Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3055. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3056. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3057. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3058. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3059. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3060. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3061. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3062. Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3063. Mr. AKAKA (for himself and Mr. INOUYE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3064. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3065. Mr. CARDIN (for himself and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3066. Mrs. BOXER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3067. Mr. PRYOR (for himself, Mrs. BOXER, and Mr. ROCKEFELLER) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3068. Mr. KYL (for himself, Mr. ROBERTS, Mr. VITTER, Mr. GRASSLEY, Mr. CRAPO, Mr. COBURN, Mr. BARRASSO, and Mr. JOHANNS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3069. Mr. KOHL submitted an amendment intended to be proposed by him to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3070. Mrs. HAGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3071. Mrs. HAGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3072. Mrs. HAGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3073. Mrs. FEINSTEIN submitted an amendment intended to be proposed by her to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3074. Mrs. FEINSTEIN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3075. Mr. DURBIN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3076. Mr. DURBIN (for himself and Mr. SANDERS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3077. Mr. DURBIN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3078. Ms. KLOBUCHAR (for herself and Ms. SNOWE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

## TEXT OF AMENDMENTS

**SA 3001.** Mrs. HAGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 974, between lines 9 and 10, insert the following:

**SEC. 3316. IMPROVEMENT IN PART D MEDICATION THERAPY MANAGEMENT (MTM) PROGRAMS.**

(a) IN GENERAL.—Section 1860D–4(c)(2) of the Social Security Act (42 U.S.C. 1395w–104(c)(2)) is amended—

(1) by redesignating subparagraphs (C), (D), and (E) as subparagraphs (E), (F), and (G), respectively; and

(2) by inserting after subparagraph (B) the following new subparagraphs:

''(C) REQUIRED INTERVENTIONS.—For plan years beginning on or after the date that is 2 years after the date of the enactment of the Patient Protection and Affordable Care Act, prescription drug plan sponsors shall offer medication therapy management services to targeted beneficiaries described in subparagraph (A)(ii) that include, at a minimum, the following to increase adherence to prescription medications or other goals deemed necessary by the Secretary:

''(i) An annual comprehensive medication review furnished person-to-person or using telehealth technologies (as defined by the Secretary) by a licensed pharmacist or other qualified provider. The comprehensive medication review—

''(I) shall include a review of the individual's medications and may result in the creation of a recommended medication action plan or other actions in consultation with the individual and with input from the prescriber to the extent necessary and practicable; and

''(II) shall include providing the individual with a written or printed summary of the results of the review.

The Secretary, in consultation with relevant stakeholders, shall develop a standardized format for the action plan under subclause (I) and the summary under subclause (II).

''(ii) Follow-up interventions as warranted based on the findings of the annual medication review or the targeted medication enrollment and which may be provided person-to-person or using telehealth technologies (as defined by the Secretary).

''(D) ASSESSMENT.—The prescription drug plan sponsor shall have in place a process to assess, at least on a quarterly basis, the medication use of individuals who are at risk but not enrolled in the medication therapy management program, including individuals who have experienced a transition in care, if the prescription drug plan sponsor has access to that information.

''(E) AUTOMATIC ENROLLMENT WITH ABILITY TO OPT-OUT.—The prescription drug plan sponsor shall have in place a process to—

''(i) subject to clause (ii), automatically enroll targeted beneficiaries described in subparagraph (A)(ii), including beneficiaries identified under subparagraph (D), in the medication therapy management program required under this subsection; and

''(ii) permit such beneficiaries to opt-out of enrollment in such program.''.

(b) RULE OF CONSTRUCTION.—Nothing in this section shall limit the authority of the Secretary of Health and Human Services to modify or broaden requirements for a medication therapy management program under part D of title XVIII of the Social Security Act or to study new models for medication therapy management through the Center for Medicare and Medicaid Innovation under section 1115A of such Act, as added by section 3021.

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**SA 3002.** Mrs. HAGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1722, after line 24, insert the following:

''(C) USE OF TECHNOLOGY.—The Secretary shall incorporate the use of technologies, including analytics and predictive modeling, as part of the analysis process for the purpose of identifying fraud, abuse, or improper payments prior to the payment of claims. Such analysis technologies shall at a minimum—

''(i) have the capability to detect emerging fraud schemes through the use of automated predictive modeling techniques; and

''(ii) improve the efficiency and effectiveness of current fraud and abuse detection methods by incorporating predictive risk scoring techniques that minimize investigations that result in false positive outcomes.''.

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**SA 3003.** Mrs. HAGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title III, insert the following:

**Subtitle ____—Better Diabetes Care**

**SEC. ____1. SHORT TITLE.**

This subtitle may be cited as the ''Catalyst to Better Diabetes Care Act of 2009''.

**SEC. ____2. DIABETES SCREENING COLLABORATION AND OUTREACH PROGRAM.**

(a) ESTABLISHMENT.—With respect to diabetes screening tests and for the purposes of reducing the number of undiagnosed seniors with diabetes or prediabetes, the Secretary of Health and Human Services (referred to in this subtitle as the ''Secretary''), in collaboration with the Director of the Centers for Disease Control and Prevention (referred to in this section as the ''Director''), shall—

(1) review uptake and utilization of diabetes screening benefits to identify and address any existing problems with regard to utilization and data collection mechanisms;

(2) establish an outreach program to identify existing efforts by agencies and by the private and nonprofit sectors to increase awareness among seniors and providers of diabetes screening benefits; and

(3) maximize cost effectiveness in increasing utilization of diabetes screening benefits.

(b) CONSULTATION.—In carrying out this section, the Secretary and the Director shall consult with—

(1) various units of the Federal Government, including the Centers for Medicare & Medicaid Services, the Surgeon General of the Public Health Service, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, and the National Institutes of Health; and

(2) entities with an interest in diabetes, including industry, voluntary health organizations, trade associations, and professional societies.

**SEC. ____3. ADVISORY GROUP REGARDING EMPLOYEE WELLNESS AND DISEASE MANAGEMENT BEST PRACTICES.**

(a) ESTABLISHMENT.—The Secretary shall establish an advisory group consisting of representatives of the public and private sector. The advisory group shall include—

(1) representatives of the Department of Health and Human Services;

(2) representatives of the Department of Commerce; and

(3) members of the public, representatives of the private sector, and representatives of the small business community, who have experience with diabetes or in administering and operating employee wellness and disease management programs.

(b) DUTIES.—The advisory group established under subsection (a) shall examine and make recommendations of best practices of employee wellness and disease management programs in order to—

(1) provide public and private sector entities with improved information in assessing the role of employee wellness and disease management programs in saving money and improving quality of life for patients with chronic illnesses; and

(2) encourage the adoption of effective employee wellness and disease management programs.

(c) REPORT.—Not later than 1 year after the date of the enactment of this Act, the advisory group established under subsection (a) shall submit to the Secretary the results of the examination under subsection (b)(1).

**SEC. ____4. NATIONAL DIABETES REPORT CARD.**

(a) IN GENERAL.—The Secretary, in collaboration with the Director of the Centers for Disease Control and Prevention (referred to in this section as the ''Director''), shall prepare on a biennial basis a national diabetes report card (referred to in this section as a ''Report Card'') and, to the extent possible, for each State.

(b) CONTENTS.—

(1) IN GENERAL.—Each Report Card shall include aggregate health outcomes related to individuals diagnosed with diabetes and prediabetes including—

(A) preventative care practices and quality of care;

(B) risk factors; and

(C) outcomes.

(2) UPDATED REPORTS.—Each Report Card that is prepared after the initial Report Card shall include trend analysis for the Nation and, to the extent possible, for each State, for the purpose of—

(A) tracking progress in meeting established national goals and objectives for improving diabetes care, costs, and prevalence (including Healthy People 2010); and

(B) informing policy and program development.

(c) AVAILABILITY.—The Secretary, in collaboration with the Director, shall make each Report Card publicly available, including by posting the Report Card on the Internet.

**SEC. ____5. IMPROVEMENT OF VITAL STATISTICS COLLECTION.**

(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in collaboration with appropriate agencies and States, shall—

(1) promote the education and training of physicians on the importance of birth and death certificate data and how to properly complete these documents, including the collection of such data for diabetes and other chronic diseases;

(2) encourage State adoption of the latest standard revisions of birth and death certificates; and

(3) work with States to re-engineer their vital statistics systems in order to provide cost-effective, timely, and accurate vital systems data.

(b) DEATH CERTIFICATE ADDITIONAL LANGUAGE.—In carrying out this section, the Secretary may promote improvements to the collection of diabetes mortality data, including the addition of a question for the individual certifying the cause of death regarding whether the deceased had diabetes.

**SEC. ____6. STUDY ON APPROPRIATE LEVEL OF DIABETES MEDICAL EDUCATION.**

(a) IN GENERAL.—The Secretary shall, in collaboration with the Institute of Medicine and appropriate associations and councils, conduct a study of the impact of diabetes on the practice of medicine in the United States and the appropriateness of the level of diabetes medical education that should be required prior to licensure, board certification, and board recertification.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit a report on the study under subsection (a) to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committees on Finance and Health, Education, Labor, and Pensions of the Senate.

**SEC. ____7. AUTHORIZATION OF APPROPRIATIONS.**

There are authorized to be appropriated to carry out this subtitle such sums as may be necessary.

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**SA 3004.** Mrs. HAGAN (for herself and Mr. BENNET) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 32, after line 24, add the following:

''(d) CLEAR TRANSPARENCY OF HEALTH CARE CHARGES.—

''(1) PUBLIC DISCLOSURE OF REIMBURSEMENT AMOUNTS.—A health insurance issuer offering group or individual health insurance coverage shall report at least once a year to the Secretary the current allowable reimbursement that the issuer will provide for all covered benefits and services (other than prescription medications dispensed through a licensed pharmacy), including—

''(A) with respect to services provided by in-network providers where payment is made in part or in full on a fee for service basis, the current allowed charge for specific services using currently accepted procedure coding associated with each provider; and

''(B) the expected reasonable and allowed charges made for services by out-of-network providers and the amount the issuer would reimburse for such charges.

''(2) ACCESSIBILITY.—Information submitted to the Secretary under paragraph (1) shall be maintained by the Secretary in a manner that ensures that such information is readily accessible by the public.

''(3) REGULATIONS.—Not later than one year after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall promulgate regulations to implement the requirements of this subsection.''.

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**SA 3005.** Ms. LANDRIEU (for herself, Mrs. SHAHEEN, and Ms. SNOWE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 150, line 5, strike ''small business development centers'' and insert ''resource partners of the Small Business Administration''.

**SA 3006.** Ms. LANDRIEU (for herself, Mrs. SHAHEEN, and Ms. SNOWE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1280, between lines 18 and 19, insert the following:

(VIII) small business concerns (as defined under section 3 of the Small Business Act (15 U.S.C. 632)) and self-employed individuals; and

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**SA 3007.** Ms. LANDRIEU (for herself, Mrs. SHAHEEN, and Ms. SNOWE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 163, between lines 21 and 22, insert the following:

(4) a survey of the cost and affordability of health care insurance provided under the Exchanges for owners and employees of small business concerns (as defined under section 3 of the Small Business Act (15 U.S.C. 632)), including data on enrollees in Exchanges and individuals purchasing health insurance coverage outside of Exchanges; and

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**SA 3008.** Ms. LANDRIEU (for herself, Ms. SNOWE, and Mrs. SHAHEEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2074, after line 25, add the following:

**SEC. 9024. SMALL BUSINESS PROCUREMENT.**

Part 19 of the Federal Acquisition Regulation, section 15 of the Small Business Act (15 U.S.C. 644), and any other applicable laws or regulations establishing procurement requirements relating to small business concerns (as defined in section 3 of the Small Business Act (15 U.S.C. 632)) may not be waived with respect to any contract awarded under any program or other authority under this Act or an amendment made by this Act.

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**SA 3009.** Ms. LANDRIEU (for herself, Mrs. SHAHEEN, and Ms. SNOWE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 54, between lines 16 and 17, insert the following:

(f) ALLOCATION OF FUNDING FOR SMALL BUSINESSES.—Of the amount appropriated under subsection (e), a reasonable amount, as determined by the Secretary, shall be used to provide reimbursement to participating employment-based plans of small employers with 50 or fewer employees.

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**SA 3013.** Ms. LANDRIEU (for herself, Mrs. SHAHEEN, and Ms. SNOWE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 55, line 4, strike ''website,'' and all that follows through line 5 on page 56 and insert the following: ''website, through which a resident of, or small business in, any State may identify affordable health insurance coverage options in that State.

(2) CONNECTING TO AFFORDABLE COVERAGE.—An Internet website established under paragraph (1) shall, to the extent practicable, provide ways for residents of, and small businesses in, any State to receive information on at least the following coverage options:

(A) Health insurance coverage offered by health insurance issuers, other than coverage that provides reimbursement only for the treatment or mitigation of—

(i) a single disease or condition; or

(ii) an unreasonably limited set of diseases or conditions (as determined by the Secretary).

(B) Medicaid coverage under title XIX of the Social Security Act.

(C) Coverage under title XXI of the Social Security Act.

(D) A State health benefits high risk pool, to the extent that such high risk pool is offered in such State; and

(E) Coverage under a high risk pool under section 1101.

(F) Coverage within the small group market for small businesses and their employees, including reinsurance for early retirees under section 1102, tax credits available under section 45R of the Internal Revenue Code of 1986 (as added by section 1421), and other information specifically for small businesses regarding affordable health care options.''.

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**SA 3011.** Ms. LANDRIEU (for herself, Mrs. SHAHEEN, and Mrs. LINCOLN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 349, line 16, strike all through page 350, line 14.

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**SA 3012.** Ms. LANDRIEU (for herself, Mrs. SHAHEEN, and Ms. STABENOW) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2074, after line 25, add the following:

**SEC. 9024. EXTENSION OF SMALL BUSINESS TAX CREDIT TO 5 YEARS.**

(a) IN GENERAL.—Section 45R(e)(2) of the Internal Revenue Code of 1986, as added by section 1421(a), is amended by striking ''2-consecutive-taxable year'' and inserting ''5-consecutive-taxable year''.

(b) CONFORMING AMENDMENT.—Section 45R(i)) of the Internal Revenue Code of 1986, as so added, is amended by striking ''2-year'' and inserting ''5-year''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 1421.

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**SA 3013.** Ms. LANDRIEU (for herself, Mrs. SHAHEEN, and Ms. STABENOW) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 274, after line 25, add the following:

**SEC. 90___. PARTIAL DEDUCTION FOR HEALTH INSURANCE COSTS IN COMPUTING SELF-EMPLOYMENT TAXES.**

(a) IN GENERAL.—Paragraph (4) of section 162(l) of the Internal Revenue Code of 1986 is amended to read as follows:

''(4) REDUCED DEDUCTION FOR SELF-EMPLOYMENT TAX PURPOSES.—In determining an individual's net earnings from self-employment (within the meaning of section 1402(a)) for purposes of chapter 2, the deduction allowable by reason of this subsection shall be reduced by an amount equal to 50 percent of the amount which would otherwise be allowable (determined without regard to this paragraph).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

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**SA 3014.** Ms. LANDRIEU (for herself, Mrs. SHAHEEN, and Ms. STABENOW) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2074, after line 25, add the following:

**SEC. 9024. EXTENSION OF SMALL BUSINESS TAX CREDIT TO 2010.**

(a) IN GENERAL.—Subsections (d)(3)(B)(i) and (g) of section 45R of the Internal Revenue Code of 1986, as added by section 1421(a),

is amended by striking ''2011'' each place it appears and inserting ''2010, 2011''.

(b) CONFORMING AMENDMENTS.—

(1) Section 280C(h) of the Internal Revenue Code of 1986, as added by section 1421(d)(1), is amended by striking ''2011'' and inserting ''2010, 2011''.

(2) Section 1421(f) is amended by striking ''2010'' both places it appears and inserting ''2009''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 1421.

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**SA 3015.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. PROTECTION OF ACCESS TO QUALITY HEALTH CARE THROUGH THE DEPARTMENT OF VETERANS AFFAIRS AND THE DEPARTMENT OF DEFENSE.**

(a) HEALTH CARE THROUGH DEPARTMENT OF VETERANS AFFAIRS.—Nothing in this Act shall be construed to prohibit, limit, or otherwise penalize veterans and dependents eligible for health care through the Department of Veterans Affairs under the laws administered by the Secretary of Veterans Affairs from receiving timely access to quality health care in any facility of the Department or from any non-Department health care provider through which the Secretary provides health care.

(b) HEALTH CARE THROUGH DEPARTMENT OF DEFENSE.—

(1) IN GENERAL.—Nothing in this Act shall be construed to prohibit, limit, or otherwise penalize eligible beneficiaries from receiving timely access to quality health care in any military medical treatment facility or under the TRICARE program.

(2) DEFINITIONS.—In this subsection:

(A) The term ''eligible beneficiaries'' means covered beneficiaries (as defined in section 1072(5) of title 10, United States Code) for purposes of eligibility for mental and dental care under chapter 55 of title 10, United States Code.

(B) The term ''TRICARE program'' has the meaning given that term in section 1072(7) of title 10, United States Code.

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**SA 3016.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 246, between lines 7 and 8, insert the following:

''(C) SPECIAL RULES TO ENSURE CITIZENS AND NATIONALS OF THE UNITED STATES HAVE THE SAME HEALTH CARE CHOICES AS LEGAL IMMIGRANTS.—

''(i) IN GENERAL.—Notwithstanding any other provision of this Code, the Patient Protection and Affordable Care Act, or any amendment made by that Act, any taxpayer who—

''(I) is a citizen or national of the United States; and

''(II) has a household income which is not greater than 133 percent of an amount equal to the poverty line for a family of the size involved,

may elect to enroll in a qualified health plan through the Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act instead of enrolling in the State Medicaid plan under title XIX of the Social Security, or under a waiver of such plan.

''(ii) SPECIAL RULES.—

''(I) An individual making an election under clause (i) shall waive being provided with medical assistance under the State Medicaid plan under title XIX of the Social Security, or under a waiver of such plan while enrolled in a qualified health plan.

''(II) In the case of an individual who is a child, the child's parent or legal guardian may make such an election on behalf of the child.

''(III) Any individual making such an election, or on whose behalf such an election is made, shall be treated as an applicable taxpayer with a household income which is equal to 100 percent of the poverty line for a family of the size involved.

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**SA 3017.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of part I of subtitle C of title I, insert the following:

**SEC. 1202. APPLICATION OF WELLNESS PROGRAMS PROVISIONS TO CARRIERS PROVIDING FEDERAL EMPLOYEE HEALTH BENEFITS PLANS.**

(a) IN GENERAL.—Notwithstanding section 8906 of title 5, United States Code (including subsections (b)(1) and (b)(2) of such section), section 2705(j) of the Public Health Service Act (as added by section 1201) (relating to wellness programs) shall apply to carriers entering into contracts under section 8902 of title 5, United States Code.

(b) PROPOSALS.—Carriers may submit separate proposals relating to voluntary wellness program offerings as part of the annual call for benefit and rate proposals to the Office of Personnel Management.

(c) EFFECTIVE DATE.—This subsection shall take effect on the date of enactment of this Act and shall apply to contracts entered into under section 8902 of title 5, United States Code, that take effect with respect to calendar years that begin more than 1 year after that date.

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**SA 3018.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. APPOINTMENT OF HEALTH CARE CZARS.**

Notwithstanding any other provision of this Act, any individual appointed by the President as a czar to handle health care issues shall be subject to Senate confirmation.

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**SA 3019.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 100, line 16, insert '' or meets the requirements for a high deductible health plan under section 223(c)(2) of the Internal Revenue Code of 1986'' after ''section 1302(a)''.

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**SA 3020.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. EQUIVALENT BANKRUPTCY PROTECTIONS FOR HEALTH SAVINGS ACCOUNTS AS RETIREMENT FUNDS.**

(a) IN GENERAL.—Section 522 of title 11, United States Code, is amended by adding at the end the following new subsection:

''(r) TREATMENT OF HEALTH SAVINGS ACCOUNTS.—For purposes of this section, any health savings account (as described in section 223 of the Internal Revenue Code of 1986) shall be treated in the same manner as an individual retirement account described in section 408 of such Code.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to cases commencing under title 11, United States Code, after the date of the enactment of this Act.

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**SA 3021.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 816, after line 20, insert the following:

**SEC. 3115. ENSURING THAT AN INDIVIDUAL WHO ELECTS TO OPT-OUT OF MEDICARE PART A BENEFITS IS NOT ALSO REQUIRED TO OPT-OUT OF SOCIAL SECURITY BENEFITS.**

Notwithstanding any other provision of law, in the case of an individual who elects to opt-out of benefits under part A of title XVIII of the Social Security Act, such individual shall not be required to opt-out of

benefits under title II of such Act as a condition for making such election.

**SA 3022.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 923, between lines 7 and 8, insert the following:

**SEC. ___. LIMITATION ON IMPLEMENTATION.**

Notwithstanding any other provision of law, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall not implement the amendments made by and the provisions of this part for any year unless the Secretary certifies with respect to such year that such amendments and provisions will not result in any individual who would otherwise be enrolled in a Medicare Advantage plan under part C of title XVIII of the Social Security Act being forced away from or losing their enrollment in such plan, as such enrollment was in effect on the day before the date of enactment of this Act.

**SA 3023.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1053, between lines 2 and 3, insert the following:

**SEC. 3404. ENSURING MEDICARE SAVINGS ARE KEPT IN THE MEDICARE PROGRAM.**

No reduction in outlays under the Medicare program under title XVIII of the Social Security Act under the provisions of and amendments made by this Act may be utilized to offset any outlays under any other program or activity of the Federal government.

**SA 3024.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. PROHIBITION ON USING MEDICARE SAVINGS TO OFFSET PROGRAMS UNRELATED TO MEDICARE.**

Title III of the Congressional Budget Act of 1974 (2 U.S.C. 621 et seq.) is amended by adding at the end the following:

**''SEC. 316. PROHIBITION ON USING MEDICARE SAVINGS TO OFFSET PROGRAMS UNRELATED TO MEDICARE.**

''For purposes of this title and title IV, a reduction in outlays under title XVIII of the Social Security Act may not be counted as an offset to any outlays under any other program or activity of the Federal Government.''.

**SA 3025.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1050, between lines 9 and 10, insert the following:

''(n) REDUCTIONS IN MEDICARE PROGRAM SPENDING NOT COUNTED TOWARDS THE PAY-AS-YOU-GO SCORECARD.—Any reductions in Medicare program spending enacted pursuant to this section shall not count towards the pay-as-you-go scorecard under section 201(a)(6) of S. Con. Res. 21 (110th Congress).''.

**SA 3026.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2044, between lines 7 and 8, insert the following:

(d) ADDITIONAL HOSPITAL INSURANCE TAX SOLELY DEDICATED TO MEDICARE.—It is the policy of Congress that the additional hospital insurance taxes resulting from the amendments made by this section shall, as is the case regarding such taxes under the Social Security Act as in effect on the date of the enactment of this Act, be deposited into the Federal Hospital Insurance Trust Fund and under the terms of that Trust Fund used only for purposes of funding the medicare program under part A of title XVIII of the Social Security Act.

**SA 3027.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 436, between lines 14 and 15, insert the following:

**SEC. 2008. STATE OPTION TO OPT-OUT OF MEDICAID COVERAGE EXPANSION TO AVOID ASSUMING UNFUNDED FEDERAL MANDATE.**

Notwithstanding any other provision of this Act (or an amendment made by this Act), the Governor of a State shall have the authority to opt out of any provision under this Act or any amendment made by this Act that requires the State to expand coverage under the Medicaid program if the State agency responsible for administering the State plan under title XIX certifies that such expansion would result in an increase of at least 1 percent in the total amount of expenditures by the State for providing medical assistance to all individuals enrolled under the State plan, when compared to the total amount of such expenditures for the most recently ended State fiscal year.

**SA 3028.** Mr. ENSIGN submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. STUDY AND REPORT ON MEDICARE COVERAGE FOR MEDICAL EQUIPMENT USED IN THE TREATMENT OF CIRCULATORY DISEASES.**

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study on the feasibility and advisability of providing for reimbursement under the Medicare program under title XVIII of the Social Security Act for gradient pumps and compression stockings that are used in the treatment of individuals with lymphedema, chronic venous insufficiency, and other circulatory diseases. Such study shall include an analysis of the following:

(1) The types of gradient pumps and compression stockings that are currently available on the market.

(2) The clinical appropriateness of providing gradient pumps and compression stockings for Medicare beneficiaries who have been diagnosed with lymphedema, chronic venous insufficiency, and other circulatory diseases.

(3) The financial impact on the Medicare program (including a description of any resulting costs or savings) if reimbursement were to be provided for gradient pumps and compression stockings that are used in the treatment of lymphedema, chronic venous insufficiency, and other circulatory diseases.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall submit a report to Congress on the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

**SA 3029.** Mr. THUNE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 356, between lines 19 and 20, insert the following:

''(f) LIMITATION.—A full-time employee shall not be taken into account for purposes of calculating the amount of any assessable payment imposed under subsections (a), (b), or (c) if such employee performs the majority of services in a State—

''(1) the unemployment rate of which exceeds 6 percent, and

''(2) the Governor of which has certified that the assessable penalties imposed under this section have contributed to such unemployment rate.''.

**SA 3030.** Mrs. FEINSTEIN (for herself, Mr. ROCKEFELLER, and Mr. WHITEHOUSE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 37, strike line 10 through line 14 and insert the following:

''(1) IN GENERAL.—

''(A) ESTABLISHMENT.—The Secretary, in conjunction with States, shall establish a uniform process for the annual review, beginning with the 2010 plan year and subject to subsection (b)(2)(A), of unreasonable increases in premiums for health insurance coverage.

''(B) ELECTRONIC REPORTING.—The process established under subparagraph (A) shall include an electronic reporting system established by the Secretary through which health insurance issuers shall report to the Secretary and State insurance commissioners the information requested by the Secretary pursuant to this subsection.

On page 37, between lines 24 and 25, insert the following:

''(3) HEALTH INSURANCE RATE AUTHORITY.—

''(A) IN GENERAL.—The Secretary shall establish a Health Insurance Rate Authority (referred to in this paragraph as the 'Authority') to be composed of 7 members to be appointed by the Secretary, of which—

''(i) at least 2 members shall be a consumer advocate with expertise in the insurance industry;

''(ii) at least 1 member shall be an individual who is a medical professional;

''(iii) at least 1 member shall be a representative of health insurance issuers; and

''(iv) such remaining members shall be individuals who are recognized for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, and other related fields, who provide broad geographic representation and a balance between urban and rural members.

''(B) ROLE.—In addition to the other duties of the Authority set forth in this subsection, the Authority shall advise and make recommendations to the Secretary concerning the Secretary's duties under this subsection.

''(4) CORRECTIVE ACTION FOR UNJUSTIFIED RATE INCREASES.—

''(A) IN GENERAL.—Pursuant to the procedures set forth in this paragraph, the Secretary or the relevant State insurance commissioner shall—

''(i) review potentially unreasonable rate increases and determine whether such increases are justified; and

''(ii) take action to ensure that any rate increase found to be unjustified under clause (i) is corrected, through mechanisms including—

''(I) denial of the rate increase;

''(II) modification of the rate increase;

''(III) ordering rebates to consumers; or

''(IV) any other actions that correct for the unjustified increase.

''(B) REQUIRED REPORT.—The Secretary shall ensure that, not later than 6 months after the date of enactment of the Patient Protection and Affordable Care Act, the National Association of Insurance Commissioners (referred to in this section as the 'Association'), in conjunction with States, or other appropriate body, will provide to the Secretary and the Authority a report on—

''(i) State authority to review rates in each insurance market, and methodologies used in such reviews;

''(ii) rating requests received by the State in the previous 12 months and subsequent actions taken by States to approve, deny, or modify such requests; and

''(iii) justifications by insurance issuers for rate requests.

''(C) DETERMINATION OF WHO CONDUCTS REVIEWS FOR EACH STATE.—Using the report submitted pursuant to subparagraph (B), the Secretary shall determine not later than 1 year after the date of enactment of the Patient Protection and Affordable Care Act—

''(i) for which States the State insurance commissioner shall undertake the actions described in subparagraph (A)—

''(I) based on the Secretary's determination that the State has sufficient authority and capability to deny rates, modify rates, provide rebates, or take other corrective actions; and

''(II) as a condition of receiving a grant under subsection (c)(1); and

''(ii) for which States the Secretary shall undertake the actions described in subparagraph (A), based on the Secretary's determination that such States lacks the authority and capability described in clause (i).

''(D) TRANSITION PERIOD.—Until the Secretary makes the determinations described in subparagraph (C), the relevant State insurance commissioner shall, as a condition of receiving a grant under subsection (c)(1), carry out the action described in subparagraph (A).

''(E) SUNSET.—Beginning on the date on which subsection (b)(2)(A) applies, the requirements of this paragraph shall no longer have force or effect.

''(5) PRIORITIZING PROPOSED PREMIUM INCREASES FOR REVIEW.—In determining which proposed premium increases to review under this subsection, the Secretary or the relevant State insurance commissioner may prioritize—

''(A) rate increases which exceed market averages;

''(B) rate increases that will impact large numbers of consumers; and

''(C) rate reviews requested from States, if applicable.

''(6) ANNUAL REPORT.—

''(A) UNIFORM DATA COLLECTION SYSTEM.—The Secretary, in consultation with the Association and the Authority, shall develop a uniform data collection system for rate information, which shall include information on rates, medical loss ratios, consumer complaints, solvency, reserves, and any other relevant factors of market conduct.

''(B) PREPARATION OF ANNUAL REPORT.—Using the data obtained in accordance with subparagraph (A), the Authority shall annually produce a single, aggregate report on insurance market behavior, which includes—

''(i) State-by-State information on rate increases from one year to the next, including by issuer and by market and including medical trends, benefit changes, and relevant demographic changes; and

''(ii) a national growth rate percentage for every issuer, which shall be based on aggregated data of such issuer from premiums sold in the each market.

''(C) DISTRIBUTION.—The Authority shall share the annual report described in subparagraph (B) with States, and include such report in the information disclosed to the public.

''(7) RECOMMENDATION ON EXCHANGE PARTICIPATION.—

''(A) IN GENERAL.—Based on the information provided pursuant to this subsection and other relevant information, the official described in subparagraph (B) shall make recommendations to State Exchanges about whether particular health insurance issuers should be excluded from participation in the Exchange based on a pattern of excessive premium increases, low medical loss ratios, or market conduct.

''(B) REVIEWING OFFICIAL.—Either the Secretary or the relevant State insurance commissioner or commissioners, based on the determination in paragraph (4)(C), shall make the recommendations described in subparagraph (A).

On page 144, line 12, strike ''may'' and insert ''shall''.

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**SA 3031.** Mr. WHITEHOUSE (for himself and Mr. CASEY) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1507, after line 19, insert the following:

**SEC. 5510. SUPPORT OF GRADUATE MEDICAL EDUCATION PROGRAMS IN WOMEN'S HOSPITALS.**

Subpart IX of part D of title III of the Public Health Service Act (42 U.S.C. 256e et seq.) is amended—

(1) in the subpart heading, by adding ''**and Women's Hospitals**'' at the end; and

(2) by adding at the end the following:

**''SEC. 340E-1. SUPPORT OF GRADUATE MEDICAL EDUCATION PROGRAMS IN WOMEN'S HOSPITALS.**

''(a) PAYMENTS.—The Secretary shall make two payments under this section to each women's hospital for each of fiscal years 2010 through 2014, one for the direct expenses and the other for indirect expenses associated with operating approved graduate medical residency training programs. The Secretary shall promulgate regulations pursuant to the rulemaking requirements of title 5, United States Code, which shall govern payments made under this subpart.

''(b) AMOUNT OF PAYMENTS.—

''(1) IN GENERAL.—Subject to paragraphs (2) and (3), the amounts payable under this section to a women's hospital for an approved graduate medical residency training program for a fiscal year shall be each of the following:

''(A) DIRECT EXPENSE AMOUNT.—The amount determined in accordance with subsection (c) for direct expenses associated with operating approved graduate medical residency training programs for a fiscal year.

''(B) INDIRECT EXPENSE AMOUNT.—The amount determined in accordance with subsection (c) for indirect expenses associated with the treatment of more severely ill patients and the additional costs relating to teaching residents in such programs for a fiscal year.

''(2) CAPPED AMOUNT.—

''(A) IN GENERAL.—The total of the payments made to women's hospitals under paragraph (1) in a fiscal year shall not exceed the funds appropriated under subsection (e) for such payments for that fiscal year.

''(B) PRO RATA REDUCTIONS OF PAYMENTS.—If the Secretary determines that the amount of funds appropriated under subsection (e) for a fiscal year is insufficient to provide the total amount of payments otherwise due for such periods under paragraph (1), the Secretary shall reduce the amounts so payable on a pro rata basis to reflect such shortfall.

''(3) ANNUAL REPORTING REQUIRED.—The provisions of subsection (b)(3) of section 340E shall apply to women's hospitals under this section in the same manner as such provisions apply to children's hospitals under such section 340E. In applying such provisions, the Secretary may make such modifications as may be necessary to apply such provisions to women's hospitals.

''(c) APPLICATION OF CERTAIN PROVISIONS.—The provisions of subsections (c) and (d) of section 340E shall apply to women's hospitals under this section in the same manner as such provisions apply to children's hospitals under such section 340E. In applying such provisions, the Secretary may make such modifications as may be necessary to apply such provisions to women's hospitals.

''(d) MAKING OF PAYMENTS.—

''(1) INTERIM PAYMENTS.—The Secretary shall determine, before the beginning of each fiscal year involved for which payments may be made for a hospital under this section, the amounts of the payments for direct graduate medical education and indirect medical education for such fiscal year and shall (subject to paragraph (2)) make the payments of such amounts in 12 equal interim installments during such period. Such interim payments to each individual hospital shall be based on the number of residents reported in the hospital's most recently filed Medicare cost report prior to the application date for the Federal fiscal year for which the interim payment amounts are established. In the case of a hospital that does not report residents on a Medicare cost report, such interim payments shall be based on the number of residents trained during the hospital's most recently completed Medicare cost report filing period.

''(2) WITHHOLDING.—The Secretary shall withhold up to 25 percent from each interim installment for direct and indirect graduate medical education paid under paragraph (1) as necessary to ensure a hospital will not be overpaid on an interim basis.

''(3) RECONCILIATION.—Prior to the end of each fiscal year, the Secretary shall determine any changes to the number of residents reported by a hospital in the application of the hospital for the current fiscal year to determine the final amount payable to the hospital for the current fiscal year for both direct expense and indirect expense amounts. Based on such determination, the Secretary shall recoup any overpayments made and pay any balance due to the extent possible. The final amount so determined shall be considered a final intermediary determination for the purposes of section 1878 of the Social Security Act and shall be subject to administrative and judicial review under that section in the same manner as the amount of payment under section 1886(d) of such Act is subject to review under such section.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $12,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2014.

''(f) DEFINITIONS.—In this section:

''(1) APPROVED GRADUATE MEDICAL RESIDENCY TRAINING PROGRAM.—The term 'approved graduate medical residency training program' has the meaning given the term 'approved medical residency training program' in section 1886(h)(5)(A) of the Social Security Act.

''(2) DIRECT GRADUATE MEDICAL EDUCATION COSTS.—The term 'direct graduate medical education costs' has the meaning given such term in section 1886(h)(5)(C) of the Social Security Act.

''(3) WOMEN'S HOSPITAL.—The term 'women's hospital' means a hospital—

''(A) that has a Medicare provider agreement under title XVIII of the Social Security Act;

''(B) that has an approved graduate medical residency training program;

''(C) that has not been excluded from the Medicare prospective payment system;

''(D) that had at least 3,000 births during 2007, as determined by the Centers for Medicare & Medicaid Services; and

''(E) with respect to which and as determined by the Centers for Medicare & Medicaid Services, less than 4 percent of the total discharges from the hospital during 2007 were Medicare discharges of individuals who, as of the time of the discharge—

''(i) were enrolled in the original Medicare fee-for-service program under part A of title XVIII of the Social Security Act; and

''(ii) were not enrolled in—

''(I) a Medicare Advantage plan under part C of title XVIII of that Act;

''(II) an eligible organization under section 1876 of that Act; or

''(III) a PACE program under section 1894 of that Act.''.

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**SA 3032.** Mrs. BOXER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 36, strike line 23 and insert the following: ''be necessary to carry out this section.

**''SEC. 2793A. IMPROVING OVERSIGHT OF INSURER SERVICE TO BENEFICIARIES.**

''(a) DEFINITIONS.—In this section—

''(1) the term 'database' means the database established under subsection (b); and

''(2) the term 'NAIC' means the National Association of State Insurance Commissioners.

''(b) MONITORING INSURER HANDLING OF REQUESTS FOR COVERAGE OF MEDICAL CARE.—

''(1) ESTABLISHMENT.—The Secretary shall, in consultation with the NAIC, establish and maintain a nationally consistent database that, using standardized definitions, tracks claims handling performance by—

''(A) all group health plans (and health insurance issuers offering group health insurance coverage in connection with a group health plan) and health insurance issuers that offer health insurance coverage in the individual market; and

''(B) external review organizations that consider and resolve external appeals from such plans and issuers.

''(2) CONTENT.—The database shall include information on the nature, timing, final disposal, and other relevant details (as determined by the Secretary) of claims, appeals, reviews, and requests for or denials of treatment by the entities described in paragraph (1). The Secretary may limit the content of the database to those claims that are monetarily significant, as determined by the Secretary.

''(3) COLLECTION OF DATA.—The Secretary shall have the authority to collect and audit data from entities described in paragraph (1) necessary to implement the database, except that, in the case of such plans and issuers subject to the Employee Retirement Income Security Act of 1974, such data shall be collected by the Secretary of Labor for use by the Secretary. At the discretion of the Secretary, such data collection authority may be delegated to State insurance regulators.

''(4) DATA PROTECTION AND PRIVACY.—The Secretary and the Secretary of Labor shall ensure the confidentiality and privacy of any claims data submitted pursuant to this section. Within 1 year of the date of enactment of this section, the Secretary shall promulgate a proposed regulation to ensure that such data is protected against any violation of the privacy and confidentiality of an individual's medical records. Within 180 days of such promulgation, the Comptroller General shall publish a report on the adequacy of such regulation to ensure such protection. The database shall not include names, unencrypted Social Security numbers, addresses, or other information that may uniquely identify an individual.

''(5) TABULATION; CLASSIFICATION.—The Secretary shall work with the NAIC to develop a procedure for centralized tabulation and classification of consumer complaints related to claims handling, appeals, and reviews by the entities described in paragraph (1).

''(c) IMPLEMENTATION.—The Secretary shall implement the database not later than 2 years after the date of enactment of this section.

''(d) DISSEMINATION.—The Secretary shall make the database available to State insurance regulators, health exchanges, and consumer assistance ombudsmen, provided that such entities ensure the confidentiality and privacy of medical records and comply with all existing privacy laws, and shall update the database on a quarterly basis.

''(e) REPORTING.—Not later than January 1, 2013, and on an annual basis thereafter, the Secretary shall issue a public report assessing the performance of the plans and issuers described in subsection (b)(1)(A) regarding claims handling, appeals, and reviews. Such report shall assess whether there is any evidence of a pattern of denial or delay of medically necessary claims or appeals.''.

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**SA 3033.** Mr. CASEY (for himself and Mr. SPECTER) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1133, between lines 22 and 23, insert the following:

**SEC. 3511. CONSISTENT QUALITY ACCREDITATION REQUIREMENTS FOR PROVIDERS CONTRACTING WITH MEDICARE ADVANTAGE PLANS AND STATE MEDICAID PROGRAMS.**

(a) MEDICARE ADVANTAGE.—Section 1854(a)(6)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–24(a)(6)(B)(iii)) is amended—

(1) by striking ''In order to'' and inserting the following:

''(aa) IN GENERAL.—In order to''; and

(2) by adding at the end the following:

''(bb) QUALITY ASSURANCE.—An MA organization shall not prohibit a particular hospital, physician or other entity within a category of healthcare providers from eligibility to contract with the MA organization because of a separate policy of the MA organization that does not recognize an approved nationally recognized accreditation organization with the appropriate 'deeming authority' from the Secretary.''.

(b) STATE MEDICAID PLAN REQUIREMENT.—Section 1902(a)(23) of the Social Security Act (42 U.S.C. 1396a(a)(23)) is amended by inserting ''and (C) the State plan and a primary

care case-management system (described in section 1915(b)(1)), a medicaid managed care organization, or a similar entity shall not prohibit a particular hospital, physician or other entity within a category of healthcare providers from being qualified to perform a service or services because of a separate policy of the State plan, system, organization, or entity that does not recognize an approved nationally recognized accreditation organization with the appropriate 'deeming authority' from the Secretary'' after ''subsection (g) and in section 1915''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on the date of enactment of this Act and, in the case of MA organizations under part C of title XVIII of the Social Security Act, apply to plan years beginning after that date.

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**SA 3034.** Mr. TESTER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 828, between lines 3 and 4, insert the following:

**SEC. 3130. CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM FOR RURAL ENTITIES.**

(a) IN GENERAL.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by inserting after section 1602 the following:

**''SEC. 1603. CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM FOR RURAL ENTITIES.**

''(a) AUTHORITY TO MAKE AND GUARANTEE LOANS.—

''(1) AUTHORITY TO MAKE LOANS.—The Secretary may make loans from the fund established under section 1602(d) to any rural entity for projects for capital improvements, including—

''(A) the acquisition of software and hardware necessary to implement electronic health records as required under section 3011;

''(B) the acquisition of land necessary for the capital improvements;

''(C) the renovation or modernization of any building;

''(D) the acquisition or repair of fixed or major movable equipment; and

''(E) such other project expenses as the Secretary determines appropriate.

''(2) AUTHORITY TO GUARANTEE LOANS.—

''(A) IN GENERAL.—The Secretary may guarantee the payment of principal and interest for loans made to rural entities for projects for any capital improvement described in paragraph (1) to any non-Federal lender.

''(B) INTEREST SUBSIDIES.—In the case of a guarantee of any loan made to a rural entity under subparagraph (A), the Secretary may pay to the holder of such loan, for and on behalf of the project for which the loan was made, amounts sufficient to reduce (by not more than 3 percent) the net effective interest rate otherwise payable on such loan.

''(b) AMOUNT OF LOAN.—The principal amount of a loan directly made or guaranteed under subsection (a) for a project for capital improvement may not exceed $2,500,000.

''(c) FUNDING LIMITATIONS.—

''(1) GOVERNMENT CREDIT SUBSIDY EXPOSURE.—The total of the Government credit subsidy exposure under the Federal Credit Reform Act of 1990 scoring protocol with respect to the loans outstanding at any time with respect to which guarantees have been issued, or which have been directly made, under subsection (a) may not exceed $50,000,000 per year.

''(2) TOTAL AMOUNTS.—Subject to paragraph (1), the total of the principal amount of all loans directly made or guaranteed under subsection (a) may not exceed $400,000,000 per year.

''(d) CAPITAL ASSESSMENT AND PLANNING GRANTS.—

''(1) NONREPAYABLE GRANTS.—Subject to paragraph (2), the Secretary may make a grant to a rural entity, in an amount not to exceed $50,000, for purposes of capital assessment and business planning.

''(2) LIMITATION.—The cumulative total of grants awarded under this subsection may not exceed $2,500,000 per year.

''(e) TERMINATION OF AUTHORITY.—The Secretary may not directly make or guarantee any loan under subsection (a) or make a grant under subsection (d) after September 30, 2013.''.

(b) RURAL ENTITY DEFINED.—Section 1624 of the Public Health Service Act (42 U.S.C. 300s–3) is amended by adding at the end the following:

''(15)(A) The term 'rural entity' includes—

''(i) a rural health clinic, as defined in section 1861(aa)(2) of the Social Security Act;

''(ii) any medical facility with at least 1 bed, but not more than 49 beds, that is located in—

''(I) a county that is not part of a metropolitan statistical area; or

''(II) a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)); and

''(iii) a hospital that is classified as a critical access hospital or a rural hospital with fewer than 1,500 discharges per year.

''(B) For purposes of subparagraph (A), the fact that a clinic, facility, or hospital has been geographically reclassified under the Medicare program under title XVIII of the Social Security Act shall not preclude a hospital from being considered a rural entity under clause (i) or (ii) of subparagraph (A).''.

(c) CONFORMING AMENDMENTS.—Section 1602 of the Public Health Service Act (42 U.S.C. 300q–2) is amended—

(1) in subsection (b)(2)(D), by inserting ''or 1603(a)(2)(B)'' after ''1601(a)(2)(B)''; and

(2) in subsection (d)—

(A) in paragraph (1)(C), by striking ''section 1601(a)(2)(B)'' and inserting ''sections 1601(a)(2)(B) and 1603(a)(2)(B)''; and

(B) in paragraph (2)(A), by inserting ''or 1603(a)(2)(B)'' after ''1601(a)(2)(B)''.

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**SA 3035.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ____. HEALTH CARE SAFETY NET ENHANCEMENT.**

(a) LIMITATION ON LIABILITY.—Notwithstanding any other provision of law, a health care professional shall not be liable in any medical malpractice lawsuit for a cause of action arising out of the provision of, or the failure to provide, any medical service to a medically underserved or indigent individual while engaging in the provision of pro bono medical services.

(b) REQUIREMENTS.—Subsection (a) shall not apply—

(1) to any act or omission by a health care professional that is outside the scope of the services for which such professional is deemed to be licensed or certified to provide, unless such act or omission can reasonably be determined to be necessary to prevent serious bodily harm or preserve the life of the individual being treated;

(2) if the services on which the medical malpractice claim is based did not arise out of the rendering of pro bono care for a medically underserved or indigent individual; or

(3) to an act or omission by a health care professional that constitutes willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights or safety of the individual harmed by such professional.

(c) DEFINITION.—In this section—

(1) the term ''medically underserved individual'' means an individual who does not have health care coverage under a group health plan, health insurance coverage, or any other health care coverage program; and

(2) the term ''indigent individual'' means and individual who is unable to pay for the health care services that are provided to the individual.

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**SA 3036.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ____. DISASTER VOLUNTEER HEALTH CARE PROFESSIONAL PROTECTION.**

(a) LIMITATION ON LIABILITY.—Notwithstanding any other provision of law, with respect to an area in which a major disaster has been declared in accordance with the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5721 et seq.), a health care professional who is providing health or dental services on a voluntary basis in such area, or to a non-resident victim of the disaster involved, shall not be liable for damages in a medical malpractice lawsuit for a cause of action arising out of an act or omission of such professional in providing the services involved.

(b) REQUIREMENTS.—Subsection (a) shall not apply—

(1) to any act or omission by a health care professional that is outside the scope of the services for which such professional is deemed to be licensed or certified to provide, unless such act or omission can reasonably be determined to be necessary to prevent serious bodily harm or preserve the life of the individual being treated;

(2) if the services on which the medical malpractice claim is based did not arise out of the rendering of voluntary care in the disaster area or were provided to an individual who was not a victim of the disaster; or

(3) to an act or omission by a health care professional that constitutes willful or criminal misconduct, gross negligence, reckless misconduct, or a conscious, flagrant indifference to the rights or safety of the individual harmed by such professional.

(c) LIMITATION ON VICARIOUS LIABILITY.—An individual or a health care institution that deploys or uses a volunteer described in subsection (a) shall not be vicariously liable in a medical malpractice lawsuit with respect to services described in such subsection unless the volunteer involved is determined to be liable.

(d) RECIPROCITY WITH RESPECT TO LICENSED OR CERTIFIED HEALTH CARE PROFESSIONALS.—A health care professional that is licensed or certified in a State and who is providing health or dental services on a voluntary basis in an area in which a major disaster has been declared in accordance with the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5721 et seq.), shall be deemed to be licensed or certified by the State in which such area is located with respect to such health or dental services, subject to any additional conditions, limitations, or expansions that may be applied by the chief executive of the State in which such area is located.

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**SA 3037.** Mr. JOHNSON (for himself, Mr. FRANKEN, Mr. BURRIS, and Mr. WARNER) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 731, between lines 16 and 17, insert the following:

''(xix) Utilizing a diverse network of providers of services and suppliers to improve care coordination for applicable individuals described in subsection (a)(4)(A)(i) with 2 or more chronic conditions and a history of prior-year hospitalization through interventions developed under the Medicare Coordinated Care Demonstration Project under section 4016 of the Balanced Budget Act of 1997 (42 U.S.C. 1395b–1 note).

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**SA 3038.** Mr. ROCKEFELLER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 436, between lines 14 and 15, insert the following:

**SEC. 2008. EXTENSION OF ARRA INCREASE IN FMAP.**

Section 5001 of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5) is amended—

(1) in subsection (a)(3), by striking ''first calendar quarter'' and inserting ''first 3 calendar quarters'';

(2) in subsection (b)(2), by inserting before the period at the end the following: '', and such paragraph shall not apply to calendar quarters beginning on or after October 1, 2010'';

(3) in subsection (c)(4)(C)(ii), by striking ''December 2009'' and ''January 2010'' and inserting ''June 2010'' and ''July 2010'', respectively;

(4) in subsection (d), by inserting ''ending before October 1, 2010'' after ''entire fiscal years'' and after ''with respect to fiscal years'';

(5) in subsection (g)(1), by striking ''September 30, 2011'' and inserting ''December 31, 2011''; and

(6) in subsection (h)(3), by striking ''December 31, 2010'' and inserting ''June 30, 2011''.

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**SA 3039.** Mr. ROCKEFELLER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 436, between lines 14 and 15, insert the following:

**SEC. 2008. MANAGED CARE ORGANIZATIONS.**

(a) MINIMUM MEDICAL LOSS RATIO.—

(1) MEDICAID.—Section 1903(m)(2)(A) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)) is amended—

(A) by striking ''and'' at the end of clause (xi);

(B) by striking the period at the end of clause (xii) and inserting ''; and''; and

(C) by adding at the end the following new clause:

''(xiii) such contract has a medical loss ratio, as determined in accordance with a methodology specified by the Secretary, that is a percentage (not less than 85 percent) specified by the Secretary.''.

(2) CHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)), as amended by sections 2101(d)(2), 2101(e), and 6401(c), is amended—

(A) by redesignating subparagraphs (H) through (O) as subparagraphs (I) through (P); and

(B) by inserting after subparagraph (G) the following new subparagraph:

''(H) Section 1903(m)(2)(A)(xiv) (relating to application of minimum loss ratios), with respect to comparable contracts under this title.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to contracts entered into or renewed on or after July 1, 2010.

(b) PATIENT ENCOUNTER DATA.—

(1) IN GENERAL.—Section 1903(m)(2)(A)(xi) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)(xi)) is amended by inserting ''and for the provision of such data to the State at a frequency and level of detail to be specified by the Secretary'' after ''patients''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to contract years beginning on or after January 1, 2010.

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**SA 3040.** Mr. ROCKEFELLER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 436, between lines 14 and 15, insert the following:

**SEC. 2008. AUTOMATIC INCREASE IN THE FEDERAL MEDICAL ASSISTANCE PERCENTAGE DURING PERIODS OF NATIONAL ECONOMIC DOWNTURN.**

(a) NATIONAL ECONOMIC DOWNTURN ASSISTANCE FMAP.—

(1) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3), 2006, 4106(b), and 4107, is amended—

(A) in subsection (b), in the first sentence—

(i) by striking ''and (5)'' and inserting ''(5)''; and

(ii) by inserting ''and (6) with respect to each fiscal year quarter other than the first quarter of a national economic downturn assistance period described in subsection (cc)(1), the Federal medical assistance percentage for any State described in subsection (cc)(2) shall be equal to the national economic downturn assistance FMAP determined for the State for the quarter under subsection (cc)(3)'' before the period; and

(B) by adding at the end the following:

''(cc) NATIONAL ECONOMIC DOWNTURN ASSISTANCE FMAP.—For purposes of clause (6) of the first sentence of subsection (b):

''(1) NATIONAL ECONOMIC DOWNTURN ASSISTANCE PERIOD.—A national economic downturn assistance period described in this paragraph—

''(A) begins with the first fiscal year quarter for which the Secretary determines that for at least 23 States, the rolling average unemployment rate for that quarter has increased by at least 10 percent over the corresponding quarter for the most recent preceding 12-month period for which data are available (in this subsection referred to as the 'trigger quarter'); and

''(B) ends with the first succeeding fiscal year quarter for which the Secretary determines that less than 23 States have a rolling average unemployment rate for that quarter with an increase of at least 10 percent over the corresponding quarter for the most recent preceding 12-month period for which data are available.

''(2) ELIGIBLE STATE.—A State described in this paragraph is a State for which the Secretary determines that the rolling average unemployment rate for the State for any quarter occurring during a national economic downturn assistance period described in paragraph (1) has increased over the corresponding quarter for the most recent preceding 12-month period for which data are available.

''(3) DETERMINATION OF NATIONAL ECONOMIC DOWNTURN ASSISTANCE FMAP.—

''(A) IN GENERAL.—The national economic downturn assistance FMAP for a fiscal year quarter determined with respect to a State under this paragraph is equal to the Federal medical assistance percentage for the State for that quarter increased by the number of percentage points determined by—

''(i) dividing—

''(I) the Medicaid additional unemployed increased cost amount determined under subparagraph (B) for the quarter; by

''(II) the State's total Medicaid quarterly spending amount determined under subparagraph (C) for the quarter; and

''(ii) multiplying the quotient determined under clause (i) by 100.

''(B) MEDICAID ADDITIONAL UNEMPLOYED INCREASED COST AMOUNT.—For purposes of subparagraph (A)(i)(I), the Medicaid additional unemployed increased cost amount determined under this subparagraph with respect to a State and a quarter is the product of the following:

''(i) STATE INCREASE IN ROLLING AVERAGE NUMBER OF UNEMPLOYED INDIVIDUALS FROM THE BASE QUARTER OF UNEMPLOYMENT.—

''(I) IN GENERAL.—The amount determined by subtracting the rolling average number of

unemployed individuals in the State for the base unemployment quarter for the State determined under subclause (II) from the rolling average number of unemployed individuals in the State for the quarter.

''(II) BASE UNEMPLOYMENT QUARTER DEFINED.—

''(aa) IN GENERAL.—For purposes of subclause (I), except as provided in item (bb), the base quarter for a State is the quarter with the lowest rolling average number of unemployed individuals in the State in the 12-month period preceding the trigger quarter for a national economic downturn assistance period described in paragraph (1).

''(bb) EXCEPTION.—If the rolling average number of unemployed individuals in a State for a quarter occurring during a national economic downturn assistance period described in paragraph (1) is less than the rolling average number of unemployed individuals in the State for the base quarter determined under item (aa), that quarter shall be treated as the base quarter for the State for such national economic downturn assistance period.

''(ii) NATIONAL AVERAGE AMOUNT OF ADDITIONAL FEDERAL MEDICAID SPENDING PER ADDITIONAL UNEMPLOYED INDIVIDUAL.—In the case of—

''(I) a calendar quarter occurring in fiscal year 2012, $350; and

''(II) a calendar quarter occurring in any succeeding fiscal year, the amount applicable under this clause for calendar quarters occurring during the preceding fiscal year, increased by the annual percentage increase in the medical care component of the consumer price index for all urban consumers (U.S. city average), as rounded up in an appropriate manner.

''(iii) STATE NONDISABLED, NONELDERLY ADULTS AND CHILDREN MEDICAID SPENDING INDEX.—

''(I) IN GENERAL.—With respect to a State, the quotient (not to exceed 1.00) of—

''(aa) the State expenditure per person in poverty amount determined under subclause (II); divided by—

''(bb) the National expenditure per person in poverty amount determined under subclause (III).

''(II) STATE EXPENDITURE PER PERSON IN POVERTY AMOUNT.—For purposes of subclause (I)(aa), the State expenditure per person in poverty amount is the quotient of—

''(aa) the total amount of annual expenditures by the State for providing medical assistance under the State plan to nondisabled, nonelderly adults and children; divided by

''(bb) the total number of nonelderly adults and children in poverty who reside in the State, as determined under paragraph (4)(A).

''(III) NATIONAL EXPENDITURE PER PERSON IN POVERTY AMOUNT.—For purposes of subclause (I)(bb), the National expenditure per person in poverty amount is the quotient of—

''(aa) the sum of the total amounts determined under subclause (II)(aa) for all States; divided by

''(bb) the sum of the total amounts determined under subclause (II)(bb) for all States.

''(C) STATE'S TOTAL MEDICAID QUARTERLY SPENDING AMOUNT.—For purposes of subparagraph (A)(i)(II), the State's total Medicaid quarterly spending amount determined under this subparagraph with respect to a State and a quarter is the amount equal to—

''(i) the total amount of expenditures by the State for providing medical assistance under the State plan to all individuals enrolled in the plan for the most recent fiscal year for which data is available; divided by

''(ii) 4.

''(4) DATA.—In making the determinations required under this subsection, the Secretary shall use, in addition to the most recent available data from the Bureau of Labor Statistics Local Area Unemployment Statistics for each State referred to in paragraph (5), the most recently available—

''(A) data from the Bureau of the Census with respect to the number of nonelderly adults and children who reside in a State described in paragraph (2) with family income below the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved (or, if the Secretary determines it appropriate, a multiyear average of such data);

''(B) data reported to the Secretary by a State described in paragraph (2) with respect to expenditures for medical assistance under the State plan under this title for nondisabled, nonelderly adults and children; and

''(C) econometric studies of the responsiveness of Medicaid enrollments and spending to changes in rolling average unemployment rates and other factors, including State spending on certain Medicaid populations.

''(5) DEFINITION OF 'ROLLING AVERAGE NUMBER OF UNEMPLOYED INDIVIDUALS', 'ROLLING AVERAGE UNEMPLOYMENT RATE'.—In this subsection, the term—

''(A) 'rolling average number of unemployed individuals' means, with respect to a calendar quarter and a State, the average of the 12 most recent months of seasonally adjusted unemployment data for each State;

''(B) 'rolling average unemployment rate' means, with respect to a calendar quarter and a State, the average of the 12 most recent monthly unemployment rates for the State; and

''(C) 'monthly unemployment rate' means, with respect to a State, the quotient of—

''(i) the monthly seasonally adjusted number of unemployed individuals for the State; divided by

''(ii) the monthly seasonally adjusted number of the labor force for the State,

using the most recent data available from the Bureau of Labor Statistics Local Area Unemployment Statistics for each State,

''(6) INCREASE IN CAP ON PAYMENTS TO TERRITORIES.—With respect to any fiscal year quarter for which the national economic downturn assistance Federal medical assistance percentage applies to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa, the amounts otherwise determined for such commonwealth or territory under subsections (f) and (g) of section 1108 shall be increased by such percentage of such amounts as the Secretary determines is equal to twice the average increase in the national economic downturn assistance FMAP determined for all States described in paragraph (2) for the quarter.

''(7) SCOPE OF APPLICATION.—The national economic downturn assistance FMAP shall only apply for purposes of payments under section 1903 for a quarter and shall not apply with respect to—

''(A) disproportionate share hospital payments described in section 1923;

''(B) payments under title IV or XXI; or

''(C) any payments under this title that are based on the enhanced FMAP described in section 2105(b).

''(8) ADDITIONAL REQUIREMENT FOR CERTAIN STATES.—In the case of a State described in paragraph (2) that requires political subdivisions within the State to contribute toward the non-Federal share of expenditures required under section 1902(a)(2), the State shall not require that such political subdivisions pay for any fiscal year quarters occurring during a national economic downturn assistance period a greater percentage of the non-Federal share of such expenditures, or a greater percentage of the non-Federal share of payments under section 1923, than the respective percentage that would have been required by the State under State law in effect on the first day of the fiscal year quarter occurring immediately prior to the trigger quarter for the period.''.

(2) EFFECTIVE DATE; NO RETROACTIVE APPLICATION.—The amendments made by paragraph (1) take effect on January 1, 2012. In no event may a State receive a payment on the basis of the national economic downturn assistance Federal medical assistance percentage determined for the State under section 1905(cc)(3) of the Social Security Act for amounts expended by the State prior to January 1, 2012.

(b) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the United States shall analyze the previous periods of national economic downturn, including the most recent such period in effect as of the date of enactment of this Act, and the past and projected effects of temporary increases in the Federal medical assistance percentage under the Medicaid program with respect to such periods.

(2) REPORT.—Not later than April 1, 2011, the Comptroller General of the United States shall submit a report to Congress on the results of the analysis conducted under paragraph (1). Such report shall include such recommendations as the Comptroller General determines appropriate for modifying the national economic downturn assistance FMAP established under section 1905(cc) of the Social Security Act (as added by subsection (a)) to improve the effectiveness of the application of such percentage in addressing the needs of States during periods of national economic downturn, including recommendations for—

(A) improvements to the factors that begin and end the application of such percentage;

(B) how the determination of such percentage could be adjusted to address State and regional economic variations during such periods; and

(C) how the determination of such percentage could be adjusted to be more responsive to actual Medicaid costs incurred by States during such periods, as well as to the effects of any other specific economic indicators that the Comptroller General determines appropriate.

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**SA 3041.** Mr. ROCKEFELLER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 397, beginning on line 2, strike ''under'' and all that follows through line 6, and insert ''not pregnant and are''

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**SA 3042.** Mr. ROCKEFELLER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 553, between lines 14 and 15, insert the following:

**SEC. 2708. EVALUATION OF STATE COMPLIANCE WITH PROVISION OF COMMUNITY-BASED SERVICES TO INDIVIDUALS WITH DISABILITIES.**

Not later than December 31, 2010, and annually thereafter, the Inspector General of the Department of Justice shall prepare and submit a report to Congress that evaluates the adequacy of efforts by States to provide appropriate home and community-based services to individuals with disabilities in accordance with the requirements under Olmstead v. L.C., 527 U.S. 581 (1999).

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**SA 3043.** Mr. ROCKEFELLER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 397, strike line 15 and all that follows through page 398, line 25.

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**SA 3044.** Mr. ROCKEFELLER submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. __. PAYMENT OF MEDICARE LIABILITY TO STATES AS A RESULT OF THE SPECIAL DISABILITY WORKLOAD PROJECT.**

(a) IN GENERAL.—The Secretary, in consultation with the Commissioner, shall work with each State to reach an agreement, not later than 6 months after the date of enactment of this Act, on the amount of a payment for the State related to the Medicare program liability as a result of the Special Disability Workload project, subject to the requirements of subsection (c).

(b) PAYMENTS.—

(1) DEADLINE FOR MAKING PAYMENTS.—Not later than 30 days after reaching an agreement with a State under subsection (a), the Secretary shall pay the State, from the amounts appropriated under paragraph (2), the payment agreed to for the State.

(2) APPROPRIATION.—Out of any money in the Treasury not otherwise appropriated, there is appropriated $4,000,000,000 for fiscal year 2010 for making payments to States under paragraph (1).

(3) LIMITATIONS.—In no case may the aggregate amount of payments made by the Secretary to States under paragraph (1) exceed $4,000,000,000.

(c) REQUIREMENTS.—The requirements of this subsection are the following:

(1) FEDERAL DATA USED TO DETERMINE AMOUNT OF PAYMENTS.—The amount of the payment under subsection (a) for each State is determined on the basis of the most recent Federal data available, including the use of proxies and reasonable estimates as necessary, for determining expeditiously the amount of the payment that shall be made to each State that enters into an agreement under this section. The payment methodology shall consider the following factors:

(A) The number of SDW cases found to have been eligible for benefits under the Medicare program and the month of the initial Medicare program eligibility for such cases.

(B) The applicable non-Federal share of expenditures made by a State under the Medicaid program during the time period for SDW cases.

(C) Such other factors as the Secretary and the Commissioner, in consultation with the States, determine appropriate.

(2) CONDITIONS FOR PAYMENTS.—A State shall not receive a payment under this section unless the State—

(A) waives the right to file a civil action (or to be a party to any action) in any Federal or State court in which the relief sought includes a payment from the United States to the State related to the Medicare liability under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as a result of the Special Disability Workload project; and

(B) releases the United States from any further claims for reimbursement of State expenditures as a result of the Special Disability Workload project (other than reimbursements being made under agreements in effect on the date of enactment of this Act as a result of such project, including payments made pursuant to agreements entered into under section 1616 of the Social Security Act or section 211(1)(1)(A) of Public Law 93–66).

(3) NO INDIVIDUAL STATE CLAIMS DATA REQUIRED.—No State shall be required to submit individual claims evidencing payment under the Medicaid program as a condition for receiving a payment under this section.

(4) INELIGIBLE STATES.—No State that is a party to a civil action in any Federal or State court in which the relief sought includes a payment from the United States to the State related to the Medicare liability under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as a result of the Special Disability Workload project shall be eligible to receive a payment under this section while such an action is pending or if such an action is resolved in favor of the State.

(d) DEFINITIONS.—In this section:

(1) COMMISSIONER.—The term ''Commissioner'' means the Commissioner of Social Security.

(2) MEDICAID PROGRAM.—The term ''Medicaid program'' means the program of medical assistance established under title XIX of the Social Security Act (42 U.S.C. 1396a et seq.) and includes medical assistance provided under any waiver of that program approved under section 1115 or 1915 of such Act (42 U.S.C. 1315, 1396n) or otherwise.

(3) MEDICARE PROGRAM.—The term ''Medicare program'' means the program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(4) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(5) SDW CASE.—The term ''SDW case'' means a case in the Special Disability Workload project involving an individual determined by the Commissioner to have been eligible for benefits under title II of the Social Security Act (42 U.S.C. 401 et seq.) for a period during which such benefits were not provided to the individual and who was, during all or part of such period, enrolled in a State Medicaid program.

(6) SPECIAL DISABILITY WORKLOAD PROJECT.—The term ''Special Disability Workload project'' means the project described in the 2008 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds, H.R. Doc. No. 110–104, 110th Cong. (2008).

(7) STATE.—The term ''State'' means each of the 50 States and the District of Columbia.

**SEC. __. REQUIREMENTS FOR MEDICAID PROVIDERS TO ACCEPT IN-NETWORK PAYMENT RATES FOR SERVICES PROVIDED TO MEDICAID MANAGED CARE ENROLLEES.**

(a) IN GENERAL.—Section 1932(b) of the Social Security Act (42 U.S.C. 1396u–2(b)) is amended by adding at the end the following

''(9) ASSURING ACCESS TO SERVICES FURNISHED BY NON-CONTRACT PROVIDERS.—Any provider of items or services for which medical assistance is provided under the State plan or under a waiver of the plan that does not have in effect a contract with a Medicaid managed care entity that establishes payment amounts for items or services furnished to a beneficiary enrolled in the entity's Medicaid managed care plan shall accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the beneficiary received medical assistance under this title other than through enrollment in such an entity. In a State where rates paid to hospitals under the State plan are negotiated by contract and not publicly released, the payment amount applicable under this subparagraph shall be the average contract rate that would apply under the State plan for general acute care hospitals or the average contract rate that would apply under such plan for tertiary hospitals.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on January 1, 2010.

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**SA 3045.** Mr. KERRY (for himself, Mr. KIRK, Mr. SCHUMER, Mrs. GILLIBRAND, Mr. LEAHY, Mr. SANDERS, Mr. CARPER, and Mr. KAUFMAN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 402, strike line 15 and all that follows through page 403, line 9, and insert the following:

''(A) NEWLY ELIGIBLE.—The term ''newly eligible'' means an individual described in subclause (VIII) of section 1902(a)(10)(A)(i) who, on the date of enactment of the Patient Protection and Affordable Care Act, is not eligible under the State plan for full benefits or for benchmark coverage described in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2), or is eligible but not enrolled (or is on a waiting list) for such benefits or coverage through a waiver under the plan that has a capped or limited enrollment that is full.

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**SA 3046.** Mr. KERRY (for himself, Ms. STABENOW, Ms. COLLINS, Ms. SNOWE, Mr. WYDEN, Mrs. LINCOLN, Mr. JOHNSON, Mr. SPECTER, and Mrs. GILLIBRAND) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which

was ordered to lie on the table; as follows:

Beginning on page 983, strike line 11 and all that follows through page 984, line 3, and insert the following:

''(vi) PRODUCTIVITY ADJUSTMENT.—After determining the home health market basket percentage increase under clause (iii), and after application of clause (v), the Secretary shall reduce such percentage, for 2015 and each subsequent year, by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II). The application of the preceding sentence may result in the home health market basket percentage increase under clause (iii) being less than 0.0 for a year, and may result in payment rates under the system under this subsection for a year being less than such payment rates for the preceding year.''.

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**SA 3047.** Mr. KERRY (for himself, Mr. WYDEN, Mr. WHITEHOUSE, Mr. REED) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ____. MEDICARE PATIENT IVIG ACCESS DEMONSTRATION PROJECT.**

(a) ESTABLISHMENT.—The Secretary shall establish and implement a demonstration project under title XVIII of the Social Security Act to evaluate the benefits of providing payment for items and services needed for the administration, within the homes of Medicare beneficiaries, of intravenous immune globin for the treatment of primary immune deficiency diseases.

(b) DURATION AND SCOPE.—

(1) DURATION.—Beginning not later than January 1, 2011, the Secretary shall conduct the demonstration project for a period of 3 years.

(2) SCOPE.—The Secretary shall enroll not greater than 4,000 Medicare beneficiaries who have been diagnosed with primary immunodeficiency disease for participation in the demonstration project. A Medicare beneficiary may participate in the demonstration project on a voluntary basis and may terminate participation at any time.

(c) REIMBURSEMENT.—The Secretary shall establish an hourly rate for payment for items and services needed for the administration of intravenous immune globin based on the low-utilization payment adjustment under the prospective payment system for home health services established under section 1895 of the Social Security Act (42 U.S.C. 1395fff).

(d) STUDY AND REPORT TO CONGRESS.—

(1) INTERIM EVALUATION AND REPORT.—Not later than 24 months after the date of enactment of this Act, the Secretary shall submit to Congress a report that contains the following:

(A) An interim evaluation of the impact of the demonstration project on access for Medicare beneficiaries to items and services needed for the administration of intravenous immune globin within the home.

(B) An analysis of the appropriateness of implementing a new methodology for payment for intravenous immune globulins in all care settings under part B of title XVIII of the Social Security Act (42 U.S.C. 1395k et seq.).

(C) An analysis of the feasability of reducing the lag time with respect to data used to determine the average sales price under section 1847A of the Social Security Act (42 U.S.C. 1395w-3a).

(D) An update to the report entitled ''Analysis of Supply, Distribution, Demand, and Access Issues Associated with Immune Globulin Intravenous (IGIV)'', issued in February 2007 by the Office of the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services.

(2) FINAL EVALUATION AND REPORT.—Not later than July 1, 2014, the Secretary shall submit to Congress a report that contains a final evaluation of the impact of the demonstration project on access for Medicare beneficiaries to items and services needed for the administration of intravenous immune globin within the home.

(e) OFFSET.—

(1) IN GENERAL.—Section 1861(n) of the Social Security Act (42 U.S.C. 1395x(n)) is amended by adding at the end the following: ''Such term includes disposable drug delivery systems, including elastomeric infusion pumps, for the treatment of colorectal cancer.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items furnished on or after the date of enactment of this Act.

(f) DEFINITIONS.—In this section:

(1) DEMONSTRATION PROJECT.—The term ''demonstration project'' means the demonstration project conducted under this section.

(2) MEDICARE BENEFICIARY.—The term ''Medicare beneficiary'' means an individual who is entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act or enrolled for benefits under part B of such title.

(3) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

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**SA 3048.** Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 172, between lines 11 and 12, insert the following:

(E) REPAYMENT OF FUNDS.—A person that receives Federal funds under a loan or grant under this section shall be required to reimburse the Federal Government for the full amount received under such loan or grant on terms established by the Secretary, but in no event shall such repayment be made later than 10 years after the date on which such loan or grant was made.

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**SA 3049.** Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 436, between lines 14 and 15, insert the following:

**SEC. 2008. PROTECTION OF MEDICAID WAIVER AUTHORITY.**

No provision of this Act or any amendment made by this Act shall limit or otherwise restrict any authority in effect on the date of enactment of this Act which the Secretary of Health and Human Services may exercise under section 1915 or 1115 of the Social Security Act or otherwise to encourage States to develop innovation programs to provide health insurance to uninsured individuals or to contain health care costs by granting States budget neutral Medicaid waivers Any provision of this Act or an amendment of this Act that is contrary to the preceding sentence is null and void.

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**SA 3050.** Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1998, strike lines 13 through 24.

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**SA 3051.** Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 816, after line 20, insert the following:

**SEC. 3115. RURAL HEALTH CLINIC REIMBURSEMENT.**

Section 1833(f) of the Social Security Act (42 U.S.C. 13951(f)) is amended—

(1) in paragraph (1), by striking '', and'' at the end and inserting a semicolon;

(2) in paragraph (2)—

(A) by striking ''in a subsequent year'' and inserting ''after 1988 and before 2010''; and

(B) by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following new paragraphs:

''(3) in 2010, at $85 per visit; and

''(4) in a subsequent year, at the limit established under this subsection for the previous year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4)) furnished as of the first day of that year.''.

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**SA 3052.** Mr. BARRASSO submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1266, between lines 17 and 18, insert the following:

**SEC. 4403. RURAL HEALTH CLINIC AND COMMUNITY HEALTH CENTER COLLABORATIVE ACCESS EXPANSION.**

Section 330 of the Public Health Service Act (42 U.S.C. 254b), as amended by section 4206, is amended by adding at the end the following:

''(t) RULE OF CONSTRUCTION WITH RESPECT TO RURAL HEALTH CLINICS.—

''(1) IN GENERAL.—Nothing in this section shall be construed to prevent a community health center from contracting with a federally certified rural health clinic (as defined by section 1861(aa)(2) of the Social Security Act) for the delivery of primary health care services that are available at the rural health clinic to individuals who would otherwise be eligible for free or reduced cost care if that individual were able to obtain that care at the community health center. Such services may be limited in scope to those primary health care services available in that rural health clinic.

''(2) ASSURANCES.—In order for a rural health clinic to receive funds under this section through a contract with a community health center under paragraph (1), such rural health clinic shall establish policies to ensure—

''(A) nondiscrimination based upon the ability of a patient to pay; and

''(B) the establishment of a sliding fee scale for low-income patients.''.

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**SA 3053.** Mr. INHOFE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2026, strike line 3 and insert the following:

(i) EXCLUSION OF ASSISTIVE DEVICES FOR PEOPLE WITH DISABILITIES.—

(1) IN GENERAL.—The term ''medical device sales'' shall not include sales of any assistive device for people with disabilities.

(2) REDUCTION OF AGGREGATE FEE AMOUNT.—The $2,000,000,000 amount in subsection (b)(1) shall be reduced in each calendar year by the amount which bears the same ratio to such $2,000,000,000 amount as the amount of the sales of devices described in paragraph (1) for such calendar year bears to the amount of total medical device sales (without regard to this subsection) for such calendar year, as determined by the Secretary.

(j) APPLICATION OF SECTION.—This section shall

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**SA 3054.** Mr. ROBERTS (for himself and Mr. KYL) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1703, between lines 4 and 5, insert the following:

**SEC. 6303. PROHIBITION ON THE USE OF COST IN COMPARATIVE EFFECTIVENESS RESEARCH.**

(a) IN GENERAL.—Notwithstanding any other provision of law, in no case may the cost of any medical treatment, item, or service described in subsection (b) be considered a factor in any comparative effectiveness research conducted—

(1) by the Federal Government; or

(2) by any other entity using funding provided by the Federal Government.

(b) MEDICAL TREATMENT, ITEM, OR SERVICE.—The medical treatments, services, and items described in this subsection are health care interventions, protocols for treatment, care management, and delivery, procedures, medical devices, diagnostic tools, pharmaceuticals (including drugs and biologicals), integrative health practices, and any other strategies or items being used in the treatment, management, and diagnosis of, or prevention of illness or injury in, individuals.

(c) INCLUSION.—The comparative effectiveness research described under subsection (a) includes any such research conducted or funded by—

(1) the Patient-Centered Outcomes Research Institute under section 1181 of the Social Security Act (as added by section 6301);

(2) the Department of Health and Human Services, including the Agency for Healthcare Research and Quality and the National Institutes of Health; and

(3) the Federal Coordinating Council for Comparative Effectiveness Research established under section 804 of Division A of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. 299b–8).

(d) APPLICATION.—This section shall apply to any comparative effectiveness research—

(1) that is ongoing as of the date of enactment of this Act; or

(2) that is conducted after the date of enactment of this Act.

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**SA 3055.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1983, strike lines 1–11 and insert the following:

''(II) the 3-year average FEHB program premium increase for such year.

If any amount determined under this clause is not a multiple of $50, such amount shall be rounded to the nearest multiple of $50.

(iv) 3-YEAR AVERAGE FEHB PROGRAM PREMIUM INCREASE.—For purposes of clause (iii)—

(I) IN GENERAL.—The term ''3-year average FEHB program premium increase'' means, with respect to any calendar year, the average of the FEHB program premium increases for the preceding 3 calendar years.

(II) FEHB PREMIUM INCREASE.—The term ''FEHB program premium increase'' means, with respect to any calendar year, the average amount of the increases in premiums (if any) for all plans offered under the Federal Employee Health Benefits Program under chapter 89 of title 5, United States Code, which were offered under such program for the preceding calendar year.

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**SA 3056.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 340, strike lines 1 through 14 and insert the following:

''(A) WAIVER OF CRIMINAL AND CIVIL PENALTIES AND INTEREST.—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section—

''(i) such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure, and

''(ii) no penalty, addition to tax, or interest shall be imposed with respect to such failure or such penalty.

''(B) LIMITED COLLECTION ACTIONS PERMITTED.—In the case of the assessment of any penalty imposed by this section, the Secretary shall not take any action with respect to the collection of such penalty other than—

''(i) giving notice and demand for such penalty under section 6303,

''(ii) crediting under section 6402(a) the amount of any overpayment of the taxpayer against such penalty, and

''(iii) offsetting any payment owed by any Federal agency to the taxpayer against such penalty under the Treasury offset program.''.

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**SA 3057.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 334, line 19, strike all through page 335, line 2, and insert the following:

''(2) MIDDLE INCOME INDIVIDUALS AND FAMILIES.—Any applicable individual for any month during a calendar year if the individual's household income for the taxable year described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act is less than $200,000 ($250,000 in the case of a joint return), determined in the same manner as under subsection (c)(4).

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**SA 3058.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2074, after line 25, add the following:

**SEC. _____. NO FEDERAL TAX INCREASE IMPOSED ON MIDDLE INCOME INDIVIDUALS AND FAMILIES.**

(a) IN GENERAL.—Notwithstanding any provision of, or amendment made by this Act, no such provision or amendment which, directly or indirectly, results in a Federal tax increase shall be administered in such manner as to impose such an increase on any middle income taxpayer.

(b) MIDDLE INCOME TAXPAYER.—For purposes of this section, the term ''middle income taxpayer'' means, for any taxable year,

any taxpayer with adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986) of less than $200,000 ($250,000 in the case of a joint return of tax).

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**SA 3059.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1999, strike lines 1 through 20.

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**SA 3060.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 9004.

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**SA 3061.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 2074, after line 25, add the following:

**SEC. 9024. TAXES NOT FEES, PENALTIES, OR ASSESSABLE PAYMENTS.**

(a) TAXES NOT FEES.—Sections 4375, 4376, 4377, and 9511 of the Internal Revenue Code of 1986 (as added by section 6301(e)) and sections 9008, 9009, and 9010 are each amended by striking ''fee'' or ''fees'' each place they appear and inserting ''tax'' or ''taxes'', respectively.

(b) TAXES NOT PENALTIES.—Section 5000A of the Internal Revenue Code of 1986 (as added by section 1501(b)) is amended by striking ''penalty'' each place it appears (other than the second place in paragraphs (1) and (2)(A) of subsection (g) thereof) and inserting ''tax''.

(c) TAXES NOT ASSESSABLE PAYMENTS.—Section 4980H of the Internal Revenue Code of 1986 (as added by section 1513(a)) and section 1513(c)(1) are each amended by striking ''assessable payment'' or ''assessable payments''each place they appear and inserting ''tax'' or ''taxes'', respectively.

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**SA 3062.** Mr. ENSIGN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 357, strike line 15 and insert the following:

(d) REPORT ON IMPACT OF PENALTIES.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the assessable payments imposed under section 4980H of the Internal Revenue Code of 1986 (as added by the amendments made by this section). The report submitted under this subsection shall include a detailed analysis of the impact of such assessable penalty on—

(1) employer profits,

(2) Federal revenues, including any decrease in tax revenues due to any decrease in employer profits as a result of such assessable penalties,

(3) the level of wages and benefits of employees,

(4) the hours worked by employees, including whether employees are classified as part-time or full-time employees, and

(5) the termination of employees.

(e) EFFECTIVE DATE.—The amendments made by

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**SA 3063.** Mr. AKAKA (for himself and Mr. INOUYE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 515 of the amendment, between lines 11 and 12, insert the following:

**SEC. 2552. ESTABLISHMENT OF PERMANENT MEDICAID DSH ALLOTMENT FOR HAWAII.**

(a) IN GENERAL.—Section 1923(f)(6) of the Social Security Act (42 U.S.C. 1396r–4(f)(6)) is amended—

(1) by striking the paragraph heading and inserting the following: ''ALLOTMENT ADJUSTMENTS FOR TENNESSEE AND HAWAII''; and

(2) in subparagraph (B), by adding at the end the following:

''(iii) ALLOTMENT FOR 2D, 3RD, AND 4TH QUARTER OF FISCAL YEAR 2012, FISCAL YEAR 2013, AND SUCCEEDING FISCAL YEARS.—Notwithstanding the table set forth in paragraph (2) or paragraph (7):

''(I) 2D, 3RD, AND 4TH QUARTER OF FISCAL YEAR 2012.—The DSH allotment for Hawaii for the 2d, 3rd, and 4th quarters of fiscal year 2012 shall be $7,500,000.

''(II) TREATMENT AS A LOW-DSH STATE FOR FISCAL YEAR 2013 AND SUCCEEDING FISCAL YEARS.—With respect to fiscal year 2013, and each fiscal year thereafter, the DSH allotment for Hawaii shall be increased in the same manner as allotments for low DSH States are increased for such fiscal year under clauses (ii) and (iii) of paragraph (5)(B).

''(III) CERTAIN HOSPITAL PAYMENTS.—The Secretary may not impose a limitation on the total amount of payments made to hospitals under the QUEST section 1115 Demonstration Project except to the extent that such limitation is necessary to ensure that a hospital does not receive payments in excess of the amounts described in subsection (g), or as necessary to ensure that such payments under the waiver and such payments pursuant to the allotment provided in this clause do not, in the aggregate in any year, exceed the amount that the Secretary determines is equal to the Federal medical assistance percentage component attributable to disproportionate share hospital payment adjustments for such year that is reflected in the budget neutrality provision of the QUEST Demonstration Project.''.

(b) CONFORMING AMENDMENT.—Effective October 1, 2011, paragraph (7) of section 1923(f) of such Act (42 U.S.C. 1396r–4(f)), as added by section 2551, is amended—

(1) in subparagraph (A), in the matter preceding clause (i), by striking ''subparagraph (E)'' and inserting ''subparagraphs (E) and (G)''; and

(2) by adding at the end the following:

''(G) NONAPPLICATION.—The preceding provisions of this paragraph shall not apply to the DSH allotment determined for the State of Hawaii for a fiscal year under paragraph (6).''.

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**SA 3064.** Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 124, between lines 16 and 17, insert the following:

(4) NONDISCRIMINATION ON ABORTION AND RESPECT FOR RIGHTS OF CONSCIENCE.—

(A) NONDISCRIMINATION.—A Federal agency or program, and any State or local government that receives Federal financial assistance under this Act (or an amendment made by this Act), may not—

(i) subject any individual or institutional health care entity to discrimination; or

(ii) require any health plan created or regulated under this Act (or an amendment made by this Act) to subject any individual or institutional health care entity to discrimination,

on the basis that the health care entity does not provide, pay for, provide coverage of, or refer for abortions.

(B) DEFINITION.——In this section, the term ''health care entity'' includes an individual physician or other health care professional, a hospital, a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.

(C) ADMINISTRATION.—The Office for Civil Rights of the Department of Health and Human Services is designated to receive complaints of discrimination based on this section, and coordinate the investigation of such complaints.

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**SA 3065.** Mr. CARDIN (for himself and Mr. BROWN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 396, between lines 8 and 9, insert the following:

**Subtitle H—Patient Protections**

**PART I—IMPROVING MANAGED CARE**

**Subpart A—Utilization Review; Claims**

**SEC. 1601. UTILIZATION REVIEW ACTIVITIES.**

(a) COMPLIANCE WITH REQUIREMENTS.—

(1) IN GENERAL.—A group health plan, and a health insurance issuer that provides health insurance coverage, shall conduct utilization review activities in connection with the provision of benefits under such plan or coverage only in accordance with a utilization review program that meets the requirements of this section and section 1602.

(2) USE OF OUTSIDE AGENTS.—Nothing in this section shall be construed as preventing a group health plan or health insurance issuer from arranging through a contract or otherwise for persons or entities to conduct utilization review activities on behalf of the plan or issuer, so long as such activities are conducted in accordance with a utilization review program that meets the requirements of this section.

(3) UTILIZATION REVIEW DEFINED.—For purposes of this section, the terms ''utilization review'' and ''utilization review activities'' mean procedures used to monitor or evaluate the use or coverage, clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings, and includes prospective review, concurrent review, second opinions, case management, discharge planning, or retrospective review.

(b) WRITTEN POLICIES AND CRITERIA.—

(1) WRITTEN POLICIES.—A utilization review program shall be conducted consistent with written policies and procedures that govern all aspects of the program.

(2) USE OF WRITTEN CRITERIA.—

(A) IN GENERAL.—Such a program shall utilize written clinical review criteria developed with input from a range of appropriate actively practicing health care professionals, as determined by the plan, pursuant to the program. Such criteria shall include written clinical review criteria that are based on valid clinical evidence where available and that are directed specifically at meeting the needs of at-risk populations and covered individuals with chronic conditions or severe illnesses, including gender-specific criteria and pediatric-specific criteria where available and appropriate.

(B) CONTINUING USE OF STANDARDS IN RETROSPECTIVE REVIEW.—If a health care service has been specifically pre-authorized or approved for a participant, beneficiary, or enrollee under such a program, the program shall not, pursuant to retrospective review, revise or modify the specific standards, criteria, or procedures used for the utilization review for procedures, treatment, and services delivered to the enrollee during the same course of treatment.

(C) REVIEW OF SAMPLE OF CLAIMS DENIALS.—Such a program shall provide for a periodic evaluation of the clinical appropriateness of at least a sample of denials of claims for benefits.

(c) CONDUCT OF PROGRAM ACTIVITIES.—

(1) ADMINISTRATION BY HEALTH CARE PROFESSIONALS.—A utilization review program shall be administered by qualified health care professionals who shall oversee review decisions.

(2) USE OF QUALIFIED, INDEPENDENT PERSONNEL.—

(A) IN GENERAL.—A utilization review program shall provide for the conduct of utilization review activities only through personnel who are qualified and have received appropriate training in the conduct of such activities under the program.

(B) PROHIBITION OF CONTINGENT COMPENSATION ARRANGEMENTS.—Such a program shall not, with respect to utilization review activities, permit or provide compensation or anything of value to its employees, agents, or contractors in a manner that encourages denials of claims for benefits.

(C) PROHIBITION OF CONFLICTS.—Such a program shall not permit a health care professional who is providing health care services to an individual to perform utilization review activities in connection with the health care services being provided to the individual.

(3) ACCESSIBILITY OF REVIEW.—Such a program shall provide that appropriate personnel performing utilization review activities under the program, including the utilization review administrator, are reasonably accessible by toll-free telephone during normal business hours to discuss patient care and allow response to telephone requests, and that appropriate provision is made to receive and respond promptly to calls received during other hours.

(4) LIMITS ON FREQUENCY.—Such a program shall not provide for the performance of utilization review activities with respect to a class of services furnished to an individual more frequently than is reasonably required to assess whether the services under review are medically necessary and appropriate.

**SEC. 1602. PROCEDURES FOR INITIAL CLAIMS FOR BENEFITS AND PRIOR AUTHORIZATION DETERMINATIONS.**

(a) PROCEDURES OF INITIAL CLAIMS FOR BENEFITS.—

(1) IN GENERAL.—A group health plan, or health insurance issuer offering health insurance coverage, shall—

(A) make a determination on an initial claim for benefits by a participant, beneficiary, or enrollee (or authorized representative) regarding payment or coverage for items or services under the terms and conditions of the plan or coverage involved, including any cost-sharing amount that the participant, beneficiary, or enrollee is required to pay with respect to such claim for benefits; and

(B) notify a participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional involved regarding a determination on an initial claim for benefits made under the terms and conditions of the plan or coverage, including any cost-sharing amounts that the participant, beneficiary, or enrollee may be required to make with respect to such claim for benefits.

(2) ACCESS TO INFORMATION.—

(A) TIMELY PROVISION OF NECESSARY INFORMATION.—With respect to an initial claim for benefits, the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional (if any) shall provide the plan or issuer with access to information requested by the plan or issuer that is necessary to make a determination relating to the claim. Such access shall be provided not later than 5 days after the date on which the request for information is received, or, in a case described in subparagraph (B) or (C) of subsection (b)(1), by such earlier time as may be necessary to comply with the applicable timeline under such subparagraph.

(B) LIMITED EFFECT OF FAILURE ON PLAN OR ISSUER'S OBLIGATIONS.—Failure of the participant, beneficiary, or enrollee to comply with the requirements of subparagraph (A) shall not remove the obligation of the plan or issuer to make a decision in accordance with the medical exigencies of the case and as soon as possible, based on the available information, and failure to comply with the time limit established by this paragraph shall not remove the obligation of the plan or issuer to comply with the requirements of this section.

(3) ORAL REQUESTS.—In the case of a claim for benefits involving an expedited or concurrent determination, a participant, beneficiary, or enrollee (or authorized representative) may make an initial claim for benefits orally, but a group health plan, or health insurance issuer offering health insurance coverage, may require that the participant, beneficiary, or enrollee (or authorized representative) provide written confirmation of such request in a timely manner on a form provided by the plan or issuer. In the case of such an oral request for benefits, the making of the request (and the timing of such request) shall be treated as the making at that time of a claims for such benefits without regard to whether and when a written confirmation of such request is made.

(b) TIMELINE FOR MAKING DETERMINATIONS.—

(1) PRIOR AUTHORIZATION DETERMINATION.—

(A) IN GENERAL.—A group health plan, or health insurance issuer offering health insurance coverage, shall make a prior authorization determination on a claim for benefits (whether oral or written) in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 14 days from the date on which the plan or issuer receives information that is reasonably necessary to enable the plan or issuer to make a determination on the request for prior authorization and in no case later than 28 days after the date of the claim for benefits is received.

(B) EXPEDITED DETERMINATION.—Notwithstanding subparagraph (A), a group health plan, or health insurance issuer offering health insurance coverage, shall expedite a prior authorization determination on a claim for benefits described in such subparagraph when a request for such an expedited determination is made by a participant, beneficiary, or enrollee (or authorized representative) at any time during the process for making a determination and a health care professional certifies, with the request, that a determination under the procedures described in subparagraph (A) would seriously jeopardize the life or health of the participant, beneficiary, or enrollee or the ability of the participant, beneficiary, or enrollee to maintain or regain maximum function. Such determination shall be made in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 72 hours after the time the request is received by the plan or issuer under this subparagraph.

(C) ONGOING CARE.—

(i) CONCURRENT REVIEW.—

(I) IN GENERAL.—Subject to clause (ii), in the case of a concurrent review of ongoing care (including hospitalization), which results in a termination or reduction of such care, the plan or issuer must provide by telephone and in printed form notice of the concurrent review determination to the individual or the individual's designee and the individual's health care provider in accordance with the medical exigencies of the case and as soon as possible.

(II) CONTENTS OF NOTICE.—Such notice shall include, with respect to ongoing health care items and services, the number of ongoing services approved, the new total of approved services, the date of onset of services, and the next review date, if any, as well as a statement of the individual's rights to further appeal.

(ii) RULE OF CONSTRUCTION.—Clause (i) shall not be construed as requiring plans or issuers to provide coverage of care that would exceed the coverage limitations for such care.

(2) RETROSPECTIVE DETERMINATION.—A group health plan, or health insurance issuer offering health insurance coverage, shall make a retrospective determination on a claim for benefits in accordance with the medical exigencies of the case and as soon as

possible, but not later than 30 days after the date on which the plan or issuer receives information that is reasonably necessary to enable the plan or issuer to make a determination on the claim, or, if earlier, 60 days after the date of receipt of the claim for benefits.

(c) NOTICE OF A DENIAL OF A CLAIM FOR BENEFITS.—Written notice of a denial made under an initial claim for benefits shall be issued to the participant, beneficiary, or enrollee (or authorized representative) and the treating health care professional in accordance with the medical exigencies of the case and as soon as possible, but in no case later than 2 days after the date of the determination (or, in the case described in subparagraph (B) or (C) of subsection (b)(1), within the 72-hour or applicable period referred to in such subparagraph).

(d) REQUIREMENTS OF NOTICE OF DETERMINATIONS.—The written notice of a denial of a claim for benefits determination under subsection (c) shall be provided in printed form and written in a manner calculated to be understood by the participant, beneficiary, or enrollee and shall include—

(1) the specific reasons for the determination (including a summary of the clinical or scientific evidence used in making the determination); and

(2) the procedures for obtaining additional information concerning the determination.

(e) DEFINITIONS.—For purposes of this part:

(1) AUTHORIZED REPRESENTATIVE.—The term ''authorized representative'' means, with respect to an individual who is a participant, beneficiary, or enrollee, any health care professional or other person acting on behalf of the individual with the individual's consent or without such consent if the individual is medically unable to provide such consent.

(2) CLAIM FOR BENEFITS.—The term ''claim for benefits'' means any request for coverage (including authorization of coverage), for eligibility, or for payment in whole or in part, for an item or service under a group health plan or health insurance coverage.

(3) DENIAL OF CLAIM FOR BENEFITS.—The term ''denial'' means, with respect to a claim for benefits, a denial (in whole or in part) of, or a failure to act on a timely basis upon, the claim for benefits and includes a failure to provide benefits (including items and services) required to be provided under this part.

(4) TREATING HEALTH CARE PROFESSIONAL.—The term ''treating health care professional'' means, with respect to services to be provided to a participant, beneficiary, or enrollee, a health care professional who is primarily responsible for delivering those services to the participant, beneficiary, or enrollee.

**Subpart B—Access to Care**

**SEC. 1611. CHOICE OF HEALTH CARE PROFESSIONAL.**

(a) PRIMARY CARE.—If a group health plan, or a health insurance issuer that offers health insurance coverage, requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, then the plan or issuer shall permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

(b) SPECIALISTS.—

(1) IN GENERAL.—Subject to paragraph (2), a group health plan and a health insurance issuer that offers health insurance coverage shall permit each participant, beneficiary, or enrollee to receive medically necessary and appropriate specialty care, pursuant to appropriate referral procedures, from any qualified participating health care professional who is available to accept such individual for such care.

(2) LIMITATION.—Paragraph (1) shall not apply to specialty care if the plan or issuer clearly informs participants, beneficiaries, and enrollees of the limitations on choice of participating health care professionals with respect to such care.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as affecting the application of section 114 (relating to access to specialty care).

**SEC. 1612. ACCESS TO EMERGENCY CARE.**

(a) COVERAGE OF EMERGENCY SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage offered by a health insurance issuer, provides or covers any benefits with respect to services in an emergency department of a hospital, the plan or issuer shall cover emergency services (as defined in paragraph (2)(B))—

(A) without the need for any prior authorization determination;

(B) whether the health care provider furnishing such services is a participating provider with respect to such services;

(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee—

(i) by a nonparticipating health care provider with or without prior authorization, or

(ii) by a participating health care provider without prior authorization, the participant, beneficiary, or enrollee is not liable for amounts that exceed the amounts of liability that would be incurred if the services were provided by a participating health care provider with prior authorization; and

(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2701 of the Public Health Service Act, section 701 of the Employee Retirement Income Security Act of 1974, or section 9801 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

(2) DEFINITIONS.—In this section:

(A) EMERGENCY MEDICAL CONDITION.—The term ''emergency medical condition'' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act.

(B) EMERGENCY SERVICES.—The term ''emergency services'' means, with respect to an emergency medical condition—

(i) a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 of such Act to stabilize the patient.

(C) STABILIZE.—The term ''to stabilize'', with respect to an emergency medical condition (as defined in subparagraph (A)), has the meaning give in section 1867(e)(3) of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

(b) REIMBURSEMENT FOR MAINTENANCE CARE AND POST-STABILIZATION CARE.—A group health plan, and health insurance coverage offered by a health insurance issuer, must provide reimbursement for maintenance care and post-stabilization care in accordance with the requirements of section 1852(d)(2) of the Social Security Act (42 U.S.C. 1395w–22(d)(2)). Such reimbursement shall be provided in a manner consistent with subsection (a)(1)(C).

(c) COVERAGE OF EMERGENCY AMBULANCE SERVICES.—

(1) IN GENERAL.—If a group health plan, or health insurance coverage provided by a health insurance issuer, provides any benefits with respect to ambulance services and emergency services, the plan or issuer shall cover emergency ambulance services (as defined in paragraph (2)) furnished under the plan or coverage under the same terms and conditions under subparagraphs (A) through (D) of subsection (a)(1) under which coverage is provided for emergency services.

(2) EMERGENCY AMBULANCE SERVICES.—For purposes of this subsection, the term ''emergency ambulance services'' means ambulance services (as defined for purposes of section 1861(s)(7) of the Social Security Act) furnished to transport an individual who has an emergency medical condition (as defined in subsection (a)(2)(A)) to a hospital for the receipt of emergency services (as defined in subsection (a)(2)(B)) in a case in which the emergency services are covered under the plan or coverage pursuant to subsection (a)(1) and a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that the absence of such transport would result in placing the health of the individual in serious jeopardy, serious impairment of bodily function, or serious dysfunction of any bodily organ or part.

**SEC. 1613. TIMELY ACCESS TO SPECIALISTS.**

(a) TIMELY ACCESS.—

(1) IN GENERAL.—A group health plan or health insurance issuer offering health insurance coverage shall ensure that participants, beneficiaries, and enrollees receive timely access to specialists who are appropriate to the condition of, and accessible to, the participant, beneficiary, or enrollee, when such specialty care is a covered benefit under the plan or coverage.

(2) RULE OF CONSTRUCTION.—Nothing in paragraph (1) shall be construed—

(A) to require the coverage under a group health plan or health insurance coverage of benefits or services;

(B) to prohibit a plan or issuer from including providers in the network only to the extent necessary to meet the needs of the plan's or issuer's participants, beneficiaries, or enrollees; or

(C) to override any State licensure or scope-of-practice law.

(3) ACCESS TO CERTAIN PROVIDERS.—

(A) IN GENERAL.—With respect to specialty care under this section, if a participating specialist is not available and qualified to provide such care to the participant, beneficiary, or enrollee, the plan or issuer shall provide for coverage of such care by a nonparticipating specialist.

(B) TREATMENT OF NONPARTICIPATING PROVIDERS.—If a participant, beneficiary, or enrollee receives care from a nonparticipating specialist pursuant to subparagraph (A), such specialty care shall be provided at no additional cost to the participant, beneficiary, or enrollee beyond what the participant, beneficiary, or enrollee would otherwise pay for such specialty care if provided by a participating specialist.

(b) REFERRALS.—

(1) AUTHORIZATION.—Subject to subsection (a)(1), a group health plan or health insurance issuer may require an authorization in order to obtain coverage for specialty services under this section. Any such authorization—

(A) shall be for an appropriate duration of time or number of referrals, including an authorization for a standing referral where appropriate; and

(B) may not be refused solely because the authorization involves services of a non-participating specialist (described in subsection (a)(3)).

(2) REFERRALS FOR ONGOING SPECIAL CONDITIONS.—

(A) IN GENERAL.—Subject to subsection (a)(1), a group health plan or health insurance issuer shall permit a participant, beneficiary, or enrollee who has an ongoing special condition (as defined in subparagraph (B)) to receive a referral to a specialist for the treatment of such condition and such specialist may authorize such referrals, procedures, tests, and other medical services with respect to such condition, or coordinate the care for such condition, subject to the terms of a treatment plan (if any) referred to in subsection (c) with respect to the condition.

(B) ONGOING SPECIAL CONDITION DEFINED.—In this subsection, the term ''ongoing special condition'' means a condition or disease that—

(i) is life-threatening, degenerative, potentially disabling, or congenital; and

(ii) requires specialized medical care over a prolonged period of time.

(c) TREATMENT PLANS.—

(1) IN GENERAL.—A group health plan or health insurance issuer may require that the specialty care be provided—

(A) pursuant to a treatment plan, but only if the treatment plan—

(i) is developed by the specialist, in consultation with the case manager or primary care provider, and the participant, beneficiary, or enrollee, and

(ii) is approved by the plan or issuer in a timely manner, if the plan or issuer requires such approval; and

(B) in accordance with applicable quality assurance and utilization review standards of the plan or issuer.

(2) NOTIFICATION.—Nothing in paragraph (1) shall be construed as prohibiting a plan or issuer from requiring the specialist to provide the plan or issuer with regular updates on the specialty care provided, as well as all other reasonably necessary medical information.

(d) SPECIALIST DEFINED.—For purposes of this section, the term ''specialist'' means, with respect to the condition of the participant, beneficiary, or enrollee, a health care professional, facility, or center that has adequate expertise through appropriate training and experience (including, in the case of a child, appropriate pediatric expertise) to provide high quality care in treating the condition.

**SEC. 1614. ACCESS TO PEDIATRIC CARE.**

(a) PEDIATRIC CARE.—In the case of a person who has a child who is a participant, beneficiary, or enrollee under a group health plan, or health insurance coverage offered by a health insurance issuer, if the plan or issuer requires or provides for the designation of a participating primary care provider for the child, the plan or issuer shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics as the child's primary care provider if such provider participates in the network of the plan or issuer.

(b) CONSTRUCTION.—Nothing in subsection (a) shall be construed to waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of pediatric care.

**SEC. 1615. PATIENT ACCESS TO OBSTETRICAL AND GYNECOLOGICAL CARE.**

(a) GENERAL RIGHTS.—

(1) DIRECT ACCESS.—A group health plan, or health insurance issuer offering health insurance coverage, described in subsection (b) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in subsection (b)(2)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology.

(2) OBSTETRICAL AND GYNECOLOGICAL CARE.—A group health plan or health insurance issuer described in subsection (b) shall treat the provision of obstetrical and gynecological care, and the ordering of related obstetrical and gynecological items and services, pursuant to the direct access described under paragraph (1), by a participating health care professional who specializes in obstetrics or gynecology as the authorization of the primary care provider.

(b) APPLICATION OF SECTION.—A group health plan, or health insurance issuer offering health insurance coverage, described in this subsection is a group health plan or coverage that—

(1) provides coverage for obstetric or gynecologic care; and

(2) requires the designation by a participant, beneficiary, or enrollee of a participating primary care provider.

(c) CONSTRUCTION.—Nothing in subsection (a) shall be construed to—

(1) waive any exclusions of coverage under the terms and conditions of the plan or health insurance coverage with respect to coverage of obstetrical or gynecological care; or

(2) preclude the group health plan or health insurance issuer involved from requiring that the obstetrical or gynecological provider notify the primary care health care professional or the plan or issuer of treatment decisions.

**SEC. 1616. CONTINUITY OF CARE.**

(a) TERMINATION OF PROVIDER.—

(1) IN GENERAL.—If—

(A) a contract between a group health plan, or a health insurance issuer offering health insurance coverage, and a treating health care provider is terminated (as defined in subsection (e)(4)), or

(B) benefits or coverage provided by a health care provider are terminated because of a change in the terms of provider participation in such plan or coverage,

the plan or issuer shall meet the requirements of paragraph (3) with respect to each continuing care patient.

(2) TREATMENT OF TERMINATION OF CONTRACT WITH HEALTH INSURANCE ISSUER.—If a contract for the provision of health insurance coverage between a group health plan and a health insurance issuer is terminated and, as a result of such termination, coverage of services of a health care provider is terminated with respect to an individual, the provisions of paragraph (1) (and the succeeding provisions of this section) shall apply under the plan in the same manner as if there had been a contract between the plan and the provider that had been terminated, but only with respect to benefits that are covered under the plan after the contract termination.

(3) REQUIREMENTS.—The requirements of this paragraph are that the plan or issuer—

(A) notify the continuing care patient involved, or arrange to have the patient notified pursuant to subsection (d)(2), on a timely basis of the termination described in paragraph (1) (or paragraph (2), if applicable) and the right to elect continued transitional care from the provider under this section;

(B) provide the patient with an opportunity to notify the plan or issuer of the patient's need for transitional care; and

(C) subject to subsection (c), permit the patient to elect to continue to be covered with respect to the course of treatment by such provider with the provider's consent during a transitional period (as provided for under subsection (b)).

(4) CONTINUING CARE PATIENT.—For purposes of this section, the term ''continuing care patient'' means a participant, beneficiary, or enrollee who—

(A) is undergoing a course of treatment for a serious and complex condition from the provider at the time the plan or issuer receives or provides notice of provider, benefit, or coverage termination described in paragraph (1) (or paragraph (2), if applicable);

(B) is undergoing a course of institutional or inpatient care from the provider at the time of such notice;

(C) is scheduled to undergo non-elective surgery from the provider at the time of such notice;

(D) is pregnant and undergoing a course of treatment for the pregnancy from the provider at the time of such notice; or

(E) is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) at the time of such notice, but only with respect to a provider that was treating the terminal illness before the date of such notice.

(b) TRANSITIONAL PERIODS.—

(1) SERIOUS AND COMPLEX CONDITIONS.—The transitional period under this subsection with respect to a continuing care patient described in subsection (a)(4)(A) shall extend for up to 90 days (as determined by the treating health care professional) from the date of the notice described in subsection (a)(3)(A).

(2) INSTITUTIONAL OR INPATIENT CARE.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(B) shall extend until the earlier of—

(A) the expiration of the 90-day period beginning on the date on which the notice under subsection (a)(3)(A) is provided; or

(B) the date of discharge of the patient from such care or the termination of the period of institutionalization, or, if later, the date of completion of reasonable follow-up care.

(3) SCHEDULED NON-ELECTIVE SURGERY.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(C) shall extend until the completion of the surgery involved and post-surgical follow-up care relating to the surgery and occurring within 90 days after the date of the surgery.

(4) PREGNANCY.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(D) shall extend through the provision of post-partum care directly related to the delivery.

(5) TERMINAL ILLNESS.—The transitional period under this subsection for a continuing care patient described in subsection (a)(4)(E) shall extend for the remainder of the patient's life for care that is directly related to the treatment of the terminal illness or its medical manifestations.

(c) PERMISSIBLE TERMS AND CONDITIONS.—A group health plan or health insurance issuer may condition coverage of continued treatment by a provider under this section upon the provider agreeing to the following terms and conditions:

(1) The treating health care provider agrees to accept reimbursement from the plan or issuer and continuing care patient involved (with respect to cost-sharing) at the rates applicable prior to the start of the transitional period as payment in full (or, in the case described in subsection (a)(2), at the rates applicable under the replacement plan or coverage after the date of the termination of the contract with the group health plan or health insurance issuer) and not to impose cost-sharing with respect to the patient in

an amount that would exceed the cost-sharing that could have been imposed if the contract referred to in subsection (a)(1) had not been terminated.

(2) The treating health care provider agrees to adhere to the quality assurance standards of the plan or issuer responsible for payment under paragraph (1) and to provide to such plan or issuer necessary medical information related to the care provided.

(3) The treating health care provider agrees otherwise to adhere to such plan's or issuer's policies and procedures, including procedures regarding referrals and obtaining prior authorization and providing services pursuant to a treatment plan (if any) approved by the plan or issuer.

(d) RULES OF CONSTRUCTION.—Nothing in this section shall be construed—

(1) to require the coverage of benefits which would not have been covered if the provider involved remained a participating provider; or

(2) with respect to the termination of a contract under subsection (a) to prevent a group health plan or health insurance issuer from requiring that the health care provider—

(A) notify participants, beneficiaries, or enrollees of their rights under this section; or

(B) provide the plan or issuer with the name of each participant, beneficiary, or enrollee who the provider believes is a continuing care patient.

(e) DEFINITIONS.—In this section:

(1) CONTRACT.—The term ''contract'' includes, with respect to a plan or issuer and a treating health care provider, a contract between such plan or issuer and an organized network of providers that includes the treating health care provider, and (in the case of such a contract) the contract between the treating health care provider and the organized network.

(2) HEALTH CARE PROVIDER.—The term ''health care provider'' or ''provider'' means—

(A) any individual who is engaged in the delivery of health care services in a State and who is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State; and

(B) any entity that is engaged in the delivery of health care services in a State and that, if it is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State, is so licensed.

(3) SERIOUS AND COMPLEX CONDITION.—The term ''serious and complex condition'' means, with respect to a participant, beneficiary, or enrollee under the plan or coverage—

(A) in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or

(B) in the case of a chronic illness or condition, is an ongoing special condition (as defined in section (b)(2)(B)).

(4) TERMINATED.—The term ''terminated'' includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

**Subpart C—Protecting the Doctor-Patient Relationship**

**SEC. 1621. PROHIBITION OF INTERFERENCE WITH CERTAIN MEDICAL COMMUNICATIONS.**

(a) GENERAL RULE.—The provisions of any contract or agreement, or the operation of any contract or agreement, between a group health plan or health insurance issuer in relation to health insurance coverage (including any partnership, association, or other organization that enters into or administers such a contract or agreement) and a health care provider (or group of health care providers) shall not prohibit or otherwise restrict a health care professional from advising such a participant, beneficiary, or enrollee who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan or coverage, if the professional is acting within the lawful scope of practice.

(b) NULLIFICATION.—Any contract provision or agreement that restricts or prohibits medical communications in violation of subsection (a) shall be null and void.

**Subpart D—Definitions**

**SEC. 1631. DEFINITIONS.**

(a) INCORPORATION OF GENERAL DEFINITIONS.—Except as otherwise provided, the provisions of section 2791 of the Public Health Service Act shall apply for purposes of this part in the same manner as they apply for purposes of title XXVII of such Act.

(b) SECRETARY.—Except as otherwise provided, the term ''Secretary'' means the Secretary of Health and Human Services, in consultation with the Secretary of Labor and the term ''appropriate Secretary'' means the Secretary of Health and Human Services in relation to carrying out this part under sections 2706 and 2751 of the Public Health Service Act and the Secretary of Labor in relation to carrying out this part under section 713 of the Employee Retirement Income Security Act of 1974.

(c) ADDITIONAL DEFINITIONS.—For purposes of this part:

(1) APPLICABLE AUTHORITY.—The term ''applicable authority'' means—

(A) in the case of a group health plan, the Secretary of Health and Human Services and the Secretary of Labor; and

(B) in the case of a health insurance issuer with respect to a specific provision of this part, the applicable State authority (as defined in section 2791(d) of the Public Health Service Act), or the Secretary of Health and Human Services, if such Secretary is enforcing such provision under section 2722(a)(2) or 2761(a)(2) of the Public Health Service Act.

(2) ENROLLEE.—The term ''enrollee'' means, with respect to health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

(3) GROUP HEALTH PLAN.—The term ''group health plan'' has the meaning given such term in section 733(a) of the Employee Retirement Income Security Act of 1974, except that such term includes a employee welfare benefit plan treated as a group health plan under section 732(d) of such Act or defined as such a plan under section 607(1) of such Act.

(4) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means an individual who is licensed, accredited, or certified under State law to provide specified health care services and who is operating within the scope of such licensure, accreditation, or certification.

(5) HEALTH CARE PROVIDER.—The term ''health care provider'' includes a physician or other health care professional, as well as an institutional or other facility or agency that provides health care services and that is licensed, accredited, or certified to provide health care items and services under applicable State law.

(6) NETWORK.—The term ''network'' means, with respect to a group health plan or health insurance issuer offering health insurance coverage, the participating health care professionals and providers through whom the plan or issuer provides health care items and services to participants, beneficiaries, or enrollees.

(7) NONPARTICIPATING.—The term ''nonparticipating'' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage, a health care provider that is not a participating health care provider with respect to such items and services.

(8) PARTICIPATING.—The term ''participating'' means, with respect to a health care provider that provides health care items and services to a participant, beneficiary, or enrollee under group health plan or health insurance coverage offered by a health insurance issuer, a health care provider that furnishes such items and services under a contract or other arrangement with the plan or issuer.

(9) PRIOR AUTHORIZATION.—The term ''prior authorization'' means the process of obtaining prior approval from a health insurance issuer or group health plan for the provision or coverage of medical services.

(10) TERMS AND CONDITIONS.—The term ''terms and conditions'' includes, with respect to a group health plan or health insurance coverage, requirements imposed under this part with respect to the plan or coverage.

**SEC. 1632. PREEMPTION; STATE FLEXIBILITY; CONSTRUCTION.**

(a) CONTINUED APPLICABILITY OF STATE LAW WITH RESPECT TO HEALTH INSURANCE ISSUERS.—

(1) IN GENERAL.—Subject to paragraph (2), this part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers (in connection with group health insurance coverage or otherwise) except to the extent that such standard or requirement prevents the application of a requirement of this part.

(2) CONTINUED PREEMPTION WITH RESPECT TO GROUP HEALTH PLANS.—Nothing in this part shall be construed to affect or modify the provisions of section 514 of the Employee Retirement Income Security Act of 1974 with respect to group health plans.

(3) CONSTRUCTION.—In applying this section, a State law that provides for equal access to, and availability of, all categories of licensed health care providers and services shall not be treated as preventing the application of any requirement of this part.

(b) APPLICATION OF SUBSTANTIALLY COMPLIANT STATE LAWS.—

(1) IN GENERAL.—In the case of a State law that imposes, with respect to health insurance coverage offered by a health insurance issuer and with respect to a group health plan that is a non-Federal governmental plan, a requirement that substantially complies (within the meaning of subsection (c)) with a patient protection requirement (as defined in paragraph (3)) and does not prevent the application of other requirements under this subtitle (except in the case of other substantially compliant requirements), in applying the requirements of this part under section 2720 and 2754 (as applicable) of the Public Health Service Act (as added by part II), subject to subsection (a)(2)—

(A) the State law shall not be treated as being superseded under subsection (a); and

(B) the State law shall apply instead of the patient protection requirement otherwise applicable with respect to health insurance coverage and non-Federal governmental plans.

(2) LIMITATION.—In the case of a group health plan covered under title I of the Employee Retirement Income Security Act of 1974, paragraph (1) shall be construed to apply only with respect to the health insurance coverage (if any) offered in connection with the plan.

(3) DEFINITIONS.—In this section:

(A) PATIENT PROTECTION REQUIREMENT.—The term ''patient protection requirement'' means a requirement under this part, and includes (as a single requirement) a group or related set of requirements under a section or similar unit under this part.

(B) SUBSTANTIALLY COMPLIANT.—The terms ''substantially compliant'', substantially complies'', or ''substantial compliance'' with respect to a State law, mean that the State law has the same or similar features as the patient protection requirements and has a similar effect.

(c) DETERMINATIONS OF SUBSTANTIAL COMPLIANCE.—

(1) CERTIFICATION BY STATES.—A State may submit to the Secretary a certification that a State law provides for patient protections that are at least substantially compliant with one or more patient protection requirements. Such certification shall be accompanied by such information as may be required to permit the Secretary to make the determination described in paragraph (2)(A).

(2) REVIEW.—

(A) IN GENERAL.—The Secretary shall promptly review a certification submitted under paragraph (1) with respect to a State law to determine if the State law substantially complies with the patient protection requirement (or requirements) to which the law relates.

(B) APPROVAL DEADLINES.—

(i) INITIAL REVIEW.—Such a certification is considered approved unless the Secretary notifies the State in writing, within 90 days after the date of receipt of the certification, that the certification is disapproved (and the reasons for disapproval) or that specified additional information is needed to make the determination described in subparagraph (A).

(ii) ADDITIONAL INFORMATION.—With respect to a State that has been notified by the Secretary under clause (i) that specified additional information is needed to make the determination described in subparagraph (A), the Secretary shall make the determination within 60 days after the date on which such specified additional information is received by the Secretary.

(3) APPROVAL.—

(A) IN GENERAL.—The Secretary shall approve a certification under paragraph (1) unless—

(i) the State fails to provide sufficient information to enable the Secretary to make a determination under paragraph (2)(A); or

(ii) the Secretary determines that the State law involved does not provide for patient protections that substantially comply with the patient protection requirement (or requirements) to which the law relates.

(B) STATE CHALLENGE.—A State that has a certification disapproved by the Secretary under subparagraph (A) may challenge such disapproval in the appropriate United States district court.

(C) DEFERENCE TO STATES.—With respect to a certification submitted under paragraph (1), the Secretary shall give deference to the State's interpretation of the State law involved and the compliance of the law with a patient protection requirement.

(D) PUBLIC NOTIFICATION.—The Secretary shall—

(i) provide a State with a notice of the determination to approve or disapprove a certification under this paragraph;

(ii) promptly publish in the Federal Register a notice that a State has submitted a certification under paragraph (1);

(iii) promptly publish in the Federal Register the notice described in clause (i) with respect to the State; and

(iv) annually publish the status of all States with respect to certifications.

(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the certification (and approval of certification) of a State law under this subsection solely because it provides for greater protections for patients than those protections otherwise required to establish substantial compliance.

(5) PETITIONS.—

(A) PETITION PROCESS.—Effective on the date on which the provisions of this subtitle become effective, as provided for in section 1652, a group health plan, health insurance issuer, participant, beneficiary, or enrollee may submit a petition to the Secretary for an advisory opinion as to whether or not a standard or requirement under a State law applicable to the plan, issuer, participant, beneficiary, or enrollee that is not the subject of a certification under this subsection, is superseded under subsection (a)(1) because such standard or requirement prevents the application of a requirement of this part.

(B) OPINION.—The Secretary shall issue an advisory opinion with respect to a petition submitted under subparagraph (A) within the 60-day period beginning on the date on which such petition is submitted.

(d) DEFINITIONS.—For purposes of this section:

(1) STATE LAW.—The term ''State law'' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) STATE.—The term ''State'' includes a State, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, any political subdivisions of such, or any agency or instrumentality of such.

**SEC. 1633. REGULATIONS.**

The Secretaries of Health and Human Services and Labor shall issue such regulations as may be necessary or appropriate to carry out this part. Such regulations shall be issued consistent with section 104 of Health Insurance Portability and Accountability Act of 1996. Such Secretaries may promulgate any interim final rules as the Secretaries determine are appropriate to carry out this part.

**SEC. 1634. INCORPORATION INTO PLAN OR COVERAGE DOCUMENTS.**

The requirements of this part with respect to a group health plan or health insurance coverage are deemed to be incorporated into, and made a part of, such plan or the policy, certificate, or contract providing such coverage and are enforceable under law as if directly included in the documentation of such plan or such policy, certificate, or contract.

## PART II—APPLICATION OF QUALITY CARE STANDARDS TO GROUP HEALTH PLANS AND HEALTH INSURANCE COVERAGE UNDER THE PUBLIC HEALTH SERVICE ACT

**SEC. 1641. APPLICATION TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.**

(a) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act, as amended by section 1001, is further amended by adding at the end the following new section:

**''SEC. 2720. PATIENT PROTECTION STANDARDS.**

''Each group health plan shall comply with patient protection requirements under part I of subtitle H of title I of the Patient Protection and Affordable Care Act, and each health insurance issuer shall comply with patient protection requirements under such part with respect to group health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.''.

(b) CONFORMING AMENDMENT.—Section 2721(b)(2)(A) of such Act (42 U.S.C. 300gg–21(b)(2)(A)) is amended by inserting ''(other than section 2720)'' after ''requirements of such subparts''.

**SEC. 1642. APPLICATION TO INDIVIDUAL HEALTH INSURANCE COVERAGE.**

Part B of title XXVII of the Public Health Service Act is amended by inserting after section 2753 the following new section:

**''SEC. 2754. PATIENT PROTECTION STANDARDS.**

''Each health insurance issuer shall comply with patient protection requirements under part I of subtitle H of title I of the Patient Protection and Affordable Care Act with respect to individual health insurance coverage it offers, and such requirements shall be deemed to be incorporated into this subsection.''.

**SEC. 1643. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.**

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–91 et seq.), as amended by section 1002, is further amended by adding at the end the following:

**''SEC. 2795. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.**

''(a) AGREEMENT WITH STATES.—A State may enter into an agreement with the Secretary for the delegation to the State of some or all of the Secretary's authority under this title to enforce the requirements applicable under part I of subtitle H of title I of the Patient Protection and Affordable Care Act with respect to health insurance coverage offered by a health insurance issuer and with respect to a group health plan that is a non-Federal governmental plan.

''(b) DELEGATIONS.—Any department, agency, or instrumentality of a State to which authority is delegated pursuant to an agreement entered into under this section may, if authorized under State law and to the extent consistent with such agreement, exercise the powers of the Secretary under this title which relate to such authority.''.

## PART III—AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

**SEC. 1651. APPLICATION OF PATIENT PROTECTION STANDARDS TO GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.**

(a) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by section 1562, is further amended by adding at the end the following new section:

**''SEC. 716. PATIENT PROTECTION STANDARDS.**

''(a) IN GENERAL.—Subject to subsection (b), a group health plan (and a health insurance issuer offering group health insurance coverage in connection with such a plan) shall comply with the requirements of part I of subtitle H of title I of the Patient Protection and Affordable Care Act (as in effect as of the date of the enactment of such Act), and such requirements shall be deemed to be incorporated into this subsection.

''(b) PLAN SATISFACTION OF CERTAIN REQUIREMENTS.—

''(1) SATISFACTION OF CERTAIN REQUIREMENTS THROUGH INSURANCE.—For purposes of subsection (a), insofar as a group health plan provides benefits in the form of health insurance coverage through a health insurance issuer, the plan shall be treated as meeting

the following requirements of part I of subtitle H of title I of the Patient Protection and Affordable Care Act with respect to such benefits and not be considered as failing to meet such requirements because of a failure of the issuer to meet such requirements so long as the plan sponsor or its representatives did not cause such failure by the issuer:

''(A) Section 1611 (relating to choice of health care professional).

''(B) Section 1612 (relating to access to emergency care).

''(C) Section 1613 (relating to timely access to specialists).

''(D) Section 1614 (relating to access to pediatric care).

''(E) Section 1615 (relating to patient access to obstetrical and gynecological care).

''(F) Section 1616 (relating to continuity of care), but only insofar as a replacement issuer assumes the obligation for continuity of care.

''(2) APPLICATION TO PROHIBITIONS.—Pursuant to rules of the Secretary, if a health insurance issuer offers health insurance coverage in connection with a group health plan and takes an action in violation of section 1621 of the Patient Protection and Affordable Care Act (relating to prohibition of interference with certain medical communications), the group health plan shall not be liable for such violation unless the plan caused such violation.

''(3) CONSTRUCTION.—Nothing in this subsection shall be construed to affect or modify the responsibilities of the fiduciaries of a group health plan under part 4 of subtitle B.

''(4) TREATMENT OF SUBSTANTIALLY COMPLIANT STATE LAWS.—For purposes of applying this subsection, any reference in this subsection to a requirement in a section or other provision in subtitle H of title I of the Patient Protection and Affordable Care Act with respect to a health insurance issuer is deemed to include a reference to a requirement under a State law that substantially complies (as determined under section 1632(c) of such Act) with the requirement in such section or other provisions.

''(c) CONFORMING REGULATIONS.—The Secretary shall issue regulations to coordinate the requirements on group health plans and health insurance issuers under this section with the requirements imposed under the other provisions of this title.''.

(b) SATISFACTION OF ERISA CLAIMS PROCEDURE REQUIREMENT.—Section 503 of such Act (29 U.S.C. 1133) is amended by inserting ''(a)'' after ''SEC. 503.'' and by adding at the end the following new subsection:

''(b) In the case of a group health plan (as defined in section 733) compliance with the requirements of subpart A of part I of subtitle H of title I of the Patient Protection and Affordable Care Act, and compliance with regulations promulgated by the Secretary, in the case of a claims denial shall be deemed compliance with subsection (a) with respect to such claims denial.''.

(c) CONFORMING AMENDMENTS.—(1) Section 732(a) of such Act (29 U.S.C. 1185(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 716''.

(2) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 715 the following new item:

''Sec. 716. Patient protection standards''.

(d) EFFECT ON COLLECTIVE BARGAINING AGREEMENTS.—In the case of health insurance coverage maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers that was ratified before the date of enactment of this title, the provisions of this section (and the amendments made by this section) shall not apply until the date on which the last of the collective bargaining agreements relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage which amends the coverage solely to conform to any requirement added by this section (or amendments) shall not be treated as a termination of such collective bargaining agreement.

**SEC. 1652. EFFECTIVE DATE.**

This subtitle (and the amendments made by this subtitle) shall become effective for plan years beginning on or after the date that is 6 months after the date of enactment of this Act.

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**SA 3066.** Mrs. BOXER submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1907, after line 25, add the following:

''(P) An entity that is owned or operated by a unit of local government which provides mental health or health care services and is located in a county in which the rate of uninsurance is above the national rate of uninsurance for the under-65 population, based on the best available estimate of the rate of uninsurance published by the Bureau of the Census.''.

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**SA 3067.** Mr. PRYOR (for himself, Mrs. BOXER, and Mr. ROCKEFELLER) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. FEDERAL TRADE COMMISSION OVERSIGHT OVER HEALTH INSURANCE ISSUERS.**

Section 6 of the Federal Trade Commission Act (15 U.S.C. 46) is amended in the undesignated matter following subsection (l), by striking ''Nothing'' and all that follows through ''was made.'' and inserting the following:

''Notwithstanding the Act of March 9, 1945 (15 U.S.C. 1011 et seq.) and the definition of corporation in section 4, the Commission may use the authority described in this section to conduct studies, prepare reports, and disclose information relating to insurance, without regard to whether the subject of the study, report, or the information is for-profit or not-for-profit.

''Subject to the Act of March 9, 1945 (15 U.S.C. 1011 et seq.) and notwithstanding the definition of corporation in section 4, the provisions of this Act shall apply to an insurer without regard to whether such insurer is for-profit or not-for-profit. For purposes of this paragraph, an employer or membership organization not organized for its own profit or that of its members that provides health care or medical malpractice benefits only to its employees or members shall not be deemed to be a health insurer or a medical malpractice insurer, provided that this exclusion shall not apply to a separate entity that issues insurance or to an organization whose sole or primary membership benefit is insurance.''.

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**SA 3068.** Mr. KYL (for himself, Mr. ROBERTS, Mr. VITTER, Mr. GRASSLEY, Mr. CRAPO, Mr. COBURN, Mr. BARRASSO, and Mr. JOHANNS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. ___. PROHIBITION ON CERTAIN USES OF DATA OBTAINED FROM COMPARATIVE EFFECTIVENESS RESEARCH; ACCOUNTING FOR PERSONALIZED MEDICINE AND DIFFERENCES IN PATIENT TREATMENT RESPONSE.**

(a) IN GENERAL.—Notwithstanding any other provision of law, a Federal department, office, or representative—

(1) shall not use data obtained from the conduct of comparative effectiveness research, including such research that is conducted or supported using funds appropriated under the American Recovery and Reinvestment Act of 2009 (Public Law 111–5), to deny coverage of an item or service under a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f))), including under plans offered under the Federal Employees Health Benefits Program (under chapter 89 of title 5, United States Code), or under private health insurance; and

(2) shall ensure that comparative effectiveness research conducted or supported by the Federal Government accounts for factors contributing to differences in the treatment response and treatment preferences of patients, including patient-reported outcomes, genomics and personalized medicine, the unique needs of health disparity populations, and indirect patient benefits.

(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as affecting the authority of the Commissioner of Food and Drugs under the Federal Food, Drug, and Cosmetic Act or the Public Health Service Act.

(c) PATIENT CENTERED OUTCOMES RESEARCH INSTITUTE BOARD.—Notwithstanding section 1181(f)(1)(A) and (B) of the Social Security Act (as added by section 6301(a)), no Federal officer or employee (including Federally elected officials and members of Congress) shall serve on the Board of Governors of the Patient Centered Outcomes Research Institute.

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**SA 3069**. Mr. KOHL submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

## TITLE ____—COMBATING ELDER ABUSE AND SILVER ALERTS

**SEC. __11. SHORT TITLE.**

This title may be cited as the ''Combating Elder Abuse and National Silver Alert Act of 2009''.

### Subtitle A—Elder Abuse Victims Act of 2009

**SEC. __21. SHORT TITLE.**

This subtitle may be cited as the ''Elder Abuse Victims Act of 2009''.

### PART I—ELDER ABUSE VICTIMS

**SEC. __31. ANALYSIS, REPORT, AND RECOMMENDATIONS RELATED TO ELDER JUSTICE PROGRAMS.**

(a) IN GENERAL.—Subject to the availability of appropriations to carry out this section, the Attorney General, in consultation with the Secretary of Health and Human Services, shall carry out the following:

(1) STUDY.—Conduct a study of laws and practices relating to elder abuse, neglect, and exploitation, which shall include—

(A) a comprehensive description of State laws and practices relating to elder abuse, neglect, and exploitation;

(B) a comprehensive analysis of the effectiveness of such State laws and practices; and

(C) an examination of State laws and practices relating to specific elder abuse, neglect, and exploitation issues, including—

(i) the definition of—

(I) ''elder'';

(II) ''abuse'';

(III) ''neglect'';

(IV) ''exploitation''; and

(V) such related terms the Attorney General determines to be appropriate;

(ii) mandatory reporting laws, with respect to—

(I) who is a mandated reporter;

(II) to whom must they report and within what time frame; and

(III) any consequences for not reporting;

(iii) evidentiary, procedural, sentencing, choice of remedies, and data retention issues relating to pursuing cases relating to elder abuse, neglect, and exploitation;

(iv) laws requiring reporting of all nursing home deaths to the county coroner or to some other individual or entity;

(v) fiduciary laws, including guardianship and power of attorney laws;

(vi) laws that permit or encourage banks and bank employees to prevent and report suspected elder abuse, neglect, and exploitation;

(vii) laws relating to fraud and related activities in connection with mail, telemarketing, or the Internet;

(viii) laws that may impede research on elder abuse, neglect, and exploitation;

(ix) practices relating to the enforcement of laws relating to elder abuse, neglect, and exploitation; and

(x) practices relating to other aspects of elder justice.

(2) DEVELOPMENT OF PLAN.—Develop objectives, priorities, policies, and a long-term plan for elder justice programs and activities relating to—

(A) prevention and detection of elder abuse, neglect, and exploitation;

(B) intervention and treatment for victims of elder abuse, neglect, and exploitation;

(C) training, evaluation, and research related to elder justice programs and activities; and

(D) improvement of the elder justice system in the United States.

(3) REPORT.—Not later than 2 years after the date of enactment of this Act, submit to the chairman and ranking member of the Special Committee on Aging of the Senate, and the Speaker and minority leader of the House of Representatives, and the Secretary of Health and Human Services, and make available to the States, a report that contains—

(A) the findings of the study conducted under paragraph (1);

(B) a description of the objectives, priorities, policies, and a long-term plan developed under paragraph (2); and

(C) a list, description, and analysis of the best practices used by States to develop, implement, maintain, and improve elder justice systems, based on such findings.

(b) GAO RECOMMENDATIONS.—Not later than 18 months after the date of enactment of this Act, the Comptroller General shall review existing Federal programs and initiatives in the Federal criminal justice system relevant to elder justice and shall submit to Congress—

(1) a report on such programs and initiatives; and

(2) any recommendations the Comptroller General determines are appropriate to improve elder justice in the United States.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $6,000,000 for each of the fiscal years 2010 through 2016.

**SEC. __32. VICTIM ADVOCACY GRANTS.**

(a) GRANTS AUTHORIZED.—The Attorney General, after consultation with the Secretary of Health and Human Services, may award grants to eligible entities to study the special needs of victims of elder abuse, neglect, and exploitation.

(b) AUTHORIZED ACTIVITIES.—Funds awarded pursuant to subsection (a) shall be used for pilot programs that—

(1) develop programs for and provide training to health care, social, and protective services providers, law enforcement, fiduciaries (including guardians), judges and court personnel, and victim advocates; and

(2) examine special approaches designed to meet the needs of victims of elder abuse, neglect, and exploitation.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $3,000,000 for each of the fiscal years 2010 through 2016.

**SEC. __33. SUPPORTING LOCAL PROSECUTORS AND COURTS IN ELDER JUSTICE MATTERS.**

(a) GRANTS AUTHORIZED.—Subject to the availability of appropriations under this section, the Attorney General, after consultation with the Secretary of Health and Human Services, shall award grants to eligible entities to provide training, technical assistance, policy development, multidisciplinary coordination, and other types of support to local prosecutors and courts handling elder justice-related cases, including—

(1) funding specially designated elder justice positions or units in local prosecutors' offices and local courts; and

(2) funding the creation of a Center for the Prosecution of Elder Abuse, Neglect, and Exploitation to advise and support local prosecutors and courts nationwide in the pursuit of cases involving elder abuse, neglect, and exploitation.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $6,000,000 for each of the fiscal years 2010 through 2016.

**SEC. __34. SUPPORTING STATE PROSECUTORS AND COURTS IN ELDER JUSTICE MATTERS.**

(a) IN GENERAL.—Subject to the availability of appropriations under this section, the Attorney General, after consultation with the Secretary of Health and Human Services, shall award grants to eligible entities to provide training, technical assistance, multidisciplinary coordination, policy development, and other types of support to State prosecutors and courts, employees of State Attorneys General, and Medicaid Fraud Control Units handling elder justice-related matters.

(b) CREATING SPECIALIZED POSITIONS.—Grants under this section may be made for—

(1) the establishment of specially designated elder justice positions or units in State prosecutors' offices and State courts; and

(2) the creation of a position to coordinate elder justice-related cases, training, technical assistance, and policy development for State prosecutors and courts.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $6,000,000 for each of the fiscal years 2010 through 2016.

**SEC. __35. SUPPORTING LAW ENFORCEMENT IN ELDER JUSTICE MATTERS.**

(a) IN GENERAL.—Subject to the availability of appropriations under this section, the Attorney General, after consultation with the Secretary of Health and Human Services, the Postmaster General, and the Chief Postal Inspector for the United States Postal Inspection Service, shall award grants to eligible entities to provide training, technical assistance, multidisciplinary coordination, policy development, and other types of support to police, sheriffs, detectives, public safety officers, corrections personnel, and other first responders who handle elder justice-related matters, to fund specially designated elder justice positions or units designed to support first responders in elder justice matters.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $8,000,000 for each of the fiscal years 2010 through 2016.

**SEC. __36. EVALUATIONS.**

(a) GRANTS UNDER THIS PART.—

(1) IN GENERAL.—In carrying out the grant programs under this part, the Attorney General shall—

(A) require each recipient of a grant to use a portion of the funds made available through the grant to conduct a validated evaluation of the effectiveness of the activities carried out through the grant by such recipient; or

(B) as the Attorney General considers appropriate, use a portion of the funds available under this part for a grant program under this part to provide assistance to an eligible entity to conduct a validated evaluation of the effectiveness of the activities carried out through such grant program by each of the grant recipients.

(2) APPLICATIONS.—

(A) SUBMISSION.—To be eligible to receive a grant under this part, an entity shall submit an application to the Attorney General at such time, in such manner, and containing such information as the Attorney General may require, which shall include—

(i) a proposal for the evaluation required in accordance with paragraph (1)(A); and

(ii) the amount of assistance under paragraph (1)(B) the entity is requesting, if any.

(B) REVIEW AND ASSISTANCE.—

(i) IN GENERAL.—An employee of the Department of Justice, after consultation with an employee of the Department of Health and Human Services with expertise in evaluation methodology, shall review each application described in subparagraph (A) and determine whether the methodology described in the proposal under subparagraph (A)(i) is adequate to gather meaningful information.

(ii) DENIAL.—If the reviewing employee determines the methodology described in such proposal is inadequate, the reviewing employee shall recommend that the Attorney General deny the application for the grant,

or make recommendations for how the application should be amended.

(iii) NOTICE TO APPLICANT.—If the Attorney General denies the application on the basis of such proposal, the Attorney General shall inform the applicant of the reasons the application was denied, and offer assistance to the applicant in modifying the proposal.

(b) OTHER GRANTS.—Subject to the availability of appropriations under this section, the Attorney General shall award grants to appropriate entities to conduct validated evaluations of grant activities that are funded by Federal funds not provided under this part, or other funds, to reduce elder abuse, neglect, and exploitation.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $7,000,000 for each of the fiscal years 2010 through 2016.

**SEC. __37. DEFINITIONS.**

In this part:

(1) ELDER.—The term ''elder'' means an individual age 60 or older.

(2) ELDER JUSTICE.—The term ''elder justice'' means—

(A) from a societal perspective, efforts to—

(i) prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation; and

(ii) protect elders with diminished capacity while maximizing their autonomy; and

(B) from an individual perspective, the recognition of an elder's rights, including the right to be free of abuse, neglect, and exploitation.

(3) ELIGIBLE ENTITIES.—The term ''eligible entity'' means a State or local government agency, Indian tribe or tribal organization, or any other public or nonprofit private entity that is engaged in and has expertise in issues relating to elder justice or a field necessary to promote elder justice efforts.

**PART II—ELDER SERVE VICTIM GRANT PROGRAMS**

**SEC. __41. ESTABLISHMENT OF ELDER SERVE VICTIM GRANT PROGRAMS.**

(a) ESTABLISHMENT.—The Attorney General, acting through the Director of the Office of Victims of Crime of the Department of Justice (in this section referred to as the ''Director''), shall, subject to appropriations, carry out a three-year grant program to be known as the Elder Serve Victim grant program (in this section referred to as the ''Program'') to provide grants to eligible entities to establish programs to facilitate and coordinate programs described in subsection (e) for victims of elder abuse.

(b) ELIGIBILITY REQUIREMENTS FOR GRANTEES.—To be eligible to receive a grant under the Program, an entity must meet the following criteria:

(1) ELIGIBLE CRIME VICTIM ASSISTANCE PROGRAM.—The entity is a crime victim assistance program receiving a grant under the Victims of Crime Act of 1984 (42 U.S.C. 1401 et seq.) for the period described in subsection (c)(2) with respect to the grant sought under this section.

(2) COORDINATION WITH LOCAL COMMUNITY BASED AGENCIES AND SERVICES.—The entity shall demonstrate to the satisfaction of the Director that such entity has a record of community coordination or established contacts with other county and local services that serve elderly individuals.

(3) ABILITY TO CREATE ECRT ON TIMELY BASIS.—The entity shall demonstrate to the satisfaction of the Director the ability of the entity to create, not later than 6 months after receiving such grant, an Emergency Crisis Response Team program described in subsection (e)(1) and the programs described in subsection (e)(2).

For purposes of meeting the criteria described in paragraph (2), for each year an entity receives a grant under this section the entity shall provide a record of community coordination or established contacts described in such paragraph through memoranda of understanding, contracts, subcontracts, and other such documentation.

(c) ADMINISTRATIVE PROVISIONS.—

(1) CONSULTATION.—Each program established pursuant to this section shall be developed and carried out in consultation with the following entities, as appropriate:

(A) Relevant Federal, State, and local public and private agencies and entities, relating to elder abuse, neglect, and exploitation and other crimes against elderly individuals.

(B) Local law enforcement including police, sheriffs, detectives, public safety officers, corrections personnel, prosecutors, medical examiners, investigators, and coroners.

(C) Long-term care and nursing facilities.

(2) GRANT PERIOD.—Grants under the Program shall be issued for a three-year period.

(3) LOCATIONS.—The Program shall be carried out in six geographically and demographically diverse locations, taking into account—

(A) the number of elderly individuals residing in or near an area; and

(B) the difficulty of access to immediate short-term housing and health services for victims of elder abuse.

(d) PERSONNEL.—In providing care and services, each program established pursuant to this section may employ a staff to assist in creating an Emergency Crisis Response Teams under subsection (e)(1).

(e) USE OF GRANTS.—

(1) EMERGENCY CRISIS RESPONSE TEAM.—Each entity that receives a grant under this section shall use such grant to establish an Emergency Crisis Response Team program by not later than the date that is six months after the entity receives the grant. Under such program the following shall apply:

(A) Such program shall include immediate, short-term emergency services, including shelter, care services, food, clothing, transportation to medical or legal appointment as appropriate, and any other life services deemed necessary by the entity for victims of elder abuse.

(B) Such program shall provide services to victims of elder abuse, including those who have been referred to the program through the adult protective services agency of the local law enforcement or any other relevant law enforcement or referral agency.

(C) A victim of elder abuse may not receive short-term housing under the program for more than 30 consecutive days.

(D) The entity that established the program shall enter into arrangements with the relevant local law enforcement agencies so that the program receives quarterly reports from such agencies on elder abuse.

(2) ADDITIONAL SERVICES REQUIRED TO BE PROVIDED.—Not later than one year after the date an entity receives a grant under this section, such entity shall have established the following programs (and community collaborations to support such programs):

(A) COUNSELING.—A program that provides counseling and assistance for victims of elder abuse accessing health care, educational, pension, or other benefits for which seniors may be eligible under Federal or applicable State law.

(B) MENTAL HEALTH SCREENING.—A program that provides mental health screenings for victims of elder abuse to identify and seek assistance for potential mental health disorders such as depression or substance abuse.

(C) EMERGENCY LEGAL ADVOCACY.—A program that provides legal advocacy for victims of elder abuse and, as appropriate, their families.

(D) JOB PLACEMENT ASSISTANCE.—A program that provides job placement assistance and information on employment, training, or volunteer opportunities for victims of elder abuse.

(E) BEREAVEMENT COUNSELING.—A program that provides bereavement counseling for families of victims of elder abuse.

(F) OTHER SERVICES.—A program that provides such other care, services, and assistance as the entity considers appropriate for purposes of the program.

(f) TECHNICAL ASSISTANCE.—The Director shall enter into contracts with private entities with experience in elder abuse coordination or victim services to provide such technical assistance to grantees under this section as the entity determines appropriate.

(g) REPORTS TO CONGRESS.—Not later than 12 months after the commencement of the Program, and annually thereafter, the entity shall submit a report to the Chairman and Ranking Member of the Committee on the Judiciary of the House of Representatives, and the Chairman and Ranking Member of the Special Committee on Aging of the Senate. Each report shall include the following:

(1) A description and assessment of the implementation of the Program.

(2) An assessment of the effectiveness of the Program in providing care and services to seniors, including a comparative assessment of effectiveness for each of the locations designated under subsection (c)(3) for the Program.

(3) An assessment of the effectiveness of the coordination for programs described in subsection (e) in contributing toward the effectiveness of the Program.

(4) Such recommendations as the entity considers appropriate for modifications of the Program in order to better provide care and services to seniors.

(h) DEFINITIONS.—For purposes of this section:

(1) ELDER ABUSE.—The term ''elder abuse'' means any type of violence or abuse, whether mental or physical, inflicted upon an elderly individual, and any type of criminal financial exploitation of an elderly individual.

(2) ELDERLY INDIVIDUAL.—The term ''elderly individual'' means an individual who is age 60 or older.

(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated for the Department of Justice to carry out this section $3,000,000 for each of the fiscal years 2010 through 2012.

**Subtitle B—National Silver Alert**

**SEC. __51. SHORT TITLE.**

This subtitle may be cited as the ''National Silver Alert Act''.

**SEC. __52. DEFINITIONS.**

For purposes of this subtitle:

(1) STATE.—The term ''State'' means each of the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

(2) MISSING SENIOR.—The term ''missing senior'' refers to any individual who—

(A) is reported to, or identified by, a law enforcement agency as a missing person; and

(B) meets the requirements to be designated as a missing senior, as determined by the State in which the individual is reported or identified as a missing person.

**SEC. __53. SILVER ALERT COMMUNICATIONS NETWORK.**

The Attorney General shall, subject to the availability of appropriations under section __57, establish a national Silver Alert communications network within the Department of Justice to provide assistance to regional and local search efforts for missing seniors through the initiation, facilitation, and promotion of local elements of the network

(known as Silver Alert plans) in coordination with States, units of local government, law enforcement agencies, and other concerned entities with expertise in providing services to seniors.

**SEC. __54. SILVER ALERT COORDINATOR.**

(a) NATIONAL COORDINATOR WITHIN DEPARTMENT OF JUSTICE.—The Attorney General shall designate an individual of the Department of Justice to act as the national coordinator of the Silver Alert communications network. The individual so designated shall be known as the Silver Alert Coordinator of the Department of Justice (referred to in this subtitle as the ''Coordinator'').

(b) DUTIES OF THE COORDINATOR.—In acting as the national coordinator of the Silver Alert communications network, the Coordinator shall—

(1) work with States to encourage the development of additional Silver Alert plans in the network;

(2) establish voluntary guidelines for States to use in developing Silver Alert plans that will promote compatible and integrated Silver Alert plans throughout the United States, including—

(A) a list of the resources necessary to establish a Silver Alert plan;

(B) criteria for evaluating whether a situation warrants issuing a Silver Alert, taking into consideration the need for the use of such Alerts to be limited in scope because the effectiveness of the Silver Alert communications network may be affected by overuse, including criteria to determine—

(i) whether the mental capacity of a senior who is missing, and the circumstances of his or her disappearance, warrant the issuance a Silver Alert; and

(ii) whether the individual who reports that a senior is missing is an appropriate and credible source on which to base the issuance of a Silver Alert;

(C) a description of the appropriate uses of the Silver Alert name to readily identify the nature of search efforts for missing seniors; and

(D) recommendations on how to protect the privacy, dignity, independence, and autonomy of any missing senior who may be the subject of a Silver Alert;

(3) develop proposed protocols for efforts to recover missing seniors and to reduce the number of seniors who are reported missing, including protocols for procedures that are needed from the time of initial notification of a law enforcement agency that the senior is missing through the time of the return of the senior to family, guardian, or domicile, as appropriate, including—

(A) public safety communications protocol;

(B) case management protocol;

(C) command center operations;

(D) reunification protocol; and

(E) incident review, evaluation, debriefing, and public information procedures;

(4) work with States to ensure appropriate regional coordination of various elements of the network;

(5) establish an advisory group to assist States, units of local government, law enforcement agencies, and other entities involved in the Silver Alert communications network with initiating, facilitating, and promoting Silver Alert plans, which shall include—

(A) to the maximum extent practicable, representation from the various geographic regions of the United States; and

(B) members who are—

(i) representatives of senior citizen advocacy groups, law enforcement agencies, and public safety communications;

(ii) broadcasters, first responders, dispatchers, and radio station personnel; and

(iii) representatives of any other individuals or organizations that the Coordinator determines are necessary to the success of the Silver Alert communications network; and

(6) act as the nationwide point of contact for—

(A) the development of the network; and

(B) regional coordination of alerts for missing seniors through the network.

(c) COORDINATION.—

(1) COORDINATION WITH OTHER AGENCIES.—The Coordinator shall coordinate and consult with the Secretary of Transportation, the Federal Communications Commission, the Assistant Secretary for Aging of the Department of Health and Human Services, the head of the Missing Alzheimer's Disease Patient Alert Program, and other appropriate offices of the Department of Justice in carrying out activities under this subtitle.

(2) STATE AND LOCAL COORDINATION.—The Coordinator shall consult with local broadcasters and State and local law enforcement agencies in establishing minimum standards under section __55 and in carrying out other activities under this subtitle, as appropriate.

(d) ANNUAL REPORTS.—Not later than one year after the date of enactment of this Act, and annually thereafter, the Coordinator shall submit to Congress a report on the activities of the Coordinator and the effectiveness and status of the Silver Alert plans of each State that has established or is in the process of establishing such a plan. Each such report shall include—

(1) a list of States that have established Silver Alert plans;

(2) a list of States that are in the process of establishing Silver Alert plans;

(3) for each State that has established such a plan, to the extent the data is available—

(A) the number of Silver Alerts issued;

(B) the number of individuals located successfully;

(C) the average period of time between the issuance of a Silver Alert and the location of the individual for whom such Alert was issued;

(D) the State agency or authority issuing Silver Alerts, and the process by which Silver Alerts are disseminated;

(E) the cost of establishing and operating such a plan;

(F) the criteria used by the State to determine whether to issue a Silver Alert; and

(G) the extent to which missing individuals for whom Silver Alerts were issued crossed State lines;

(4) actions States have taken to protect the privacy and dignity of the individuals for whom Silver Alerts are issued;

(5) ways that States have facilitated and improved communication about missing individuals between families, caregivers, law enforcement officials, and other authorities; and

(6) any other information the Coordinator determines to be appropriate.

**SEC. __55. MINIMUM STANDARDS FOR ISSUANCE AND DISSEMINATION OF ALERTS THROUGH SILVER ALERT COMMUNICATIONS NETWORK.**

(a) ESTABLISHMENT OF MINIMUM STANDARDS.—Subject to subsection (b), the Coordinator shall establish minimum standards for—

(1) the issuance of alerts through the Silver Alert communications network; and

(2) the extent of the dissemination of alerts issued through the network.

(b) LIMITATIONS.—

(1) VOLUNTARY PARTICIPATION.—The minimum standards established under subsection (a) of this section, and any other guidelines and programs established under section __54, shall be adoptable on a voluntary basis only.

(2) DISSEMINATION OF INFORMATION.—The minimum standards shall, to the maximum extent practicable (as determined by the Coordinator in consultation with State and local law enforcement agencies), provide that appropriate information relating to the special needs of a missing senior (including health care needs) are disseminated to the appropriate law enforcement, public health, and other public officials.

(3) GEOGRAPHIC AREAS.—The minimum standards shall, to the maximum extent practicable (as determined by the Coordinator in consultation with State and local law enforcement agencies), provide that the dissemination of an alert through the Silver Alert communications network be limited to the geographic areas which the missing senior could reasonably reach, considering the missing senior's circumstances and physical and mental condition, the modes of transportation available to the missing senior, and the circumstances of the disappearance.

(4) AGE REQUIREMENTS.—The minimum standards shall not include any specific age requirement for an individual to be classified as a missing senior for purposes of the Silver Alert communication network. Age requirements for determinations of whether an individual is a missing senior shall be determined by each State, and may vary from State to State.

(5) PRIVACY AND CIVIL LIBERTIES PROTECTIONS.—The minimum standards shall—

(A) ensure that alerts issued through the Silver Alert communications network comply with all applicable Federal, State, and local privacy laws and regulations; and

(B) include standards that specifically provide for the protection of the civil liberties and sensitive medical information of missing seniors.

(6) STATE AND LOCAL VOLUNTARY COORDINATION.—In carrying out the activities under subsection (a), the Coordinator may not interfere with the current system of voluntary coordination between local broadcasters and State and local law enforcement agencies for purposes of the Silver Alert communications network.

**SEC. __56. TRAINING AND OTHER RESOURCES.**

(a) TRAINING AND EDUCATIONAL PROGRAMS.—The Coordinator shall make available to States, units of local government, law enforcement agencies, and other concerned entities that are involved in initiating, facilitating, or promoting Silver Alert plans, including broadcasters, first responders, dispatchers, public safety communications personnel, and radio station personnel—

(1) training and educational programs related to the Silver Alert communication network and the capabilities, limitations, and anticipated behaviors of missing seniors, which shall be updated regularly to encourage the use of new tools, technologies, and resources in Silver Alert plans; and

(2) informational materials, including brochures, videos, posters, and websites to support and supplement such training and educational programs.

(b) COORDINATION.—The Coordinator shall coordinate—

(1) with the Assistant Secretary for Aging of the Department of Health and Human Services in developing the training and educational programs and materials under subsection (a); and

(2) with the head of the Missing Alzheimer's Disease Patient Alert Program within the Department of Justice, to determine if any existing material with respect to training programs or educational materials developed or used as subtitle of such Patient Alert Program are appropriate and may be used for the programs under subsection (a).

**SEC. __57. AUTHORIZATION OF APPROPRIATIONS FOR THE SILVER ALERT COMMUNICATIONS NETWORK.**

There are authorized to be appropriated to the Department of Justice such sums as may be necessary to carry out the Silver Alert communications network as authorized under this subtitle.

**SEC. __58. GRANT PROGRAM FOR SUPPORT OF SILVER ALERT PLANS.**

(a) GRANT PROGRAM.—Subject to the availability of appropriations to carry out this section, the Attorney General shall carry out a program to provide grants to States for the development and enhancement of programs and activities for the support of Silver Alert plans and the Silver Alert communications network.

(b) ACTIVITIES.—Activities funded by grants under the program under subsection (a) may include—

(1) the development and implementation of education and training programs, and associated materials, relating to Silver Alert plans;

(2) the development and implementation of law enforcement programs, and associated equipment, relating to Silver Alert plans;

(3) the development and implementation of new technologies to improve Silver Alert communications; and

(4) such other activities as the Attorney General considers appropriate for supporting the Silver Alert communications network.

(c) FEDERAL SHARE.—The Federal share of the cost of any activities funded by a grant under the program under subsection (a) may not exceed 50 percent.

(d) DISTRIBUTION OF GRANTS ON GEOGRAPHIC BASIS.—The Attorney General shall, to the maximum extent practicable, ensure the distribution of grants under the program under subsection (a) on an equitable basis throughout the various regions of the United States.

(e) ADMINISTRATION.—The Attorney General shall prescribe requirements, including application requirements, for grants under the program under subsection (a).

(f) AUTHORIZATION OF APPROPRIATIONS.—

(1) There is authorized to be appropriated to the Department of Justice $5,000,000 for each of the fiscal years 2010 through 2014 to carry out this section and, in addition, $5,000,000 for each of the fiscal years 2010 through 2014 to carry out subsection (b)(3).

(2) Amounts appropriated pursuant to the authorization of appropriations in paragraph (1) shall remain available until expended.

**SEC. __59. SAMMY KIRK VOLUNTARY ELECTRONIC MONITORING PROGRAM.**

(a) PROGRAM AUTHORIZED.—The Attorney General, after consultation with the Secretary of Health and Human Services, is authorized to award grants to States and units of local government to carry out programs to provide voluntary electronic monitoring services to elderly individuals to assist in the location of such individuals if such individuals are reported as missing.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $2,000,000 for each of the fiscal years 2010 through 2014.

(c) DESIGNATION.—The grant program authorized under this section shall be referred to as the ''Sammy Kirk Voluntary Electronic Monitoring Program''.

**Subtitle C—Kristen's Act Reauthorization**

**SEC. __61. SHORT TITLE.**

This subtitle may be cited as ''Kristen's Act Reauthorization of 2009''.

**SEC. __62. FINDINGS.**

Congress finds the following:

(1) Every year thousands of adults become missing due to advanced age, diminished mental capacity, or foul play. Often there is no information regarding the whereabouts of these adults and many of them are never reunited with their families.

(2) Missing adults are at great risk of both physical harm and sexual exploitation.

(3) In most cases, families and local law enforcement officials have neither the resources nor the expertise to undertake appropriate search efforts for a missing adult.

(4) The search for a missing adult requires cooperation and coordination among Federal, State, and local law enforcement agencies and assistance from distant communities where the adult may be located.

(5) Federal assistance is urgently needed to help with coordination among such agencies.

**SEC. __63. GRANTS FOR THE ASSISTANCE OF ORGANIZATIONS TO FIND MISSING ADULTS.**

(a) GRANTS.—

(1) GRANT PROGRAM.—Subject to the availability of appropriations to carry out this section, the Attorney General shall make competitive grants to public agencies or nonprofit private organizations, or combinations thereof, to—

(A) maintain a national resource center and information clearinghouse for missing and unidentified adults;

(B) maintain a national, interconnected database for the purpose of tracking missing adults who are determined by law enforcement to be endangered due to age, diminished mental capacity, or the circumstances of disappearance, when foul play is suspected or circumstances are unknown;

(C) coordinate public and private programs that locate or recover missing adults or reunite missing adults with their families;

(D) provide assistance and training to law enforcement agencies, State and local governments, elements of the criminal justice system, nonprofit organizations, and individuals in the prevention, investigation, prosecution, and treatment of cases involving missing adults;

(E) provide assistance to families in locating and recovering missing adults; and

(F) assist in public notification and victim advocacy related to missing adults.

(2) APPLICATIONS.—The Attorney General shall periodically solicit applications for grants under this section by publishing a request for applications in the Federal Register and by posting such a request on the website of the Department of Justice.

(b) OTHER DUTIES.—The Attorney General shall—

(1) coordinate programs relating to missing adults that are funded by the Federal Government; and

(2) encourage coordination between State and local law enforcement and public agencies and nonprofit private organizations receiving a grant pursuant to subsection (a).

**SEC. __64. AUTHORIZATION OF APPROPRIATIONS.**

There are authorized to be appropriated to carry out this subtitle $4,000,000 for each of fiscal years 2010 through 2020.

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**SA 3070.** Mrs. HAGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 510, between lines 9 and 10, insert the following:

**SEC. 2504. EXCEPTION TO MEDICAID COVERAGE EXCLUSION OF WEIGHT LOSS DRUGS AND INCLUSION OF WEIGHT LOSS DRUGS AS COVERED MEDICARE PART D DRUGS.**

(a) ELIMINATION OF MEDICAID EXCLUSION.—Section 1927(d)(2)(A) of the Social Security Act (42 U.S.C. 1396r-8(d)(2)(A)) is amended by inserting '', other than prescription weight loss agents approved by the Food and Drug Administration when used for obese patients or for overweight patients with a weight-related co-morbidity, such as hypertension, type 2 diabetes, or dyslipidemia'' after ''weight gain''.

(b) INCLUSION OF COVERAGE UNDER MEDICARE PART D.—Section 1860D-2(e)(1) of the Social Security Act (42 U.S.C. 1395w-102(e)(1)) is amended in the flush matter after and below subparagraph (B), by inserting ''and prescription weight loss agents approved by the Food and Drug Administration when used for obese patients or for overweight patients with a weight-related co-morbidity such as hypertension, type 2 diabetes or dyslipidemia,'' before the period.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2011.

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**SA 3071.** Mrs. HAGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 861, between lines 19 and 20, insert the following:

**SEC. 3137A. TREATMENT OF CERTAIN MEDICARE GEOGRAPHIC CLASSIFICATION REVIEW BOARD (MGCRB) RECLASSIFICATIONS.**

(a) IN GENERAL.—Notwithstanding any other provision of law, for purposes of making payments under Section 1886(d) of the Social Security Act (42 U.S.C. 1395 ww (d)), the Secretary of Health and Human Services shall permit any hospital with Medicare Geographic Classification Review Board reclassifications that overlap for one fiscal year with the option to continue year three of the earlier reclassification while waiving year one of the subsequent reclassification. Such option shall be in addition to the option to immediately transition to year one of the subsequent reclassification with the loss of year three of the earlier reclassification.

(b) APPLICATION.—

(1) IN GENERAL.—Subsection (a) shall apply to discharges occurring on or after October 1, 2009.

(2) SPECIAL RULE FOR FY 2010.—In the case of any hospital whose year three Medicare Geographic Classification Review Board reclassification was lost or eliminated for fiscal 2010, the Secretary of Health and Human Services shall establish a process under which such hospital shall have 30 days from the date of the enactment of this Act to notify the Secretary of the hospital's election to continue for fiscal 2010 the third year of their earlier Medicare Geographic Classification Review Board reclassification.

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**SA 3072.** Mrs. HAGAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue

Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1255, line 14, after the first period insert the following:

**"SEC. 399MM–4. WORKPLACE DISEASE MANAGEMENT AND WELLNESS PUBLIC-PRIVATE PARTNERSHIP.**

''(a) IN GENERAL.—The Secretary, in coordination with the Secretary of Labor, the Secretary of the Treasury, the Secretary of Commerce, the Administrator of the Small Business Administration, employers (including small, medium, and large employers), employer organizations, worksite health promotion organizations, State and local health departments, Indian tribes and tribal organizations, and academic institutions, shall provide for the implementation of a national public-private partnership to—

''(1) promote the benefits of workplace wellness programs;

''(2) understand what types of disease prevention and workplace wellness programs are effective, considering different environments, factors, and circumstances;

''(3) understand the obstacles to the implementation of disease prevention and workplace wellness programs, issues relating to employer size and resources, and best practices for the scalable implementation of such programs;

''(4) understand what factors influence employees to participate in workplace disease prevention and wellness programs;

''(5) emphasize an integrated and coordinated approach to workplace disease management and wellness programs;

''(6) ensure informed decisions through the sharing of high quality information and best practices; and

''(7) recommend policies to encourage or stimulate the utilization of worksite disease management and wellness programs, including specific recommendations as to the types of technical and other assistance that may be necessary to fully implement section 399MM.

''(b) REPORT.—Not later than 180 days after the date of enactment of this Act, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives, a report that contains—

''(1) the findings of the public-private partnership implemented under subsection (a); and

''(2) recommendations for statutory changes that may be required or useful to implement the findings described in paragraph (1) and to encourage the development of worksite disease management and wellness programs.

''(c) RECOMMENDATIONS BY CDC.—The Director of the Centers for Disease Control and Prevention shall collect information concerning workplace wellness programs and make recommendations to the Secretary on ways to improve such programs.''.

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**SA 3073.** Mrs. FEINSTEIN submitted an amendment intended to be proposed by her to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

**SEC. __. ADULT DAY HEALTH CARE SERVICES.**

(a) IN GENERAL.—The Secretary of Health and Human Services shall not—

(1) withhold, suspend, disallow, or otherwise deny Federal financial participation under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) for the provision of adult day health care services, day activity and health services, or adult medical day care services, as defined under a State Medicaid plan approved during or before 1994, during such period if such services are provided consistent with such definition and the requirements of such plan; or

(2) withdraw Federal approval of any such State plan or part thereof regarding the provision of such services (by regulation or otherwise).

(b) EFFECTIVE DATE.—Subsection (a) shall apply with respect to services provided on or after October 1, 2008.

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**SA 3074.** Mrs. FEINSTEIN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 453, between lines 5 and 6, insert the following:

**SEC. 2203. PERMITTING LOCAL PUBLIC AGENCIES TO ACT AS MEDICAID ENROLLMENT BROKERS.**

Section 1903(b)(4) of the Social Security Act (42 U.S.C. 1396b(b)(4)) is amended by adding at the end the following new subparagraph:

''(C)(i) Subparagraphs (A) and (B) shall not apply in the case of a local public agency that is acting as an enrollment broker under a contract or memorandum with a State medicaid agency, provided the local public agency does not have a direct or indirect financial interest with any medicaid managed care plan for which it provides enrollment broker services.

''(ii) In determining whether a local public agency has a direct or indirect financial interest with a medicaid managed care plan under clause (i), the status of a local public agency as a contractor of the plan does not constitute having a direct or indirect financial interest with the plan.''.

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**SA 3075.** Mr. DURBIN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1266, between lines 17 and 18, insert the following:

**Subtitle F—Programs Relating to Congenital Heart Disease**

**SEC. 4501. PROGRAMS RELATING TO CONGENITAL HEART DISEASE.**

(a) SHORT TITLE.—This subtitle may be cited as the ''Congenital Heart Futures Act''.

(b) PROGRAMS RELATING TO CONGENITAL HEART DISEASE.—

(1) PUBLIC EDUCATION AND AWARENESS; NATIONAL REGISTRY; ADVISORY COMMITTEE.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.), as amended by section 4303, is further amended by adding at the end the following:

**''PART V—PROGRAMS RELATING TO CONGENITAL HEART DISEASE**

**''SEC. 399NN-1. PUBLIC EDUCATION AND AWARENESS OF CONGENITAL HEART DISEASE.**

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention and in collaboration with appropriate congenital heart disease patient organizations and professional organizations, may directly or through grants, cooperative agreements, or contracts to eligible entities conduct, support, and promote a comprehensive public education and awareness campaign to increase public and medical community awareness regarding congenital heart disease, including the need for life-long treatment of congenital heart disease survivors.

''(b) ELIGIBILITY FOR GRANTS.—To be eligible to receive a grant, cooperative agreement, or contract under this section, an entity shall be a State or private nonprofit entity and shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.''.

**''SEC. 399NN-2. NATIONAL CONGENITAL HEART DISEASE REGISTRY.**

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may—

''(1) enhance and expand infrastructure to track the epidemiology of congenital heart disease and to organize such information into a nationally-representative surveillance system with development of a population-based registry of actual occurrences of congenital heart disease, to be known as the 'National Congenital Heart Disease Registry'; or

''(2) award a grant to one eligible entity to undertake the activities described in paragraph (1).

''(b) PURPOSE.—The purpose of the Congenital Heart Disease Registry shall be to facilitate further research into the types of health services patients use and to identify possible areas for educational outreach and prevention in accordance with standard practices of the Centers for Disease Control and Prevention.

''(c) CONTENT.—The Congenital Heart Disease Registry—

''(1) may include information concerning the incidence and prevalence of congenital heart disease in the United States;

''(2) may be used to collect and store data on congenital heart disease, including data concerning—

''(A) demographic factors associated with congenital heart disease, such as age, race, ethnicity, sex, and family history of individuals who are diagnosed with the disease;

''(B) risk factors associated with the disease;

''(C) causation of the disease;

''(D) treatment approaches; and

''(E) outcome measures, such that analysis of the outcome measures will allow derivation of evidence-based best practices and guidelines for congenital heart disease patients; and

''(3) may ensure the collection and analysis of longitudinal data related to individuals of all ages with congenital heart disease, including infants, young children, adolescents, and adults of all ages.

''(d) COORDINATION WITH FEDERAL, STATE, AND LOCAL REGISTRIES.—In establishing the National Congenital Heart Registry, the Secretary may identify, build upon, expand, and coordinate among existing data and surveillance systems, surveys, registries, and other

Federal public health infrastructure, including—

''(1) State birth defects surveillance systems;

''(2) the State birth defects tracking systems of the Centers for Disease Control and Prevention;

''(3) the Metropolitan Atlanta Congenital Defects Program; and

''(4) the National Birth Defects Prevention Network.

''(e) PUBLIC ACCESS.—The Congenital Heart Disease Registry shall be made available to the public, as appropriate, including congenital heart disease researchers.

''(f) PATIENT PRIVACY.—The Secretary shall ensure that the Congenital Heart Disease Registry is maintained in a manner that complies with the regulations promulgated under section 264 of the Health Insurance Portability and Accountability Act of 1996.

''(g) ELIGIBILITY FOR GRANT.—To be eligible to receive a grant under subsection (a)(2), an entity shall—

''(1) be a public or private nonprofit entity with specialized experience in congenital heart disease; and

''(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2014.''.

**''SEC. 399NN-3. ADVISORY COMMITTEE ON CONGENITAL HEART DISEASE.**

''(a) ESTABLISHMENT.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may establish an advisory committee, to be known as the 'Advisory Committee on Congenital Heart Disease' (referred to in this section as the 'Advisory Committee').

''(b) MEMBERSHIP.—The members of the Advisory Committee may be appointed by the Secretary, acting through the Centers for Disease Control and Prevention, and shall include—

''(1) at least one representative from—

''(A) the National Institutes of Health;

''(B) the Centers for Disease Control and Prevention; and

''(C) a national patient advocacy organization with experience advocating on behalf of patients living with congenital heart disease;

''(2) at least one epidemiologist who has experience working with data registries;

''(3) clinicians, including—

''(A) at least one with experience diagnosing or treating congenital heart disease; and

''(B) at least one with experience using medical data registries; and

''(4) at least one publicly or privately funded researcher with experience researching congenital heart disease.

''(c) DUTIES.—The Advisory Committee may review information and make recommendations to the Secretary concerning—

''(1) the development and maintenance of the National Congenital Heart Disease Registry established under section 399NN-2;

''(2) the type of data to be collected and stored in the National Congenital Heart Disease Registry;

''(3) the manner in which such data is to be collected;

''(4) the use and availability of such data, including guidelines for such use; and

''(5) other matters, as the Secretary determines to be appropriate.

''(d) REPORT.—Not later than 180 days after the date on which the Advisory Committee is established and annually thereafter, the Advisory Committee shall submit a report to the Secretary concerning the information described in subsection (c), including recommendations with respect to the results of the Advisory Committee's review of such information.''.

(2) CONGENITAL HEART DISEASE RESEARCH.—Subpart 2 of part C of title IV of the Public Health Service Act (42 U.S.C. 285b et seq.) is amended by adding at the end the following:

**''SEC. 425. CONGENITAL HEART DISEASE.**

''(a) IN GENERAL.—The Director of the Institute may expand, intensify, and coordinate research and related activities of the Institute with respect to congenital heart disease, which may include congenital heart disease research with respect to—

''(1) causation of congenital heart disease, including genetic causes;

''(2) long-term outcomes in individuals with congenital heart disease, including infants, children, teenagers, adults, and elderly individuals;

''(3) diagnosis, treatment, and prevention;

''(4) studies using longitudinal data and retrospective analysis to identify effective treatments and outcomes for individuals with congenital heart disease; and

''(5) identifying barriers to life-long care for individuals with congenital heart disease.

''(b) COORDINATION OF RESEARCH ACTIVITIES.—The Director of the Institute may coordinate research efforts related to congenital heart disease among multiple research institutions and may develop research networks.

''(c) MINORITY AND MEDICALLY UNDERSERVED COMMUNITIES.—In carrying out the activities described in this section, the Director of the Institute shall consider the application of such research and other activities to minority and medically underserved communities.''.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out the amendments made by this section such sums as may be necessary for each of fiscal years 2010 through 2014.

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**SA 3076.** Mr. DURBIN (for himself and Mr. SANDERS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 4107 and insert the following:

**SEC. 4107. COVERAGE OF COMPREHENSIVE TOBACCO CESSATION SERVICES IN MEDICAID.**

(a) REQUIRING COVERAGE OF COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3)(B) and 2303, is further amended—

(1) in subsection (a)(4)—

(A) by striking ''and'' before ''(C)''; and

(B) by inserting before the semicolon at the end the following new subparagraph: ''; and (D) counseling and pharmacotherapy for cessation of tobacco use (as defined in subsection (bb))''; and

(2) by adding at the end the following:

''(bb)(1) For purposes of this title, the term 'counseling and pharmacotherapy for cessation of tobacco use' means diagnostic, therapy, and counseling services and pharmacotherapy (including the coverage of prescription and nonprescription tobacco cessation agents approved by the Food and Drug Administration) for cessation of tobacco use by individuals who use tobacco products or who are being treated for tobacco use that is furnished—

''(A) by or under the supervision of a physician; or

''(B) by any other health care professional who—

''(i) is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished; and

''(ii) is authorized to receive payment for other services under this title or is designated by the Secretary for this purpose.

''(2) Subject to paragraph (3), such term is limited to—

''(A) services recommended with respect to individuals in 'Treating Tobacco Use and Dependence: 2008 Update: A Clinical Practice Guideline', published by the Public Health Service in May 2008, or any subsequent modification of such Guideline; and

''(B) such other services that the Secretary recognizes to be effective for cessation of tobacco use.

''(3) Such term shall not include coverage for drugs or biologicals that are not otherwise covered under this title.''.

(b) EXCEPTION FROM OPTIONAL RESTRICTION UNDER MEDICAID PRESCRIPTION DRUG COVERAGE.—Section 1927(d)(2)(F) of the Social Security Act (42 U.S.C. 1396r–8(d)(2)(F)), as redesignated by section 2502(a), is amended by inserting before the period at the end the following: '', except when recommended in accordance with the Guideline referred to in section 1905(bb)(2)(A), agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation''.

(c) REMOVAL OF COST-SHARING FOR COUNSELING AND PHARMACOTHERAPY FOR CESSATION OF TOBACCO USE.—

(1) GENERAL COST-SHARING LIMITATIONS.—Section 1916 of the Social Security Act (42 U.S.C. 1396o) is amended in each of subsections (a)(2)(D) and (b)(2)(D) by inserting ''and counseling and pharmacotherapy for cessation of tobacco use (as defined in section 1905(bb)) and covered outpatient drugs (as defined in subsection (k)(2) of section 1927 and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation in accordance with the Guideline referred to in section 1905(bb)(2)(A)'' after ''section 1905(a)(4)(C),''.

(2) APPLICATION TO ALTERNATIVE COST-SHARING.—Section 1916A(b)(3)(B) of such Act (42 U.S.C. 1396o–1(b)(3)(B)) is amended by adding at the end the following:

''(xi) Counseling and pharmacotherapy for cessation of tobacco use (as defined in section 1905(bb)) and covered outpatient drugs (as defined in subsection (k)(2) of section 1927 and including nonprescription drugs described in subsection (d)(2) of such section) that are prescribed for purposes of promoting, and when used to promote, tobacco cessation in accordance with the Guideline referred to in section 1905(bb)(2)(A).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on October 1, 2010.

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**SA 3077.** Mr. DURBIN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time

homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 816, after line 20, add the following:

**SEC. 3115. MEDICARE PASS-THROUGH PAYMENTS FOR CRNA SERVICES.**

(a) TREATMENT OF CRITICAL ACCESS HOSPITALS AS RURAL IN DETERMINING ELIGIBILITY FOR CRNA PASS-THROUGH PAYMENTS.—Section 9320(k) of the Omnibus Budget Reconciliation Act of 1986 (42 U.S.C. 1395k note), as added by section 608(c)(2) of the Family Support Act of 1988 and amended by section 6132 of the Omnibus Budget Reconciliation Act of 1989, is amended by adding at the end the following:

''(3) Any facility that qualifies as a critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act) shall be treated as being located in a rural area for purposes of paragraph (1) regardless of any geographic reclassification of the facility, including such a reclassification of the county in which the facility is located as an urban county (also popularly known as a Lugar county) under section 1886(d)(8)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(8)(B)).''.

(b) TREATMENT OF STANDBY AND ON-CALL COSTS.—Such section 9320(k), as amended by subsection (a), is further amended by adding at the end the following:

''(4) In determining the reasonable costs incurred by a hospital or critical access hospital for the services of a certified registered nurse anesthetist under this subsection, the Secretary shall include standby costs and on-call costs incurred by the hospital or critical access hospital, respectively, with respect to such nurse anesthetist.''.

(c) EFFECTIVE DATES.—

(1) TREATMENT OF CAHS AS RURAL IN DETERMINING CRNA PASS-THROUGH ELIGIBILITY.—The amendment made by subsection (a) shall apply to calendar years beginning on or after the date of the enactment of this Act (regardless of whether the geographic reclassification of a critical access hospital occurred before, on, or after such date).

(2) INCLUSION OF STANDBY COSTS AND ON-CALL COSTS IN DETERMINING REASONABLE COSTS OF CRNA SERVICES.—The amendment made by subsection (b) shall apply to costs incurred in cost reporting periods beginning in fiscal years after fiscal year 2003.

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**SA 3078.** Ms. KLOBUCHAR (for herself and Ms. SNOWE) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title IV, insert the following:

**SEC. ___. YOUNG WOMEN'S BREAST HEALTH AWARENESS AND SUPPORT OF YOUNG WOMEN DIAGNOSED WITH BREAST CANCER.**

(a) SHORT TITLE.—This section may be cited as the ''Young Women's Breast Health Education and Awareness Requires Learning Young Act of 2009'' or ''EARLY Act''.

(b) AMENDMENT.—Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

**''PART S—PROGRAMS RELATING TO BREAST HEALTH AND CANCER**

**''SEC. 399HH. YOUNG WOMEN'S BREAST HEALTH AWARENESS AND SUPPORT OF YOUNG WOMEN DIAGNOSED WITH BREAST CANCER.**

''(a) PUBLIC EDUCATION CAMPAIGN.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall conduct a national evidence-based education campaign to increase awareness of young women's knowledge regarding—

''(A) breast health in young women of all racial, ethnic, and cultural backgrounds;

''(B) breast awareness and good breast health habits;

''(C) the occurrence of breast cancer and the general and specific risk factors in women who may be at high risk for breast cancer based on familial, racial, ethnic, and cultural backgrounds such as Ashkenazi Jewish populations;

''(D) evidence-based information that would encourage young women and their health care professional to increase early detection of breast cancers; and

''(E) the availability of health information and other resources for young women diagnosed with breast cancer on—

''(i) fertility preservation;

''(ii) support, including social, emotional, psychosocial, financial, lifestyle, and caregiver support;

''(iii) familial risk factors; and

''(iv) prevention and early detection strategies to reduce recurrence or metastasis;

''(2) EVIDENCE-BASED, AGE APPROPRIATE MESSAGES.—The campaign shall provide evidence-based, age-appropriate messages and materials as developed by the Centers for Disease Control and Prevention and the Advisory Committee established under paragraph (4).

''(3) MEDIA CAMPAIGN.—In conducting the education campaign under paragraph (1), the Secretary shall award grants to entities to establish national multimedia campaigns oriented to young women that may include advertising through television, radio, print media, billboards, posters, all forms of existing and especially emerging social networking media, other Internet media, and any other medium determined appropriate by the Secretary.

''(4) ADVISORY COMMITTEE.—

''(A) ESTABLISHMENT.—Not later than 60 days after the date of the enactment of this section, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish an advisory committee to assist in creating and conducting the education campaigns under paragraph (1) and subsection (b)(1).

''(B) MEMBERSHIP.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall appoint to the advisory committee under subparagraph (A) such members as deemed necessary to properly advise the Secretary, and shall include organizations and individuals with expertise in breast cancer, disease prevention, early detection, diagnosis, public health, social marketing, genetic screening and counseling, treatment, rehabilitation, palliative care, and survivorship in young women.

''(b) HEALTH CARE PROFESSIONAL EDUCATION CAMPAIGN.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, and in consultation with the Administrator of the Health Resources and Services Administration, shall conduct an education campaign among physicians and other health care professionals to increase awareness—

''(A) of breast health, symptoms, and early diagnosis and treatment of breast cancer in young women, including specific risk factors such as family history of cancer and women that may be at high risk for breast cancer, such as Ashkenazi Jewish population;

''(B) on how to provide counseling to young women about their breast health, including knowledge of their family cancer history and importance of providing regular clinical breast examinations;

''(C) concerning the importance of discussing healthy behaviors, and increasing awareness of services and programs available to address overall health and wellness, and making patient referrals to address tobacco cessation, good nutrition, and physical activity;

''(D) on when to refer patients to a health care provider with genetics expertise;

''(E) on how to provide counseling that addresses long-term survivorship and health concerns of young women diagnosed with breast cancer; and

''(F) on when to provide referrals to organizations and institutions that provide credible health information and substantive assistance and support to young women diagnosed with breast cancer, including—

''(i) re-entry into the workforce or school;

''(ii) infertility as a result of treatment;

''(iii) neuro-cognitive effects;

''(iv) important effects of cardiac, vascular, muscle, and skeletal complications; and

''(v) secondary malignancies.

''(2) MATERIALS.—The education campaign under paragraph (1) may include the distribution of print, video, and Web-based materials on assisting physicians and other health care professionals in achieving the goals of this section.

''(c) PREVENTION RESEARCH ACTIVITIES.—The Secretary, acting through—

''(1) the Director of the Centers for Disease Control and Prevention, shall conduct prevention research on breast cancer in younger women, including—

''(A) behavioral, survivorship studies, and other research on the impact of breast cancer diagnosis on young women;

''(B) formative research to assist with the development of educational messages and information for the public, targeted populations, and their families about breast health, breast cancer, and healthy lifestyles;

''(C) testing and evaluating existing and new social marketing strategies targeted at young women; and

''(D) surveys of health care providers and the public regarding knowledge, attitudes, and practices related to breast health and breast cancer prevention and control in high-risk populations; and

''(2) the Director of the National Institutes of Health, shall conduct research to develop and validate new screening tests and methods for prevention and early detection of breast cancer in young women.

''(d) SUPPORT FOR YOUNG WOMEN DIAGNOSED WITH BREAST CANCER.—

''(1) IN GENERAL.—The Secretary shall award grants to organizations and institutions to provide health information from credible sources and substantive assistance directed to young women diagnosed with breast cancer and pre-neoplastic breast diseases on issues such as—

''(A) education and counseling regarding fertility preservation;

''(B) support, including social, emotional, psychosocial, financial, lifestyle, and caregiver support;

''(C) familial risk factors; and

''(D) prevention and early education strategies to reduce recurrence or metastasis.

''(2) PRIORITY.—In making grants under paragraph (1), the Secretary shall give priority to applicants that deal specifically with young women diagnosed with breast cancer and pre-neoplastic breast disease.

''(e) NO DUPLICATION OF EFFORT.—In conducting an education campaign or other program under subsections (a), (b), (c), or (d), the Secretary shall avoid duplicating other existing Federal breast cancer education efforts.

''(f) MEASUREMENT; REPORTING.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall—

''(1) measure—

''(A) young women's awareness regarding breast health, including knowledge of family cancer history, specific risk factors and early warning signs, and young women's proactive efforts at early detection;

''(B) the number or percentage of young women utilizing information regarding lifestyle interventions that foster healthy behaviors such as tobacco cessation, nutrition, and physical activity;

''(C) the number or percentage of young women receiving regular clinical breast exams; and

''(D) the number or percentage of young women who perform breast self exams, and the frequency of such exams, before the implementation of this section;

''(2) establish quantitative benchmarks to measure the impact of activities under this section;

''(3) not less than every 3 years, measure the impact of such activities; and

''(4) submit reports to the Congress on the results of such measurements.

''(g) DEFINITIONS.—In this section—

''(1) the term 'State' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, and the Trust Territory of the Pacific Islands; and

''(2) the term 'young women' means women 15 to 44 years of age.

''(h) AUTHORIZATION OF APPROPRIATIONS.—To carry out subsections (a), (b), (c)(1), and (d), there are authorized to be appropriated $9,000,000 for each of the fiscal years 2010 through 2014.''.

## AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on December 8, 2009, at 1:30 p.m.

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

COMMITTEE ON ENVIRONMENT AND PUBLIC WORKS

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Environment and Public Works be authorized to meet during the session of the Senate on December 8, 2009 at 10 a.m. in room 406 of the Dirksen Senate Office Building.

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

COMMITTEE ON FOREIGN RELATIONS

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on December 8, 2009, at 2:15 p.m.

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

SELECT COMMITTEE ON INTELLIGENCE

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on December 8, 2009, at 2:30 p.m.

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

SUBCOMMITTEE ON ENERGY

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Subcommittee on Energy be authorized to meet during the session of the Senate in order to conduct a hearing on December 8, at 2:30 p.m., in room SD–366 of the Dirksen Senate Office Building.

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

## ORDERS FOR WEDNESDAY, DECEMBER 9, 2009

Mr. SANDERS. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 9:30 a.m., Wednesday, December 9; that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of H.R. 3590, the health care reform legislation; that following any remarks of the chair and ranking member of the Finance Committee, or their designees, for up to 10 minutes each, the next 2 hours be for debate only, with the time equally divided and controlled between the two leaders or their designees, with Senators permitted to speak for up to 10 minutes each; the Republicans controlling the first 30 minutes and the majority controlling the second 30 minutes, with the remaining time equally divided and used in an alternating fashion; further, that no amendments are in order during this time.

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

## PROGRAM

Mr. SANDERS. Mr. President, rollcall votes are possible throughout the day tomorrow. Senators will be notified when any votes are scheduled.

## ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

Mr. SANDERS. Mr. President, if there is no further business to come before the Senate, I ask unanimous consent that the Senate stand adjourned under the previous order.

There being no objection, the Senate, at 8:38 p.m., adjourned until Wednesday, December 9, 2009, at 9:30 a.m.

## NOMINATIONS

Executive nominations received by the Senate:

DEPARTMENT OF TRANSPORTATION

MICHAEL PETER HUERTA, OF THE DISTRICT OF COLUMBIA, TO BE DEPUTY ADMINISTRATOR OF THE FEDERAL AVIATION ADMINISTRATION, VICE ROBERT A. STURGELL, RESIGNED.

IN THE AIR FORCE

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES AIR FORCE TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 624:

*To be brigadier general*

COL. KORY G. CORNUM

IN THE ARMY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE RESERVE OF THE ARMY TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 12203:

*To be major general*

BRIG. GEN. STEVEN W. SMITH