weighted. The new RFP significantly diminishes past performance.

Boeing complained that additional credit was given for an aircraft that had much higher capability. The new RFP offers no real additional credit for exceeding minimum capability thresholds.

Finally, the price competition has been tainted by the Air Force releasing the Northrop Grumman team's pricing data to Boeing following the previous competition and now refusing to release Boeing's pricing data to Northrop Grumman.

For these reasons, I am deeply troubled by the Departments' approach for selecting the next tanker. If the Department continues down the path that it is currently on, warfighters and taxpayers will be done a great disservice.

Mr. President, in closing, I would like to return to my initial comment.

It is clear to me that the draft RFP abandons the Air Force's need to provide a transformational and game changing aerial refueling tanker to the warfighter.

And, furthermore, I must reluctantly conclude, it did so with a bias towards one aircraft over another. If we continue down the path of this draft RFP—without competition—we are moving headlong towards a sole source contract where the warfighter and the taxpayer ultimately pay the price.

This will be a stain on the integrity of DOD's procurement process that will not be removed for decades. It is not too late. Secretary Gates has said the purpose for the RFP comment period is to allow for the DOD to correct flaws. The DOD must listen and take action.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. SESSIONS. This is a matter of such importance that I will need to speak about it again in the future.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Mexico.

HEALTH CARE REFORM

Mr. UDALL of New Mexico. Mr. President, this effort to reform our Nation's health care system is finding ways to make quality health coverage affordable and accessible to all Americans. I believe the bill we are considering in this Chamber as it currently stands goes a long way toward making that vision a reality. But even with this solid legislation, there is still a large group of Americans who continue to be left behind. I am talking about our country's first Americans, the 1.9 million American Indian and Alaska Natives who are suffering because the Federal Government isn't living up to its propositions.

The law that provides the framework under which the health care programs for Native Americans are delivered hasn't been reauthorized for more than 10 years.

This means that the Indian Health Services' delivery system is chronically underfunded and, given the rapid advance of health care technology, outdated. As a result, too many Native Americans are struggling to receive quality, timely health care.

This agency is supposed to be the principal health care provider and health advocate for Indian people. Yet every day, because we fail to act, the health care situation in Indian Country grows more urgent. Native Americans are diagnosed with diabetes at almost three times the rate of any other ethnic group. They often don't have access to preventive care. And Native American youth are attempting and committing suicide at devastating and alarming rates. Just 2 months ago, in New Mexico, a 14-year-old girl from the Mescalero Apache Reservation became the fourth young person from that tribe to take her own life—in a little more than 1 month. That is four young people in 1 month on one reservation. Tell me this doesn't cry out for action.

The Senate Indian Affairs Committee has reported the reauthorization bill. The House has put in its health care package the same kind of reauthorization bill. Both of these bills would bring us much-needed reform to the Indian health care system.

This legislation, the Senate must act upon it. We can no longer delay. For the past several years, Congress has failed to get this legislation across the finish line. It has passed both bodies in the last several years—the House at one point and the Senate at one point—but it is still not law. Now is the time to put this in the health care bill and get the job done.

I know my colleagues on both sides of the aisle are in agreement that our Nation's health care system needs reform. We know health care reform is needed now. We know the status quo is unacceptable. But what is missing is the same sense of urgency for our Native American community, this despite the alarming statistics from the Civil Rights Commission several years ago that the United States spent more than twice the amount on a Federal prisoner's health care than that of a Native American man, woman, or child; that is, $3,800 per year per Federal inmate, versus $1,900 per year per Native American. That is right, our inmates have better health care than the population with whom we signed treaties and made a promise to provide health services. American Indian and Alaskan Natives are three times as likely as Whites to be uninsured, and almost half of our low-income American Indians and Alaskan Natives lack health coverage.

The longer we wait, the more Native Americans suffer needlessly. The longer way wait, the more Native Americans go without treatment for chronic conditions such as diabetes and heart disease. The longer we wait, the more Native American teens who may take their own lives because they are not getting the help they need.

America has an obligation to provide quality, accessible health care for our country's first Americans. So I say again, it is time to act on this important piece of legislation. It is time to reform the Indian health care system and permanently reauthorize the Indian Health Care Improvement Act.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from New Hampshire is recognized.

Mrs. SHAHEEN. Mr. President, I rise today to support the health care reform legislation that is before us. I want to talk a little bit, specifically, about what the bill does to reform our health care delivery system. That is really health care jargon for the way we provide health care to people who need it.

I heard a lot of debate earlier this afternoon about the fact that the health care bill doesn't do anything to address costs. I think that is just wrong. The fact is, this health care bill does begin to address costs in our system. That is one of the reasons we have to pass it. In fact, we know that over the next 10 years it is going to reduce our deficit by $130 billion.

But more important than that are the changes that I believe this is going to begin to make in how we provide health care for the people of this country. The fact is—we all know it, even our colleagues on the other side of the aisle—our current health care system is not working; it costs too much; and for too many families quality health care is simply out of reach. One of the problems is that 30 percent of the $2.5 trillion we spend right now each year on health care goes to unnecessary, inappropriate care and administrative functions that do little to improve our health.

Our health care system didn't get this way overnight. Years of perverse incentives have encouraged health care professionals to practice more medicine rather than better medicine. They struggle to see more patients and do more procedures to keep up. Hospitals race to build new wings and state-of-the-art units. As patients, we too often live unhealthy lifestyles, and we expect the newest high-tech services to fix it. In the meantime, we have undervalued things such as primary care, preventive care, and mental health services. Despite all of our spending, we are not any healthier.

Over the past few months, I have joined, as the Presiding Officer has, with all of our freshman colleagues on the floor to discuss why we can't continue this current system. It is too costly and too inefficient.

Last week, the freshman Senators introduced a package of amendments that emphasizes cost containment. The provisions contained in our package may not be those that are currently grabbing headlines, but I believe they really go to the crux of our reform efforts. They are the delivery system reforms that will improve quality and control costs over the long run. How are these going to work? Well, our delivery system reforms build upon the

current underlying bill. They reward improvement in providing care for a better health outcome.

One way we can be more efficient in delivering care is through what are called accountable care organizations or ACOs. These ACOs allow medical providers to work in teams, to take responsibility for decisionmaking, and they offer financial rewards for better health outcomes. Our amendments allow medical providers to align Medicare, Medicaid, and private sector strategies for improving care. Doing this will help ensure all Americans receive high-quality care no matter how they are insured. ACOs provide the right kind of incentives and promote value over volume.

For years, the Dartmouth Institute of Health Policy and Clinical Practice has shown us that there are regional differences in the way care is delivered and how health care dollars are spent. Over the summer, Dr. Atul Gawande eloquently highlighted Dartmouth's findings in an article he wrote for New Yorker Magazine. He clearly made the case that higher quantity do not necessarily translate into higher quality, so that more procedures do not necessarily mean better care. Dr. Gawande's article has had a tremendous influence on the health care debate. It has been quoted frequently by President Obama and referenced right here on the floor of the Senate.

In his latest article, which just came out recently, Dr. Gawande has once again made an important contribution to the health care reform dialog. In this article, he emphasizes the importance of delivery system reforms and fixing our health care system. He points out that there is not one single answer, there is no silver bullet to what we need to do to change our health care system.

While we can all agree that something must be done, what we can't agree on is what specific model or provision will be the best and have the most desirable outcomes.

Dr. Gawande pointed out that our country faced a similar challenge before. In the article, Dr. Gawande draws a parallel between our current health care system—one that is very costly, a money drain, one that is fragmented, disorganized, and inconsistent. He compares our current health care system to the agricultural system at the start of the 20th century. At that time, more than 40 percent of a family's income went to paying for food. The inefficiency of farms meant lower crop yields, higher prices, limited choice, and uneven quality. Agriculture was on an unsustainable path. Dr. Gawande points out that the Federal Government did not, however, offer a grand solution; rather, it provided incentives to change the way farmers produced crops. Through innovation, the promotion of best practices, and smart dissemination, today food only accounts for about 8 percent of a family's income compared to that 40 percent at the start of the last century.

As you know, as we have heard discussed on the floor, we have examples of great innovation and excellence in health care, such as Dartmouth in my State; the Mayo Clinic in Minnesota, which Senator KLOBUCHAR can speak to; Intermountain in Utah, and numerous other places of excellence around the country. These institutions have developed integrated health care systems that are patient focused. Their practices have promoted high value and excellent outcomes, best practices, which should be shared throughout the country.

The Patient Protection and Affordable Choices Act identifies some of these best practices and provides the types of incentives for doctors, nurses, and patients to change the status quo and to experiment with innovation and excellence. The many programs supported in the bill before us move us in the direction of delivery system reform, which is so important to our effort.

By promoting innovative practices, such as accountable care organizations, payment reform, and medical homes, we can move away from the current fee-for-service system that rewards volume over value. That is true reform.

I urge my colleagues to support the bill.

The PRESIDING OFFICER. The Senator from Minnesota is recognized.

Ms. KLOBUCHAR. Mr. President, I thank the Senator from New Hampshire for mentioning the Mayo Clinic, along with several other great facilities in this country that have done things a little differently. They have done it by focusing on the patient, by saying what is best for the patient is best for all of us. When you do what is best for the patient, you get higher quality care. When you get higher quality care, you actually get lower costs.

I think of people when they go in to pay for a hotel room and they say: If I pay more, I will get a better view and a bigger room. That is usually true. Not in health care. If you look at trends across the country, the States, the metropolitan areas that have the least efficient health care tend to cost the most. That is what we need to change if we want true cost reform. It is good in States such as Minnesota, New Hampshire, and Wisconsin. Why? Because we tend to have higher quality care at lower costs. We are rewarded for that.

It is also good for the States that need to get their quality of care up, so that we don't see massive readmissions to hospitals. Who, when they go to a hospital and are sick, wants to go back in because they get sick in the hospital? Who wants to have something go wrong in the hospital so they have to go back? Who wants to go to an area where they have massive fraud, so all this money gets drained in the amount of $62 billion a year in Medicare fraud? That is what happens.

That is why, on delivery system reform, the courageous thing is to step back and say: How do we do this better? How do we do it so we are rewarding quality and not just quantity, so that we are putting the patients first?

That is what this bill is about. Why does this matter? I think anybody who has a checkbook understands what this means. At $2.4 trillion a year, health care spending represents close to 17 percent of the American economy, and it will exceed 20 percent by 2018 if the current trend continues. Hospitals and clinics in every part of the country are providing an estimated $56 billion in uncompensated care. That is taxpayer money going down the tubes—$2.4 trillion per year. That is where we are now. Everybody knows it is costing them and making it very difficult for big businesses to compete against businesses from other countries that have more efficient health care systems. It is making it impossible for small businesses to keep all of their employees on health care. Why? Well, their costs are 20 percent more than big businesses.

The small businesses have created 64 percent of the jobs in the last decades in this country. We have to allow them to continue to thrive, not with these health care costs that are a drag on these small businesses.

I always tell people to remember three numbers: 6, 12, and 24. Ten years ago, the average American family was paying about $6,000 in premiums. Now they are paying $12,000. That is average. We have a lot of small business owners all over our State paying $20,000 a year, $23,000 a year. If we do not do anything, if we do not do anything at all, 10 years from now it is going to cost between $24,000 and $36,000 average in this country for individual families to buy health care—$24,000 to $36,000 average per family. That is why we must act. We know inaction is not an option. If we do not act, costs will continue to skyrocket, and 14,000 Americans will continue to lose their health insurance every single day.

What does this bill do? First, it gives coverage to 31 million people who do not have coverage now. People are saying: Wow, where are they getting health care now? I will tell you where: the emergency room, such as in the hospital I used to represent when I was the county attorney for the biggest county in Minnesota. That was paid for by the taxpayers. When someone does not have insurance, when they don't have a doctor, they have diabetes, they are supposed to be doing their insulin and watching their diet and they wait and wait and they end up in the emergency room and they get their leg cut off and have big costs for all taxpayers, not to mention the disastrous quality of life for the person involved. That is going on in this country.

Last year, I was down in one of our smaller towns in southern Minnesota. I heard how one science hospital had three people come in with stomach problems, appendicitis attacks. Their appendixes burst. This was over a period of several months. They asked:

How come you didn't come in earlier? Two of them said: We work at a small business; we didn't want the premiums to go up. It would hurt everyone at the small business. Another said: I had such high premiums I would have to pay I didn't want to come in and have it checked out.

If you do not have that kind of safety net in place for people, you get more expenses on the far end. That is what this bill does. It changes the delivery system, insuring 31 million more people.

What else does it do? It helps to reduce the deficit. That is what I said from the beginning. I do not want to support a bill that adds to the deficit. Actually, this bill we are talking about—some changes are being made—reduces the deficit by billions and billions of dollars.

A third thing: What does this bill have? Insurance reforms. What does that mean? It means if you have a sick kid, you no longer are going to lose your insurance. You cannot be pushed off, put off in the deep end all by yourself if your kid gets sick. It means if you have a kid going to college, you can keep them on your insurance until they are 26 years old. That is what the bill does. It gives a safety net, consumer protections that people in this country have demanded.

Finally, with Medicare, it adds 9 years onto the life of Medicare. Right now, Medicare is scheduled to go into the red by 2017. No one wants to talk about it. We need to talk about it. What this bill does is keep it solvent for 9 more years.

I can tell you, my mom, who is 82, wants to stay on Medicare until she is way into her nineties. People in their fifties who want to get on Medicare at 65 want to make sure it is there for them, that it is solvent.

What this bill does with the reforms that are in it, with the promotion of high quality, closing that doughnut hole, which is difficult for seniors, it helps our seniors. This is an idea, someone said today—I was listening to other Members—whose time has come. This bill is not going to be perfect for everyone. I think about the people I heard from, such as the woman who wrote to me from northern Minnesota. She wrote this heartfelt letter about how she had gotten a call from her daughter whose husband worked at a small business. She said that husband, her son-in-law, had just found out they were not going to have insurance anymore at his small business. The woman who wrote, the mom, said she couldn't even understand her daughter. The daughter was sobbing, sobbing: What is wrong? What is wrong? What happened? I lost my insurance.

Do you know why this mattered so much for her family? Her daughter has cystic fibrosis. Her daughter needs this insurance every moment of her life. When that small business yanked that insurance coverage because they probably had to—I am sure they didn't want to, but they just couldn't afford it anymore—that daughter has to go on the open market now which, if you have a preexisting condition, is not an easy thing to do. She may not get insurance. That is what we are talking about when we talk about this bill.

At the end of the letter, the mom said: I need you to be my daughter's voice. She is not going to be able to go to Washington, DC, and lobby for this like all the companies that have come over here and lobbied for this thing and that thing. She needs us to be her voice, and that is what this is about.

The good thing here is that, as we look at some of the things in the bill, I didn't get everything I wanted to reduce costs, I can tell you that right now. But there are some great provisions in this bill.

Look at this. According to researchers at Dartmouth Medical School, nearly $700 billion per year is wasted on unnecessary or ineffective health care. That is 30 percent of total health care spending.

To rein in costs, we introduced a value index. I introduced a bill—Senator CANTWELL, Senator GREGG are coauthors of this bill. Senator CANTWELL got it on the Finance Committee bill and it is still in the merged bill today. What that does is it says, when you look at the Medicare fees, evaluate them on a lot of things but make sure you evaluate them on value. This indexing will help reduce unnecessary procedures because those who produce more volume will need to also improve care or the increased volume will negatively impact their fees.

Doctors will have a financial incentive to maximize quality and value of their services instead of quantity. My doctors in the State of Minnesota support this. They have supported this bill. They have endorsed this bill. They understand that if we want to get that high-quality care like we see in Minnesota in places such as the Mayo Clinic, the Cleveland Clinic, Intermountain, Kaiser—all over the country—you have to have those kinds of incentives in place.

This bill also focuses on bundling and integrated care. I was thinking, as I watched the Vikings game this weekend—I do not know if you noticed, but the Vikings won again; Brett Favre is quarterback—we are talking about a primary care provider who works with a team. We do not have 15 wide receivers running into each other. We have one person in charge—a quarterback in football, a primary care doctor in medicine—working with a team, with a wide receiver, with a tight end, with all the team they have working together, whether it is a cardiologist, whether it is a urologist, whether it is any kind of a doctor they want to work with as a team, depending on what the illness is. That is what integrated care is. You work as a team, share medical records. Patients do not get lost in the shuffle. They do not get sent to one specialist and another specialist without anyone watching over their care. That is what integrated care is about, a quarterback with a team.

The other thing about this bill is, we start to focus much more, as I mentioned, on reducing readmissions, on rewarding places such as Health Partners or St. Mary's in Duluth, places that work to have this integrated care, places that make sure we have less readmissions in the hospitals.

Finally—and I am pleased we got this in the freshman package that is coming out—there is a much bigger focus on fraud in the system. Mr. President, $60 billion a year is going down the tubes, going to fraudsters, to con men, siphoning off the system by storefronts that are not doctors' clinics that claim they should get some of the reimbursements that should be going to our seniors. That is $60 billion in Medicare fraud alone every single year.

There are increased penalties with tools to make sure we are better enforcing the law. We can reclaim some of that money and give it to the American taxpayers, give it to our seniors.

Those are a few things. I will be talking more about this, this week, when we focus on and talk about cost control in this bill.

Thank you for allowing me to share some of my thoughts on cost. Again, remember 6, 12, 24. Ten years ago, the average American family was paying $6,000 for their premiums. Now what are they spending? They are spending $12,000. What are they going to spend 10 years from now if we don't do anything? They will spend $24,000 to $36,000 a year. We know this is not going to be easy to bend this cost curve. We know there are going to be bumps in the road. We know it is not going to automatically turn itself around. To do nothing, to put our heads in the sand at this moment in history is just plain wrong. The American people deserve to have better health care. They deserve to have that high-quality, low-cost care, and this bill is the beginning.

I yield the floor.

OMNIBUS APPROPRIATIONS

Mr. AKAKA. Mr. President, I want to express my strong support for the Omnibus appropriations act for fiscal year 2010, H.R. 3288. This bill combines six appropriations bills that provide funding for essential programs related to improving education, housing, and transportation; increasing research opportunities; providing justice; strengthening our foreign operations; constructing needed military facilities; and caring for our Nation's veterans. I thank the chairman and ranking member of the Senate Appropriations Committee, Senators INOUYE and COCHRAN, as well as the various subcommittee chairmen and ranking members, for their efforts to bring this important bill to the floor.

I am pleased that included in this bill is funding for a number of K–12 and postsecondary educational initiatives,