Communities,'' is fitting. Every day, our libraries help make our communities stronger and more vibrant, as they innovate and mobilize resources to provide programs and services that meet ever-evolving community needs.

That is why I have been proud to work during my time in the Senate on ways to support our Nation's libraries. Last December, on a bipartisan basis, I secured passage and enactment of my legislation to reauthorize and enhance the Museum and Library Services Act. This law authorizes Federal funding, a relatively modest investment, through the Institute of Museum and Library Services, IMLS, to enable libraries and museums to work in partnership at the State and local levels and with nonprofits, universities, businesses, and others to support, educate, enlighten, and enrich our communities. For libraries, this law seeks to ensure they are equipped to serve community needs, in areas such as workforce, economic, and business development; digital and financial literacy; critical thinking; and new and emerging technologies. Critically, this new law ensures that increases in library formula funding will be shared more broadly across States and specifically smaller ones like Rhode Island.

Just last week, I hosted a conversation with our State's library professionals to follow-up on a similar roundtable I held in Rhode Island in 2016 as I began my work on the Museum and Library Services Act. It was inspiring to hear the many ways in which our libraries are hard at work transforming themselves to serve their diverse communities.

I was glad the director of IMLS, Dr. Kathryn Matthew, could join us for this event. We have a special duty in Rhode Island to elevate the work of IMLS, which is one of my predecessor, Senator Pell's, many lasting gifts to our Nation.

While the President's budget proposes to once again eliminate funding for IMLS, I have been able to instead secure an increase of $11 million for this agency over the last 2 years. There is broad, bipartisan support for the work IMLS does, and I am continuing to work with my colleagues to increase funding so we can advance IMLS's mission.

My work on libraries extends to ones in our schools, which also need our care and attention. Studies show that effective school library programs, staffed by a certified school librarian, have a positive impact on student achievement and educational success. Knowing how to find and use information are essential skills for college, careers, and life in general. A good school library, staffed by a trained school librarian, is where students develop and hone these skills.

Yet, according to the American Library Association, while 91 percent of the over 90,000 public and private elementary and secondary schools in the Nation have a school library, only 61 percent have a full-time librarian. A National Education Association report about trends in school libraries found that students in the highest poverty schools were less likely to have libraries at their schools and there were significant disparities in staffing at schools with high percentages of minority students. Access to an effective school library program, staffed by a certified school librarian, is an issue of educational equity.

In 2015, I was pleased to work with the library community and my colleagues on both sides of the aisle to ensure that our main Federal elementary and secondary education law continued to specifically address the critical equity issue of public school libraries. Since my time in the other body, I have worked hard to ensure Federal support for our school libraries and I continue to fight for increased funding for the Innovative Approaches to Literacy, IAL, grant program authorized in the Every Students Succeeds Act, ESSA. IAL provides competitive awards to school libraries, as well as national not-for-profit organizations to support children and families in high-need, underserved communities. By providing age-appropriate books, supporting parental engagement programs, and reinforcing professional development, the IAL program helps to support literacy skills to ensure children are best positioned for success.

I encourage all of my colleagues to visit their local libraries and school libraries to see firsthand that libraries are no longer quaint and quiet places to find the latest books, although they still offer plenty of that. They are community hubs providing innovative programming and services to spark creativity, boost learning and STEM education, promote the use of emerging technologies, and develop new career pathways. In sum, they are strengthening our communities, our States, and our Nation.

VOLUNTEER RESPONDER INCENTIVE PROTECTION ACT

Ms. COLLINS. Mr. President, I wish to introduce the Volunteer Responder Incentive Protection Act with my friend and colleague from Maryland, Senator CARDIN, which will benefit the brave women and men who volunteer at our local firehouses.

Across our Nation, volunteer firefighters play a critical role in helping to ensure the safety of our communities and the well-being of our neighbors. The State of Maine, for example, has approximately 9,785 firefighters who serve the State's 1.3 million citizens. Maine is largely a rural State, and more than 90 percent of firefighters are volunteers. Without these public-spirited citizens, many smaller communities would be unable to provide firefighting and other emergency services at all.

Often, communities seek to recruit and retain volunteers by offering modest benefits. The legislation we are introducing today would support these efforts by helping to ensure that these nominal benefits to volunteers are not treated as regular employee compensation.

The Volunteer Responder Incentive Protection Act would allow communities to provide volunteer firefighters and Emergency Medical Service, or EMS workers, with up to $600 per year of property tax reductions or other incentives, without those benefits being subject to Federal income tax and withholding. This would ease the administrative burden that local departments sometimes face when they reward their volunteers.

We should take care to protect our volunteer firefighters who serve this country with such bravery. Our legislation would help us achieve that goal, and I urge my colleagues to join us in supporting this bill.

ACCESS TO PRIMARY CARE

Mr. ALEXANDER. Mr. President, I ask unanimous consent that a copy of my opening statement at the Senate Health Education, Labor, and Pensions Committee be printed in the RECORD.

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

ACCESS TO PRIMARY CARE

Mr. ALEXANDER. Dr. Lee Gross, of Florida testified last year at this Committee's fifth hearing on the cost of health care. He told us that, after seven years as a primary care doctor, he had an epiphany: too many government mandates and insurance companies were getting between doctors and patients and making primary care more expensive than it needed to be.

So in 2010, Dr. Gross created one of the first Direct Primary Care practices. Instead of working with insurance companies and government programs, Dr. Gross' patients pay him a flat monthly fee directly: $60 a month per adult, $25 a month for one child, and $10 a month for each additional child.

Dr. Gross is one of more than 300,000 primary care doctors in the United States who most of us go to see for day-to-day medical care—receiving vaccines like the flu shot, annual physicals, and help managing chronic conditions, like diabetes. It is also our entry point to coordinate additional medical care, if, for example, we need to get our hip replaced or an MRI to diagnose a problem.

We heard from Dr. Brent James of the National Academies of Medicine at our second hearing that between 30 and 50 percent of what we spend on health care is unnecessary. I have asked for specific suggestions on what the federal government can do to lower the cost of health care for American families, and this year, I am committed to passing legislation based on that input to create better outcomes and better experiences at a lower cost.

Dr. Gross' practice is one of about a thousand similar clinics in the United States, and is a good example of how a primary care doctor can help reduce costs. The first way Dr. Gross does this is by helping with his patients' wellness. For $60 a month, Dr. Gross can do EKGs and cortisone injections, manage chronic conditions like diabetes, asthma,

and hypertension, and remove minor skin cancers right in his office.

Second, by keeping you out of the emergency room. For $60 a month, patients have unlimited office visits, and they can also email, text, call and use an app to contact his office—anytime, day or night. So for example, if you have stomach pains at 11 pm, you could text Dr. Gross, who knows that it might just be a side effect of a new medicine he prescribed you.

And third, primary care is patients' access point to more advanced care. When Dr. Gross refers people for additional care, he is able to provide cost and quality information about the different options, so his patients can choose the best option.

For example, one of his patients with rheumatoid arthritis was quoted $1,800 for blood work, but Dr. Gross was able to find a laboratory to offer the blood tests for under $100. This echoes what Adam Boehler, who leads the Center for Medicare and Medicaid Innovation, recently told me. He estimated that primary care is only 3–7 percent of health care spending but affects as much as half of all health care spending. And as Dr. Roizen of the Cleveland Clinic has said before this Committee, regular visits to your primary care doctor, along with keeping your immunizations up to date and maintaining at least four measures of good health, such as a healthy body mass index and blood pressure, will help you avoid chronic disease about 80 percent of the time.

This is important because, according to Dr. Roizen, over 84 percent of all health care spending is on chronic conditions like asthma, diabetes, and heart disease. I believe we can empower primary care doctors, nurse practitioners, and physicians assistants to go even a step further.

At our fourth hearing, we heard about how the cost of health care is in a black box—patients have no idea how much a particular treatment or test will end up costing. Even if information on the cost and quality of health care is easily accessible, patients still have trouble comparing different health care options.

For example, earlier this year, hospitals began to post their prices online, as required by the Centers for Medicare and Medicaid Services, but to the average consumer, this information has proved to be incomprehensible.

And while the data may be incomprehensible today, it is a ripe opportunity for innovation from private companies, like Health Care Bluebook, a Tennessee company that testified a hearing last fall, and non-profit organizations to arrange the data so primary care doctors, nurse practitioners, and physicians assistants can help their patients have better outcomes and better experiences at lower costs.

There are other ways to lower health care costs through expanded access to primary care. Dr. Gross' direct primary care clinic is one example. Another is community health centers, which we talked about at our last hearing and that are where 27 million Americans go for their primary care. And employers are increasingly taking an active role in their employees' health and in the cost of health care.

One of our new committee members, Senator Braun, was an employer of a thousand people and was aggressive about helping his employees reduce health care costs. Like primary care doctors, more good data could help employers like Senator Braun more effectively lower health care costs. Employers are also employing a doctor on-site so employees don't have to take time off of work to see a primary care doctor.

On-site primary care makes it easier to keep employees healthy by helping to manage a chronic condition or get a referral to a specialist. Today, I am interested in hearing more about specific recommendations to improve access to affordable primary care.

ACCESS TO CARE: HEALTH CENTERS AND PROVIDERS IN UNDERSERVED COMMUNITIES

Mr. ALEXANDER. Mr. President, I ask unanimous consent that a copy of my opening statement at the Senate Health, Education, Labor, and Pensions Committee be printed in the RECORD.

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

ACCESS TO CARE: HEALTH CENTERS AND PROVIDERS IN UNDERSERVED COMMUNITIES

Mr. ALEXANDER. This is the first hearing of the new Congress so let me take a few minutes to talk about what we hope to accomplishment these next two years.

Number one, reducing health care costs. And number two, making sure a college degree is worth students' time and money.

On health care costs, this Committee has held five hearings on reducing the cost of health care. Testimony from Dr. Brent James, a member of the National Academy of Medicine, said that up to half of health care spending is unnecessary.

That startled me and it should startle the American people. That is a massive burden on American families, businesses, and state and federal budgets.

I sent a letter to health experts, including the witnesses at our five hearings, asking for specific recommendations to reduce health care costs. I'd like to encourage anyone with a specific recommendation to submit your comment by March 1 to lowerhealthcarecosts@help.senate.gov.

A second priority is updating the Higher Education Act to ensure that the expense of a college education is worth it for students. The last time we seriously addressed higher education was in 2007. A lot has happened since then.

In 2007, there was no iPhone. A microblogging company named Twitter had just gained its own separate platform and started to scale globally. And Amazon released something called Kindle. In a new book, New York Times columnist Tom Friedman puts his finger on the year 2007 as ''the technological inflection point.'' So we need to take a look at this federal support for higher education that affects 20 million students and 6000 universities, colleges, and technical institutions. And our goal includes simplifying the federal aid application; a fairer way for students to repay their loans; and a new system of accountability for colleges.

I will be working on these priorities with Ranking Member Patty Murray, with members of the HELP Committee, and other Senators interested reaching a result on lowering health care costs and updating the Higher Education Act.

We hope to complete our work on both of these things in the first six months of this year.

And in addition, in these next few months, we need to reauthorize the Older Americans Act, which supports the organization and delivery of social and nutrition services to older adults and their caregivers and reauthorize the Child Abuse Prevention and Treatment Act, important legislation that funds major grant programs that provide a social services response to issues of child abuse and neglect.

And today's topic—extending federal funding for community health centers, as well as four other federal health programs, which are all set to expire at the end of this fiscal year.

Community health centers actually fit into a larger topic of great interest to this Committee, which is primary care. There are more than 300,000 primary care doctors in the United States, according to the American Medical Association. This is the doctor that most of us go to see for day-to-day medical care—an annual physical, flu vaccine, or help managing a chronic condition like diabetes. It is our access point to additional medical care, and can refer us to specialists, if, for example, we need to get our hip replaced or a MRI.

Adam Boehler, who leads the Center for Medicare and Medicaid Innovation, estimated that primary care is only 2–7 percent of health care spending but could help to impact as much as half of all health care spending.

We will be having a hearing next week on how primary care can help control health care costs. Today, we are talking about a prime example of primary care: 27 million Americans receive their primary care and other services at community health centers.

For example, in Tennessee, after Lewis County's only hospital closed, the closest emergency room for its 12,000 residents was 30 minutes away. The old hospital building was turned into the Lewis Health Center, a community health center which operates as something between a clinic and full hospital.

Lewis Health Center estimates they can deal with about 90 percent of patients that walk in the door. The center has a full laboratory to run tests, can perform X-rays or give IVs, and keeps an ambulance ready to take patients to a partnering hospital if they need more care. Because the Lewis Health Center is a community health center, they charge patients based on a sliding scale which means more people have access to and can afford health care.

Community health centers like Lewis Health Center are one way American families can have access to affordable health care close to home. This includes a wide range of health care, including preventive care, help managing chronic conditions like asthma or high blood pressure, vaccines, and prenatal care. There are about 1,400 federally-funded health centers that provide outpatient care to approximately 27 million people, including 400,000 Tennesseans, at about 12,000 sites across the United States. These other locations could be a mobile clinic or at a homeless shelter or school.

Community health centers have also been an important part of combating the opioid crisis that has impacted virtually every community across the country.

Last year, the Department of Health and Human Services provided over $350 million in funding specifically to support community health centers providing care for Americans in need of substance use disorder or mental health services.

And in 2017, 65,000 Americans received medication-assisted treatment for substance use disorders at a community health center. These centers accept private insurance, Medicare and Medicaid, and charge patients based on a sliding fee scale so that those who are in need of care receive it, regardless of ability to pay.

Community health centers also receive federal funding to help cover their costs. In Fiscal Year 2019, these centers received $4 billion in mandatory funding and $1.6 billion in discretionary funding. Congress has to act by the end of September to make sure community health centers continue to receive this federal funding and keep their doors open.