunity to join my colleagues on the floor to highlight health care innovations in our home States that can serve as models for national reform.

Delaware is a national leader in health care IT—information technology—and I want to take a couple of minutes this morning to talk about a truly innovative approach to health care record keeping in my State. It is called the Delaware Health Information Network.

The Delaware Health Information Network, which we call DHIN, was authorized 12 years ago and went live in 2007, becoming the first operational statewide health information exchange. A public-private partnership of physicians, hospitals, laboratories, community organizations, and patients, the DHIN provides for the fast, secure, and reliable exchange of health information among the State's many medical providers. As a result of its early success, the DHIN was one of the nine initial health information exchanges selected to participate in the U.S. Department of Health and Human Services' national health information network trial implementations. Among those nine, it was the first State to successfully establish a connection with the trial.

Right now, more than 50 percent of all providers in the State—nearly 1,300—participate in the DHIN. More than 85 percent of all lab tests are entered into the network, and 81 percent of all hospitalizations are captured by the exchange. As of June of this year, the DHIN held over 648,000 patient records, and it conducts 40 million transactions a year.

Participating providers have a choice of three options to receive lab, pathology, and radiology reports, as well as admission face sheets: they can have them sent directly into a secure in-box, similar to an e-mail account, they can have them faxed to their office, or they can get the results from an electronic medical records interface on the Web. All three provide information in a timely manner that protects the privacy of the patient.

Our State of Delaware receives four very tangible benefits from DHIN, and these are listed on this chart.

First, the DHIN provides a communication system between providers and organizations—something that did not exist previously. Individual physician offices can now easily discover if hospitals, such as Christiana, Bayhealth, and Beebe Medical Center, have admitted their patients. Doctors and hospitals can also get lab results back

from the State's clinical laboratories in a timely manner.

Second, the information exchanged electronically through DHIN helps improve the quality of care being delivered in the State. When providers have access to better, faster information at the time and place of care, either in a doctor's office or an emergency room, those providers can make better decisions and reduce the chance of medical errors. Knowing what medications a patient is on or what coexisting conditions a patient may have can give the provider more complete information when delivering care, reducing the chance of an adverse outcome.

Third, the DHIN can help reduce the cost of care within the health care system. That is what we are all looking for out of health care reform—cost reduction. With nearly 650,000 patient records in the system, providers can know what tests and procedures have already been ordered, cutting out inadvertent test duplication. In addition, the DHIN can help improve disease management by allowing multiple providers treating a person to communicate and better align the treatments and prescriptions for a particular patient.

Finally, No. 4, the DHIN can enhance privacy within the medical health care system. The DHIN is a secure system that can only be accessed by participating providers and organizations. It contains access controls, regulating who can use the network, and it contains audit requirements to ensure there are no breaches in patient privacy.

While the DHIN is still growing, it has already helped the patient care delivery system in Delaware. As it moves to include all providers in the State and works with other States' information exchanges to share ideas and successes, the DHIN will help lead our country to a widespread adoption of health information technology.

The stimulus act contained \$19 billion to promote the adoption of health IT nationwide, and the health reform effort promises to build on this momentum with even more resources. I believe it is essential that health reform boost the integration of information technology such as that provided by the DHIN throughout the health care system.

As I have said many times, it is time to gather our collective will and do the right thing during this historic opportunity by passing health care reform. We must include incentives to expand the utilization of health information technology. We can do no less. The American people deserve no less.

Mrs. HAGAN. I thank Senator KAUFMAN. A health information network is critical to improving patient care and reducing health care costs.

Now I would like to yield 5 minutes to my colleague from Alaska, Senator MARK BEGICH, to discuss customer-driven care.

The ACTING PRESIDENT pro tempore. Without objection, the Senator from Alaska is recognized.

Mr. BEGICH. Mr. President, I thank Senator HAGAN for allowing me time this morning. I am pleased to join my freshman colleagues to once again state our case for health insurance reform in this country. It is truly long overdue and very much needed.

I also wish to make a point. I have listened closely to the comments of my colleagues from the other side of the aisle over the last several weeks. A few weeks ago, I heard the Senator from North Carolina, Mr. BURR, talking on this floor about health reform. He acknowledged that we need to change the health delivery system, which I agree with, but then he said our Democratic ideas won't work. He said one reason is because government programs don't do enough innovation and wellness and they won't help people make the lifestyle changes needed to get true savings in the health system.

Quoting from the CONGRESSIONAL RECORD, here is what else he said:

Show me a government plan that pays for prevention, wellness, and chronic disease management, and I will quit coming to the floor and quit talking about the lack of reform.

Mr. President, I have one. I have a great example of just such a government plan that pays for all of those things, almost the whole thing, and gets incredible results. It comes from my home State, from an Alaska Native program called the Nuka Model of Care. It is based in Anchorage at the Southcentral Foundation, a nonprofit health system serving about 55,000 Alaska Natives.

The Nuka Model was developed about 10 years ago using the wisdom of Native leaders. They acted in response to what they saw as their own failing health care system. Like many other health providers in this country, the foundation recognized an alarming contradiction: As health costs continued to increase, the health status of their patients only got worse. More dollars going to health care only resulted in worse health outcomes.

So they decided to change things. From the ground up, they built a system of customer-driven health care. That is their term, not mine—"customer driven."

"Nuka" is a Native word associated with family, and that is certainly the approach. The Nuka model creates teams of health providers—doctors, nurses, medical assistants—to work with each patient. It requires doctors to listen to the patients, to really hear what customers are saying about their lifestyles, their jobs, their families, everything that affects their overall health.

It makes medical access much easier, guaranteeing that you can see your chosen provider for anything you want—same day. In person, via phone or e-mail—whatever is easier for the patient—same-day guarantee. Let me repeat that: same-day guarantee.

Here is another important point. Physician salaries are based on the team's overall performance. I want to make sure my friend, Senator BURR from North Carolina, hears this part. The Nuka model is funded almost entirely by the Federal Government—half by Indian Health Services and one-third by Medicaid or Medicare. It works, and it works very well.

This chart covers some of the most amazing results since the program started: a 50-percent drop in urgent care and emergency room visits; a 53-percent reduction in hospital admissions; a 65-percent drop in the need for expensive specialists; a childhood immunization rate of 93 percent, well above the State and national averages; much better management of diabetes with 50 percent of patients kept in the prediabetes stage instead of worsening into full diabetes; and happy customers. The overall satisfaction rate among our patients for this program is 91 percent.

The Nuka model has attracted attention from all over the world, as it should. Even as recent as last month, the former Speaker, Newt Gingrich, recognized this great program.

I am sure there are similar government-backed success stories throughout this country. I think I have made my point, and truly my remarks are not intended to single out any one Senator. But I will say this: As we debate health insurance reform in this Chamber, let's arm ourselves with the facts and with open minds. Let's not say no just because of partisan differences. Let's celebrate examples of innovation and excellence that work no matter where they come from, and let's use the successful models to extend good, quality care to millions more Americans.

I am proud of the Nuka model in Alaska, of the people who got it started a decade ago, and of the people who are making it work today.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from North Carolina.

Mrs. HAGAN. Mr. President, Senator BEGICH's comments on customer-driven care is certainly working in Alaska.

I now yield 5 minutes to my colleague from Colorado, Senator MICHAEL BENNET, for his discussion on transitional care.

The ACTING PRESIDENT pro tempore. The Senator from Colorado.

Mr. BENNET. Mr. President, I thank our colleague from North Carolina for organizing this discussion this morning and for the other freshmen here yet again, week after week, to talk about the urgent need for health care reform in this country.

My colleague, Senator UDALL from Colorado, did a wonderful job talking about the models we have of transitional care in Colorado, where we see some providers able to have merely a 3-percent readmission rate just because of the way they manage patients, patient-centered care, unlike the way we

do it all across the country, which is the reason we are at a 20-percent readmission hospital rate in the United States.

If we would put in some of these commonsense practices and worry about outcomes more and worry less about how many tests were given, in this case we could reduce the expenditure by \$18 billion annually and provide better quality care. It is just one of the many ideas that is bubbling up from States all across the country.

I wish to spend a couple minutes today talking about the absurd waste of time that is caused by our current system of insurance in the United States. We have two examples in Colorado that have recently been covered by the newspapers out there. The first is a story about gender discrimination when it comes to insurance. It is about a woman in my state, Peggy Robertson of Golden, CO, who was denied coverage because she had what was called a pre-existing condition, which was the C-section that she had when she gave birth to her son. The insurance company said they would not cover her unless she became sterilized.

Peggy came and testified about this in the committee, and her story has been repeated by many people across the State of Colorado. But it got the attention of another person in our State named Matt Temme of Castle Rock, CO, who wrote a letter to the editor that I almost could not believe when I read it.

We followed up with Matt, and it turned out that it was true. Matt was denied coverage because his wife, who is insured—she has her own insurance—was pregnant. Matt is a 40-year-old commercial pilot from Castle Rock. He was furloughed from his job at the end of June. His wife Wendy is a paralegal, and she is covered through her employer. They have a 6-year-old son.

As I mentioned a minute ago, Wendy is pregnant. It was too expensive for Matt and his son to join his wife's plan. Because he was furloughed, he went out shopping for a new plan on the individual market, which he thought would be easy. He first checked with his previous company's health insurance. He filled out all the paperwork for himself and his son. He is healthy, he is 40 years old, and he is not eligible for coverage because his wife found out she was pregnant. He told the insurance companies: My wife is already covered by another insurer.

They said to him: That is true, but if she suffers a fatality while giving birth to her child, that child is going to become a dependent of yours and therefore will be on the insurance you buy and therefore we are not going to sell it to you.

So now Matt had to go out to the market again. They have three plans. They have the plan his wife is on, already covered; they have another plan for his 6-year-old son; and now Matt is on a version of a public option that we have in Colorado called Cover Colorado.

When I read this letter, when we heard this story, when we talked with Matt, it reminded me again of all the stories that I have heard—that all of us have heard—over these many months when we have been discussing health care about all the wasted evenings and conversations and fights that people have over their telephone just to get basic insurance for their families so they can have the kind of stability all of us want to have for our kids, for our grandkids, and for our families.

That is what this insurance reform is about. It is time for us to set aside the usual politics, the special interests that always have prevented us from getting something done, and deliver reform that creates stability for working families all across our country, deliver reform that allows us to consume a smaller portion of our gross domestic product than we are today, deliver reform that allows us to begin to put this Federal Government back on a path of fiscal stability. It is high time to put this politics aside.

I know in this country we can do better than that. In the end, we will do better. Our working families and small businesses will be real beneficiaries of the reform that we pass.

I thank the Senator from North Carolina for giving me the opportunity to be here this morning. I appreciate her very important leadership on this critical issue.

I yield the floor.

Mrs. HAGAN. Mr. President, I thank Senator BENNET for his comments on transitional care and certainly the need to make sure no patients are denied insurance coverage for preexisting conditions and in particular because a wife is pregnant.

I yield 5 minutes to myself. I take this opportunity to talk about health care reform and how it will improve the delivery of health care to Americans.

One successful delivery system that health care reform will expand upon is patient-centered medical homes which were pioneered in my State of North Carolina. Since 1998, North Carolina has been implementing an enhanced medical home model of care and its Medicaid Program called Community Care of North Carolina.

Under this model, each patient has access to a primary care physician who is responsible for providing comprehensive and preventive care, working in collaboration with nurses, physician specialists, and other health care professionals.

The primary care physician is the go-to doctor and the gatekeeper of a patient's information. Within each network, patients are linked to a primary care provider to serve as a medical home that provides acute and preventive care, manages chronic illness, coordinates specialty care, and provides round-the-clock, on-call assistance. Case managers are integral members of the network and work in concert with the physicians to identify and manage care for high-cost, high-risk patients.

As of May of this year, Community Care of North Carolina was comprised of 14 networks that included more than 3,200 physicians and covered over 913,000 Medicaid patients in North Carolina, accounting for over 67 percent of the State's entire Medicaid population.

As an example of the benefits of a program such as this, consider the impact on asthma patients because patients get to see the same doctor and get more consistent, coordinated care. Physicians are able to quickly recognize a condition such as asthma and can more quickly and efficiently determine the most appropriate treatment. The support network then educates the patients and their families about the management of their disease.

Due to the increased likelihood of complications when asthma patients get the flu, it is very important that they receive the flu vaccine. Since 2004, within the Community Care of North Carolina, there has been a 112-percent increase in flu shots administered to asthma patients. More than 90 percent of patients are using the most appropriate medications.

Between 2003 and 2006, asthma-related hospitalizations were decreased by 40 percent, and emergency room visits decreased by 17 percent. That saves all of us dollars.

Community Care of North Carolina has improved patient care and saved the State money. An independent analysis by Mercer, which is a government consulting group, found that this program saved between \$150 million and \$170 million in 2006.

A University of North Carolina evaluation of asthma and diabetes patients found that it saved \$3.3 million for asthma patients and \$2.1 million for diabetic patients between 2000 and 2002.

In addition to asthma patients, diabetic patients also had fewer hospitalizations, and they visited the primary care doctors more often instead of specialists and had better health outcomes.

I would like to tell a story about how access to a medical home has helped someone in North Carolina overcome the challenges of an illness.

Donald from Charlotte has type 2 diabetes. This diabetic condition of his went untreated for a long time and, as a result, he began having ministrokes, had to cut back on his work in landscaping, and he ended up in an emergency room. He was referred to a Charlotte-based medical home program called Physicians Reach Out. He now has a primary care doctor who has helped get him on a medication regimen, returning his blood sugar to a normal level which allowed him to work full time again. His primary care physician was the key to teaching him how to manage his diabetes. Without his medical home, he said getting his condition under control would have been a "wild goose chase."

The Health, Education, Labor, and Pensions Committee included two provisions in the health care reform bill to

encourage patient-centered medical homes, such as we have in North Carolina. The Secretary of Health and Human Services will create a program to support the development of medical homes, and then the other States will apply for grants.

The bill also provides grants for physician training programs, giving priority to those who educate students in these physician training programs that are team-based approaches, including the patient-centered medical home.

I have been focused on a reform bill that prevents insurance companies from turning patients away who have a preexisting condition, that expands coverage, and ensures that if you like your insurance and your doctors, you keep them. This bill actually will reduce our deficit, and that, obviously, has been a requirement of mine all along. This bill also encourages innovation in the delivery of health care to Americans using successful programs, such as the Community Care of North Carolina and the Physicians Reach Out patient-centered medical home as a model.

Mr. President, now I wish to yield 5 minutes to my colleague from New Mexico, Senator TOM UDALL, to talk about a model of community health service delivery.

The ACTING PRESIDENT pro tempore. The Senator from New Mexico is recognized.

Mr. UDALL of New Mexico. I thank Senator HAGAN very much, and thank her for her statement today and leading us on the floor in this discussion of health care.

In my case, I want to talk a little bit about health care delivery systems.

First, let me say I know when we talk about a health care delivery system it is a little bit of a wonky term. Most Americans' eyes probably glaze over when experts, politicians, or pundits describe the problems with our health care delivery system. They don't know what it has to do with their health care experience, their doctors, or their lives.

The reality is health care delivery systems have everything to do with all of that. These delivery systems determine how Americans receive their care. They dictate how a doctor treats their patients, how long a patient must wait for treatment, how much a hospital charges for its services, and how the medical community is held accountable for its mistakes.

As we continue working to reform health care, we must take an honest look at our current health care delivery system and ask ourselves some basic questions, questions such as: Do the systems we currently use to deliver health care work? Are we, as patients, businesses, and governments, getting the best value for our health care dollar? Do these systems encourage efficient, coordinated care?

If you ask the experts on this subject, the answer you will likely get is a loud and resounding "no."

The way I look at the role of health care delivery systems is the same way I look at building a house. To build a strong, solid, safe house, you have to start with a strong, solid, safe foundation. Our health care delivery systems are the foundation for all of our efforts in health care. If that foundation is off center or cracked or built on uneven ground, it does not even matter how straight the walls are or how efficient the electrical system is, nothing is going to work right.

Right now, the vast majority of health care in America rests on shaky foundations. It is our job to rebuild these foundations before more Americans slip through the cracks. The good news is that across the country, communities are achieving success with innovative health care delivery programs. We should look at these models as we continue our work here in Washington.

There is one example I wish to highlight today. That example comes from my home State of New Mexico, from a county that makes up the boot heel of the southwestern corner. Hidalgo County is one of the most rural counties of my State, with a population of 5,000 people. Hidalgo faces the same health care delivery problems as other rural areas. There are not enough doctors. Patients must travel long distances for care and, as a result, there are higher rates of chronic diseases and health problems that require specialized treatment.

To meet these challenges, the Hidalgo County medical community had to think outside the box. What they came up with is the Hidalgo Health Commons. It uses four guiding principles in its approach to health care.

First, they acknowledge that in rural areas, chronic health conditions are worsened by limited access to health providers and are often compounded by poverty.

Second, to respond to this challenge they established a one-stop shop for medical and social services. At the clinic you can find doctors, nurses, and dentists, seek mental health treatment, fill a prescription, get Medicaid or Medicare, or apply for public assistance such as WIC.

Third, they work with the community to identify local health priorities and then align their services accordingly.

Finally, they are a source of local economic and social development by creating jobs, serving schools, and offering family support.

The health commons model has worked so well that it has grown to serve five sites across New Mexico and they are not stopping there. The new Hidalgo initiative, which is still in development, will expand on the success of the health commons. The goal is to enroll all 5,000 residents of Hidalgo County into the health services program.

Hidalgo County is just one example of the innovative work going on across

the country and it serves as a lesson to all of us that faulty foundations do not fix themselves. They require hard work and ingenuity and significant investment.

If we are going to fully transform our Nation's ailing health care system, we must first focus on the foundation. We must first reform our health care delivery systems.

Mr. President, I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from North Carolina is recognized.

Mrs. HAGAN. Mr. President, I thank Senator UDALL. His example of the community health service delivery in New Mexico is excellent.

Now I yield 5 minutes to my colleague from New Hampshire, Senator JEANNE SHAHEEN, to talk about reducing overutilization of emergency departments and reducing hospital readmissions.

The ACTING PRESIDENT pro tempore. The Senator from New Hampshire is recognized.

Mrs. SHAHEEN. Mr. President, I thank Senator HAGAN for organizing the effort today and also for her great work on the HELP Committee to develop a health care reform bill that can be supported by this body.

Once again we are here to talk about health care reform and why it is so urgently needed. We are at a critical juncture because health care costs are out of control. They are a threat to our families, our small businesses, our economy and, despite all the money we are spending on health care, we are not guaranteed better health outcomes. That means because we are spending money doesn't mean that people are healthier. The truth is, we can control costs and improve quality. We can do this by promoting effective delivery models. Senator UDALL did a great job of talking about what that term means in real language. We can promote effective delivery models that emphasize coordination and individualized care.

As I have said on a number of occasions, I am proud of the innovations that are changing health care delivery in New Hampshire, my home State. One of those that has been recognized nationally is the Dartmouth Atlas project, based in Hanover. Because of the work of the Dartmouth Atlas project, we now know that there are significant variations in the way health care resources are used and how money is spent depending on where we live.

Right now, providers are rewarded for volume rather than for value. There is a chart here that shows that very clearly. It shows the difference in spending among different regions of the country for Medicare patients. As you can see, the areas that are dark red are the most expensive, these areas. The areas that are lightest are the least expensive areas when it comes to cost per Medicare patient—from \$5,280 to \$6,600 in the lowest spending regions all the way up to \$8,600 to \$14,360 per Medicare

patient in these darkest regions of the country.

Unfortunately, the sad thing about this research is not the changes in cost, but it is the fact that because someone lives in an area where the spending is higher doesn't mean they are going to have better health outcomes. Put very simply, more costly care does not mean better care. This is a fundamental problem with our health care system. The way our health care dollars are being spent right now is analogous to a medical arms race. That is not my term, that is by Dr. Elliott Fisher, from the Atlas Project. Too often we judge the quality of our hospitals, for example, based on a new expansion wing or the latest medical device, and not on comparing the quality of care they provide.

Over the past several months, thousands of my constituents have expressed their concerns about our health care system. Last week, Dr. Jim Kelly, from Hollis, NH, was in my office sharing his concerns and frustrations. Dr. Kelly is a family physician and, like so many of our health care providers, he is dedicated to doing the best job he can for his patients. However, inefficiencies in our system often work against the best efforts of our providers.

Dr. Kelly shared one of those experiences. He talked about one of his patients who was a 73-year-old woman with diabetes who came into his office on a Friday morning with a swollen, red, and tender leg. In addition to her own illness, she is the sole caretaker for her 79-year-old husband who recently had a stroke. Dr. Kelly diagnosed her condition, a relatively common one, as cellulitis, a skin infection which required IV antibiotics. Dr. Kelly gave her the first dose in his office, but Medicare would not cover her infusion therapy at home. As a result, Dr. Kelly was forced to send her to the local emergency room to receive treatment over the weekend. As a result, she had to bring her disabled husband, whom she couldn't leave at home alone, to the emergency room. Both of them were forced to sit in the crowded ER, exposing them to more germs and using resources that could be used much more efficiently.

Unfortunately, our system does not always facilitate efficient and coordinated care. This is too often true with our most vulnerable patients.

But there are innovative projects across the country that have adapted to meet the needs of these individuals. By providing increased outreach and care coordination, one pilot program was able to reduce visits to the emergency room by almost two-thirds, after 2 years of participation.

I recently introduced the REDUCE Act, which is modeled after these successful pilots, and which I believe will change the way care is delivered to these high-risk patients with multiple chronic conditions. I think that is very important to point out.

The REDUCE Act will create demonstration projects in 10 States that are modeled off of these approaches that have been successful in places around the country. This is the type of delivery system reform that improves quality and reduces costs simultaneously.

As I have said many times, the challenge we face is great, but we have the resources and the tools we need to reform our health care system. We can do this in a fiscally responsible way. By improving the way we deliver care, we can maximize efficiency and we can improve quality. This is the type of reform all Americans deserve. This is the type of reform we are working on here in the Senate. This is the type of reform I hope our colleagues will all support.

I thank Senator HAGAN and I yield my time back to her.

The ACTING PRESIDENT pro tempore. The Senator from North Carolina

Mrs. HAGAN. Mr. President, I thank my colleague. She has made it abundantly clear that by reducing the overutilization of emergency departments, at the same time reducing hospital admissions, we can maximize efficiencies and improve patient health and health care.

I yield 5 minutes to my colleague from Virginia, Senator MARK WARNER, to talk about delivery system reforms in Virginia.

The ACTING PRESIDENT pro tempore. The Senator from Virginia is recognized.

Mr. WARNER. Mr. President, I thank my colleague from North Carolina for organizing the freshmen one more time to talk about our vision for health care reform. We invite our colleagues not only on our side of the aisle but our colleagues across the aisle to join us in this conversation about how to get health care reform right. I also commend my colleague from New Hampshire, Senator SHAHEEN, on her comments about how we can fix financial incentives in our current health care system. I think reforming our delivery system ought to be, clearly, part of any overall health care reform we take on.

I want to pick up, actually, where Senator SHAHEEN left off and talk about how we can readjust our financial incentives system in health care. We have them all wrong. We have a health care system right now that rewards bad practices. We have a health care system that rewards hospitals for multiple readmissions rather than a low readmission rate. We have a health care system that rewards volume of care rather than quality of care. Reforming the financial incentives in our delivery system has to be a key component of any health care reform going forward.

I join my colleagues in citing examples of delivery system reforms that are happening now in my own state. I have three examples here from the Commonwealth of Virginia.

In 2000, VCU Health System in Richmond, our capital, developed a system

called Virginia Coordinated Care to manage health care services for the uninsured. The uninsured often rely on emergency rooms to be treated for their illnesses and then go back home until they get sick again. There is no continuity of care and oftentimes that uninsured person will end up back on an emergency room doorstep because, outside of being treated for the episodic incident, there was no management of that patient's care during that period.

What VCU developed was a program that assigned a primary care physician to oversee each uninsured patient's health. The goal was to increase coordination between doctors and hospitals and, as a result, increase accountability, improve quality of care, and lower costs.

The Virginia Coordinated Care program started with a few participants in 2000; by 2009, there were over 20,000 members. One of the most important outcomes of the program was a significant drop in emergency room visits by enrolled patients. By increasing continuity of care, emergency room visits dropped 14 percent between 2000 and 2005. Costs were reduced for Richmond area hospitals, as well as surrounding Virginia hospitals as fewer patients showed up at other emergency rooms. By treating the patient earlier in their illness the program achieved better quality of care, and better results for the health care system as a whole.

Another example of delivery system reform took place at another end of our State, at Sentara Healthcare, located in Norfolk, VA. In 1999, Sentara studies found that intensive care units that were monitored by a doctor full time had lower mortality rates and shorter length of stays than those that were not. In order to improve quality of care, Sentara worked with a company called VISICU to install Web-based television cameras in each patient's room. With this technology, a single physician in a central location can follow patients in multiple rooms at the same time. Again, this kind of logical approach produced more efficient care at a lower cost. Sentara saw a 25-percent reduction in mortality among these patients, a 17-percent reduction in their length of stay, and a 150-percent return on investment in the program.

Perhaps the best example is now being modeled by the Carilion Clinic in Roanoke, VA. Carilion Clinic is a multispecialty health care organization, with more than 600 doctors and 8 health care organizations.

In 2010, next year, Carilion Clinic will join with Engelberg Center for Health Care Reform at Brookings and the Dartmouth Institute for Health Policy and Clinical Practice to implement a new and innovative health care model that rewards providers for improving patient outcomes while also lowering costs. This Accountable Care Organization will encourage physicians, hospitals, insurance companies, and the

government to work together to coordinate care, improve quality, and reduce costs. Under this model, providers will assume greater responsibility not only for treating the patient's illness but for the overall quality and cost of care to be delivered. They will actually be incentivized to take steps to keep patients healthy, while avoiding costly medications and procedures. Additionally, this model will encourage, and make it affordable, for doctors to finally practice preventive care. Carilion Clinic is doing the right thing: moving away from the current, and very flawed, fee-for-service system.

As long as our health care system—one-sixth of our economy—continues to reward providers simply based on quantity rather than quality of care, we are never going to get health care reform right. By increasing coordination of care, and putting in place smarter financial incentives, we can have higher quality care at lower costs. We can focus on the health of patients, rather than the number of procedures. Changing our payment mechanisms and restructuring financial incentives are a key part of health care reform.

I know my freshmen colleagues stand ready to work with our colleagues on this side of the aisle, and I again invite our colleagues on the other side of the aisle to join us in this effort. Getting it right will lead to improved quality of care, lower costs, and a healthier America.

I thank our leader today, the Senator from North Carolina, for granting me this time. I look forward to working with Senator HAGAN and all my colleagues as we move forward.

I yield the floor.

Mrs. HAGAN. I thank Senator WARNER. It is obvious that coordinated care will reduce costs and at the same time provide higher quality for our patients.

What Senator WARNER has discussed is very similar to the patient centered medical homes in North Carolina where we currently cover over 900,000 Medicaid patients.

Finally, I yield 5 minutes of my time to my new colleague from Massachusetts, Senator PAUL KIRK, to discuss some key national indicators.

Mr. KIRK. Mr. President, I thank the Senator from North Carolina. It is a privilege to be a member of her class and the class of distinguished colleagues of freshmen, and I commend her as well for her leadership in this discussion this morning, adding onto the role the freshman class is playing in advocating for health care reform for the American people.

I would like to speak this morning about a key national indicators system.

As we know, America is said to lead the world in health innovation. It can create the finest medical devices, the most effective drugs to treat diseases and advanced processes and procedures to care for patients. It is this wide range of remarkable innovations that has resulted in today's \$2.3 trillion

health care industry. But despite all of our medical achievements and technologies and the private and public money we spend on health care, we do not lead the world in health outcomes.

We need to innovate not only in the way we treat patients but in the way we create and implement health care policy. For that reason, one of the most promising provisions in the draft health reform measures about to come before us is the creation of a key national indicators system.

When illness strikes, we expect a health care team to carefully collect information from the patient and then consult the wide range of information available to them to achieve the appropriate diagnosis and treatment. That careful and complete process should yield the best possible course of treatment and recovery.

We need the same kind of approach in the creation of wise health care policy. In particular, we need measures to identify what is wrong with our current health care system, including what is driving the increasingly high cost of care. Abundant research and reports have analyzed such questions. What is missing is a central, independent organization that can analyze all of the research performed by various organizations and make that information readily available to Congress, to the executive branch, and the American people. That is an indispensable part of successful health reform. It will give decisionmakers easier access to all the knowledge available and eliminate wasteful spending of the hard-earned dollars of American families.

Senator Kennedy and Senator ENZI, in a strong, bipartisan effort, understood the need for this vital resource, and they designed a key national indicators system to provide it. It will be a nonpartisan, independent agency with a public-private partnership. It will foster better relations and relationships between members of the legislative, statistical, and scientific communities and will lead to greater transparency and accountability for spending on national health programs. Without such a resource, we will be at a serious disadvantage in fully understanding emerging health risks and in assessing whether the intended result is being achieved or adequate progress is being made on the health care challenges facing us.

The key national indicators system will make all its data available on a newly created, widely accessible Web site in the health care context. This unprecedented accessibility of data will assist the public in understanding what information was used by politicians in creating health care policies. It will enable policymakers to see whether progress is being made in health reform. And it will permit practitioners and researchers to use the information for the greater benefit of patients and consumers of health and medical care.

Significant progress in this area has already been accomplished. Over the years, the Institute of Medicine has been able to identify five drivers of health care quality and costs: first, health outcomes; second, health-related behaviors; third, health system performance; fourth, social and physical environment; and fifth, demographic disparities. The institute has recommended 20 specific indicators for measuring these five drivers of health care quality and cost. These indicators were carefully selected to reflect both the overall health of the Nation and the efficiency and effectiveness of our health care industry. However, the institute lacks an implementation system that can use these indicators effectively to guide future policy and practice. That is the goal and that is the mission of the new agency, the key national indicators system, we propose.

Here is one example of how this legislation will improve our health care system. A recent study conducted by the Harvard School of Public Health found that using a simple checklist during surgical procedures resulted in a one-third reduction of complications from that surgery. Reports such as these are made public, but you have to know where to look in order to access this information. The key national indicators system will take these reports, compile them, disseminate them, and make them available to the public. So any time a bill is being developed, a congressional office can go to this Web site and see all of the research that has been conducted on the topic in order to make economically sound decisions for the American people.

Currently, Congress and the executive branch continue to follow old habits. We tend to reinvent the wheel with every major new bill that is introduced. That approach leads to wasted time, wasted energy, and wasted money. Old habits are not good enough to achieve tomorrow's goals. By developing this indicator system, a process will be in place so that the efficiency and effectiveness of government spending on short-, medium-, and long-term problems can be determined quickly and in a fiscally responsible manner.

Our current system is unsustainable. It creates unnecessary confusion when Americans can least afford it. We need a system that will provide insight, foresight, transparency, and accountability. We will not be doing our job for the American people if we allow their money to be spent without assessing the cost-effectiveness of the various programs being developed.

By creating the key national indicators system, we can reassure all Americans that we did our required due diligence and that our health care reform bill will truly work for them.

I yield the floor.

Mrs. HAGAN. Mr. President, I thank Senator KIRK. I thank him for his comments and the discussion on the transparency and openness of the new key national indicators system. I think

this is critically important so that our public can see the progress we are making in improving health outcomes, healthy behavior, and cost-effectiveness.

In this last hour, we have heard from many of our new freshman colleagues about the successful efforts to reform the way we deliver health care in our country. I thank my colleagues for sharing those ideas with us.

I yield the floor.

The ACTING PRESIDENT pro tempore. The Senator from Idaho.

#### HEALTH CARE REFORM

Mr. CRAPO. I, too, would like to talk about health care. As we speak here in the Senate, the House is preparing to debate and reportedly vote by late this week or early next week on a massive new health care bill that will dramatically expand the size of our government, dramatically increase taxes, and establish a government-controlled insurance system.

While in the Senate we are not yet clearly aware of what the bill we will be debating is because it is still being crafted behind closed doors, we have an idea, and we are pretty sure some of the elements that are going to be included in it are the same elements we debated in the Finance Committee and the HELP Committee as those committees worked on their product here. In that context, we expect we will see also here in the Senate a massive new expansion of the size of government, up to \$1 trillion or more. If it is anything like what the Finance Committee bill was, we will see taxes increased on the American public by over \$500 billion, we will see cuts in Medicare, which we discussed yesterday, of over \$400 billion, and a significant expansion of the control of the Federal Government over our health care economy. Today, I want to focus on just the tax piece of this situation.

One of the most common provisions we have seen here in the Senate that we clearly expect will be in the final bill is the proposed 40-percent excise tax on high-cost or "Cadillac" health care plans. This has been defined as health care plans that are valued at more than \$8,000 for an individual or valued at more than \$21,000 for a family.

It is important to note these thresholds are not indexed to the increasing cost of health care spending but instead are indexed to inflation plus 1, which means that over time this will, similar to the alternative minimum tax, eat further and further into the American public's health care plans, which will then be taxed.

The Joint Tax Committee has scored this tax to generate \$201 billion of revenue to pay for that portion, \$201 billion of this new Federal spending proposal. Many think that because it is called an excise tax on health care plans, it is not going to impact them. They will be surprised to learn that in

my questioning of the Joint Tax Committee, we were told the vast majority of this \$201 billion tax is expected to be collected directly from the middle class, individuals who will be paying more income and payroll taxes.

Let's figure out how that can be. It turns out that as we analyze the way this tax is going to work, employers that will face a 40-percent excise tax on the health care they provide to their employees will begin to adjust the value of their health care plans so they avoid the tax. As they do so, they will reduce the health care they are providing to their employees and, presumably—and we expect they will—increase the wages they are paying to their employees so their employees' net compensation is not changed. The result of that, though, is that since the health care portion of the compensation is not taxed and the income portion of an employee's compensation is taxed, the employee will actually pay higher taxes, both on the income and on the payroll tax level.

Maybe a real-world example will demonstrate. In my State of Idaho, the Census Bureau says the median household income is about \$55,000 per year. In this case, let's take an example of a single woman who currently earns \$60,000 per year in annual compensation from her employer. We have an example represented by this chart. Let's assume she has a \$10,000 valued health policy. Her total compensation package from her employer is going to be \$60,000—\$50,000 in wages and \$10,000 in employer-provided health care benefits. She is taxed on \$50,000 and gets the \$10,000 health care benefit without taxation. What will happen in the bill, as I have indicated, is this \$10,000 health care policy will be subject to a 40-percent excise tax. In order to avoid that excise tax, the company will simply react by reducing her health care policy to below \$8,000 and increase her income.

Let's put up another chart to see what the likely reaction of the employer will be: Not to pay the insurance fee, as many here are saying, but simply to skip that and direct her tax dollars to the Federal Government. If this new high-cost plan is to be enacted, the theory is her employer will make the adjustments to change her overall compensation package in a way that she ends up with higher wages.

Let's put the next chart up to show how this would work. Under this proposal, her health care benefits are going to go down. Let's assume the company reduces her health care benefits from \$10,000 in value to \$6,000 in value and gives her the extra \$4,000 in income. Her health care benefits will go down. She will pay more taxes because she now has \$4,000 more of her package that is subject to compensation. The net value of her compensation will go down because of increased taxes. The result is, we are going to see millions of Americans pay this excise tax squarely in contravention of the

President's promise that no individuals who make less than \$200,000 will pay income taxes or payroll taxes or, in the President's words, "any other kind of taxes."

So we are clear on this, the estimates are that 84 percent of this tax is going to be paid by those who are earning less than \$200,000 per year. As a matter of fact, if we look at those who make less than \$50,000 a year, we expect somewhere in the neighborhood of 8 million Americans will fall into this category. If we look at the number who make less than \$200,000 per year, we expect that number will be above 25 million Americans who will be paying more taxes, both payroll and income taxes, and receiving less health care benefits from their employer.

The net result is, the President's promise that one can keep their health care if they like it will not be honored because of this provision. People will see, necessarily, that their employers will begin reducing health care packages to make them fit the tax structure this bill will create.

Secondly, there is the President's promise that if you make less than \$200,000 as an individual or \$250,000 as a family, you will pay no taxes under this proposal. As we have seen with this one example—and there are a number of other examples in the proposal being developed—in this one example of \$201 billion worth of the new taxes in the bill, those making less than \$200,000 will pay over 80 percent of it, and it will come directly out of their pockets and their compensation package with their employer.

In the time I have remaining, I wish to focus on one additional element. There is also a proposal to increase the bar for deductions of health care expenses. In other words, those who deduct their expenses and itemize their deductions can today deduct that portion of their income over 7.5 percent of their income that is represented by their health care expenses. This bill will increase that to 10 percent and generate over \$15 billion of additional taxes in that format. Who is the most likely to pay these taxes? People who have relatively low health care costs are going to end up not meeting that 7.5-percent threshold, now to be brought to 10 percent, and probably will not be able to benefit from the deductibility of their health care. But those who face medical crises, those who have health care expenses that exceed the value of 10 percent, will see their deductibility reduced again by these proposals. The net result: Millions of Americans making less than \$200,000 a year will pay more taxes.

I encourage the Senate, as we move forward in the debate, to recognize that the tax provisions contained in it are squarely going to hit those in the middle class.

The PRESIDING OFFICER (Mr. WARNER). The Senator from Iowa.