The House of Representatives

SATURDAY, NOVEMBER 7, 2009

The House met at 9 a.m. and was called to order by the Speaker pro tempore (Mr. JACKSON of Illinois).

DESIGNATION OF THE SPEAKER PRO TEMPORE
The SPEAKER pro tempore laid before the House the following communication from the Speaker:

WASHINGTON, DC, November 7, 2009.
I hereby appoint the Honorable JESSE L. JACKSON, Jr. to act as Speaker pro tempore on this day.

NANCY PELOSI, Speaker of the House of Representatives.

PRAYER
The Chaplain, the Reverend Daniel P. Coughlin, offered the following prayer:

Nothing genuinely human should ever fail to raise an echo in our hearts, Lord, if we are true believers in our common creation and disciples of the Supreme Master.

As members of a common humanity, our history, our origins of birth and even our different persuasions of religious belief will never dull our awareness that we are already one on a very deep level and quite interdependent upon one another.

Guide us to a greater understanding of one another. Bridge our differences with Your own powerful love for each of us.

Lift all blinders, Lord; that we may truly see one another as singular and unique yet we are able to come together, Lord, before You, with You and in You, now and forever. Amen.

THE JOURNAL
The SPEAKER pro tempore. The Chair has examined the Journal of the last day’s proceedings and announces to the House his approval thereof. Pursuant to clause 1, rule I, the Journal stands approved.

PLEDGE OF ALLEGIANCE
The SPEAKER pro tempore. Will the gentleman from Pennsylvania (Mr. TIM MURPHY) come forward and lead the House in the Pledge of Allegiance.

Mr. TIM MURPHY of Pennsylvania led the Pledge of Allegiance as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE
The SPEAKER pro tempore. The Chair will entertain up to 10 requests for 1-minute speeches from each side of the aisle.

HEALTH CARE
(Ms. SCHWARTZ asked and was given permission to address the House for 1 minute.)

Ms. SCHWARTZ, Mr. Speaker, finding a uniquely American solution to ensure that all Americans have access to meaningful, affordable health coverage has been an unfulfilled goal for decades. Today, we have the opportunity to make this moral and economic imperative a reality.

The Affordable Health Care for America Act meets the goals of health care reform: enhanced consumer protections for those with health coverage; new, affordable choices for individuals and small businesses; strengthening Medicare for our seniors, with better prescription drug coverage and access to primary care; improved delivery of services with better health outcomes for all Americans; and the containment of rapidly rising costs of health coverage.

It builds on America’s public-private system, and it is paid for now and into the future.

The status quo is unaffordable and unsustainable. Health care reform benefits all of us: families, seniors, businesses, and the Nation. I am honored to have been a part of bringing this bill to the floor, to this historic moment, and I look forward to voting for this landmark legislation and meeting the goals of health care reform for all Americans. Now is the time to act.

Heads Up: "This symbol represents the time of day during the House proceedings, e.g., 1407 is 2:07 p.m.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.

Printed on recycled paper.
There is a great deal of savings that could come from Medicare if we used scientific, evidence-based medicine to help improve chronic care conditions and deal with many other programs.

That was rejected. Instead, we will cut the money from Medicare.

Another amendment I offered makes sure that if the Senate should move forward with their provision of allowing States to opt out, the States should also be able to opt out of paying the health care taxes. In other words, we should have no taxation without hospitalization. Instead, my fear is that high taxes will remain in the bill to the point where it is going to cost our economy more jobs and cost our small businesses more.

There still is much to do in this bill, and it is not yet ready. I still hope there is time in the coming weeks to improve these bills and work on real health care reform.

HEALTH CARE
(Mr. BLUMENAUER asked and was given permission to address the House for 1 minute.)

Mr. BLUMENAUER. Mr. Speaker, one of the strangest sights, and now a symbol of the health care debate, was the red-faced protesters, edged on by my GOP colleagues to “keep government out of their Medicare”.

These people are not ignorant; they are uninformed, and unfortunately, purposely misled by some on the other side of the aisle, by Republican talking points that deny government can have a constructive role in health care, even as they rely on government for health care for seniors, veterans, emergency services and, of course, for themselves.

When most Americans are given the facts, they are pleased that it is now time to take the next steps beyond our seniors, beyond our veterans, beyond emergency services and, of course, beyond Members of Congress.

Today we can extend those benefits to more Americans while we protect those with insurance from abuse and reform a Medicare system that is in trouble. Americans await Congress to take these next critical steps to give Americans the health care they need and deserve.

UNIVERSAL GOVERNMENT-RUN VACCINE PROGRAM DISASTER
(Mr. POE of Texas asked and was given permission to address the House for 1 minute.)

Mr. POE of Texas. Mr. Speaker, the Federal Government promised to save the country by providing 120 million H1N1 virus vaccines in 3 months. Of course the government only made 20 percent of that number on time. So the government had to decide who would get medicine and who would not. Wall Street is the first group to get the shots, but vaccines didn’t go down the street to hospitals for children and pregnant women, the most vulnerable.

The Feds are also giving criminals in prison and even the terrorists at Guantanamo Bay prison flu shots while Americans who have committed no crime must get to the back of the line.

This simple shot program administered by the government is a mess and has its priorities where? Why? Because the government is in charge. The government decides who gets flu shots and who doesn’t. Patients don’t decide; doctors don’t decide. This is what a universal government-run and government-ratified health care program looks like. Welcome to the future. And get to the end of the line.

And that’s just the way it is.

HEALTH CARE
(Mr. DeFAZIO asked and was given permission to address the House for 1 minute.)

Mr. DeFAZIO. Mr. Speaker, big insurance companies and their Republican allies are bitterly opposed to health care reform, and I understand their opposition. This bill will outlaw the worst and the most lucrative consumer abuses by the insurance industry. It repeals their unfair antitrust immunity. It removes collusion and price-fixing to drive up your premiums. It outlaws the preexisting condition exclusion. It outlaws them from canceling your policy when you get sick, a common practice in the insurance industry. And no more small print, lifetime caps that drive families to bankruptcy.

It improves Medicare coverage for all Americans and improves Medicare reimbursement for Oregon seniors and the disabled. The Republicans would have none of that. In fact, they opened new loopholes for abuses by the insurance industry by allowing them to base their national plans in the new state of the Northern Mariana Islands, which they have designated as their alternative. So when you have a complaint, you can call Jack Abramoff when he gets out of jail, and he will help you with your insurance problem. That’s the Republican plan.

Our plan isn’t perfect, but it is a good step toward providing affordable health care for all Americans.

HEALTH CARE
(Mr. BROUN of Georgia asked and was given permission to address the House for 1 minute.)

Mr. BROUN of Georgia. Mr. Speaker, the American people need to know what this debate is all about. On one hand, it is a complete takeover of the health care system that the Democratic Party is proposing. On the other hand, Republicans have offered alternatives to let the patients make decisions. In fact, I offered H.R. 3889, which is totally private, doesn’t raise taxes or anything. Their plan will destroy the economy. It will put 5.5 million people out of work. It is going to destroy the doctor-patient relationship. Government bureaucrats will be making decisions for every patient. The American people need to understand: This is about a government takeover of the whole health care system. They need to call their congressman and say no to the Nancy Pelosi steamroller of socialism.

HEALTH CARE
(Mr. INSLEE asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. INSLEE. Mr. Speaker, health care is not a frivolity or a recreation; it is life itself. To a woman with early-onset breast cancer, health care is life itself. To a child with juvenile-onset diabetes, health care is life itself.

It is well that we reflect how we founded this Union. We believe that all men are endowed with certain unalienable rights, and among those are the right to life—life—liberty, and the pursuit of happiness.

We pass health care to honor life not just on parchment, but in practice. We pass health care because we cherish the lives of all Americans, not just our own. This is an American step in progress. It is an American right to life.

HEALTH CARE
(Mr. DANIEL E. LUNGREN of California asked and was given permission to address the House for 1 minute.)

Mr. LUNGREN. Mr. Speaker, if you want to know the ultimate option, open up this bill and look. You are required as an American citizen to buy a health insurance policy that has been okayed and only okayed by the Federal Government. If you don’t, you could pay a fine, and if you don’t pay that fine, you could go to prison for up to 5 years. Where is the public option? Well, if you are in prison, you are going to get free medical care. I presume that is the ultimate tragedy in this bill.

We are changing the relationship of individuals to their government. Now, for the first time in history, as a condition of remaining in the United States, you must purchase something the Federal Government requires you to under the pain of a fine, up to $250,000, and 5 years in prison. What kind of freedom is that? What kind of public option could that possibly be?

HEALTH CARE
(Ms. KILROY asked and was given permission to address the House for 1 minute.)

Ms. KILROY. Mr. Speaker, this is an historic day and a very exciting day as we move towards a vote on a bill to make health care affordable and accessible for all Americans. Like you, I have been listening to my constituents. I have been hearing their stories.
November 7, 2009  
CONGRESSIONAL RECORD—HOUSE

Even last night I got a call from a friend. Steve, after fighting off lymphoma, got a notice from his insurance company that the policy for his law office was now being canceled, giving him a lot of insecurity about what his future would be and the future of the people he had helped.

This bill would end that kind of discrimination, the discrimination against people with preexisting conditions, and provide security to millions of Americans. Americans like me with multiple sclerosis and many of us with other preexisting conditions.

This is a moral issue for people, people who will now be able to access our health care system. Mr. Speaker, it is a very proud day to be able to take this historic step and end this discrimination.

WE NEED JOBS
(Mr. WILSON of South Carolina asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. WILSON of South Carolina. Mr. Speaker, Speaker Pelosi told the American people that the misnamed stimulus bill would immediately create jobs and keep unemployment under 8 percent. However, unemployment has now topped 10 percent, with 2.8 million jobs lost since the misidentified stimulus was signed into law.

Despite these staggering numbers, Speaker Pelosi continues to push a job-killing health care takeover. Clearly, Congress has a case of misplaced priorities.

Patricia Owen lives on Hilton Head Island and owns FACES DaySpa. She is just one of the many small business owners who would be negatively impacted if this takeover is passed. With 23 employees at FACES DaySpa, the Owen family appreciates its dedicated staff. The Owen’s service-based company will face more punitive taxes in Pelosi’s health care takeover.

In conclusion, God bless our troops, and we will never forget September the 11th in the global war on terrorism. Thank you, veterans, for victory in the Cold War 20 years ago Monday with the fall of the Berlin Wall.

HISTORIC DAY IN AMERICA
(Ms. SPEIER asked and was given permission to address the House for 1 minute.)

Ms. SPEIER. Mr. Speaker, today is indeed an historic day, a day we can all be proud that on behalf of the American people we are doing something.

So what is it the American people are going to get? Well, if you’re a senior citizen in America, you’re going to have $500 more in your prescription drug benefit. You’re going to be able to get your care without many of the names being cut 50 percent less if you’re in the doughnut hole. And by 2019, that doughnut hole will be terminated.

What’s in it for young people? Well, if you’re good to your parents, you can stay on their health insurance until you’re 27.

And how about for women? For women, you are no longer going to pay 140 percent more for your health insurance, for all age. And by the way, you don’t have to fear getting pregnant, because health insurance will cover your pregnancy.

And for everyone else in America, we are going to be paying $1,400 less a year in uncompensated care.

There is nothing to fear. There is much to be jubilant about.

GOVERNMENT TAKEOVER OF AMERICAN LIVES
(Mr. FLEMIN asked and was given permission to address the House for 1 minute.)

Mr. FLEMIN. Mr. Speaker, indeed, this is an historic day. We have a choice today between two bills; one which will have a government takeover of one-sixth of our economy, which will involve the Federal Government into the day-to-day lives of each and every American, or the Republican alternative, which actually goes to the central theme of the problems that we deal with today.

Not only that, senior citizens will be the most hurt by this government takeover of health care; $500 billion taken out of Medicare, and with not one scintilla of evidence as to where it’s going to come from. It will come from access to care, of course. Furthermore, CBO says that part B will increase by $25 billion, and part D premiums by 20 percent.

I would say, in closing, God help us as the government takes over your day-to-day life.

HEALTH CARE FOR AMERICA
(Mr. COHEN asked and was given permission to address the House for 1 minute.)

Mr. COHEN. Mr. Speaker, today is indeed an historic day. As the plaque over the Speaker’s rostrum says, In our time and our generation, we should do something worthy to be remembered.

Those were Daniel Webster’s words, a man who served in this House.

We can fulfill the destiny of other people who came with us in the Federal Government, from Teddy Roosevelt to Franklin Roosevelt to Harry Truman to Hubert Humphrey and to the recently late Senator Ted Kennedy. This is an important date for America when we bring us into the 21st Century. We should have been here 50 or 60 years ago.

It is wrong that our country has an infant mortality rate equal to third-world nations. This bill will set out a new health program that will try to recoup that. It will see that private practice doctors go into the inner cities, with general practitioners having an incentive to go there. With community health centers in the inner cities and wellness and prevention programs not having a deductible, it will bring America into the 21st century.

Mr. Speaker, I am proud to be a Member of the United States Congress, and never prouder than this weekend.

AMERICANS WANT FREEDOM, NOT GOVERNMENT-RUN HEALTH CARE
(Mr. MILLER of Florida asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. MILLER of Florida. Mr. Speaker, I ask today to ask a question: Why do the Democrats come to the floor to little the hardworking people who protest this government takeover of health care? They paid their own money, they drove their own cars, they weren’t bussed here by the DCCC or the unions. They came to say, Listen to us. Listen to us, Madam Speaker. We don’t want a government takeover of our health care system.

They don’t want their children’s future mortgaged to foreign countries. They don’t want people who are not here legally to receive free health care. They want what the Founding Fathers and the Constitution wanted and guaranteed—freedom. What a noble idea—freedom.

HEALTH CARE IS FREEDOM REDEFINED
(Mr. RYAN of Ohio asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. RYAN of Ohio. Mr. Speaker, there has been a lot of talk about freedom and liberty over the last couple days in Washington, DC, but the question really is: The person who is sick and can’t get health care, are they really free? If you keep getting sick because you can’t access a doctor, you can’t get better, so you can’t go to work, so you can’t make money, is that person really free?

In 2009, we need to redefine freedom. Freedom in America in 2009 means being healthy and having access to a health care system that isn’t just for the elite, but it’s for everybody.

Now, our people are going to get a 15, 20, 30 percent increase. Businesses are going to get a 30 percent increase right now. This is what we’re trying to prevent, an $1,800 increase for the average family of four if we do absolutely nothing.

We’re going to wake up in a few weeks in America, no more denials because of preexisting conditions; no more people in America or families in America will go bankrupt. We’re going to fix this health care crisis that we have in this country.

VOTE “YES” ON PRO-LIFE AMENDMENT
(Mr. PITTTS asked and was given permission to address the House for 1 minute.)
Mr. PITTS. Mr. Speaker, I rise to inform the Members of the status of the pro-life amendment on the bill today.

Last night, there were lots of negotiations. There were a couple of compromises discussed. I went with my colleague, BART STUPAK, CHRIS SMITH, MARCY KAPTUR, and KATHY DAHLKEMPER, before the Rules Committee after midnight. The final outcome is this: There will be only one pro-life amendment offered on the floor today. It will be the Stupak-Fitler-Pitts-Smith-Kaptur-Dahlkemper amendment that will prevent Federal funds from funding abortions in both the public plan or with affordability credits. It just codifies the Hyde Amendment for the two new programs.

This actually preserves the status quo of our law today. No Federal Government funding for abortions, just like SCHIP, Medicaid, DOD, FEHBP, Indian Health.

This is a bipartisan amendment. The pro-life groups National Right to Life, Catholic Bishops, and family groups all support this. I urge the Members to support this amendment when it comes to the floor today.

PASS HEALTH CARE TODAY

(Mr. MORAN of Virginia asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. MORAN of Virginia. Mr. Speaker, we are a great Nation, a prosperous and compassionate one, but our health care system doesn't measure up to that greatness. In fact, we pay twice what every other industrialized nation pays, and yet 71 nations have enabled their people to live longer and healthier lives. The difference is that they have decided that the health of their people is a higher priority than the profit of their insurance companies.

Mr. Speaker, we, today, will have the opportunity to bring our health care system up to a standard deserving of the greatness of our Nation by controlling our costs, by covering all of our people, and by improving the quality of the care that they receive.

This bill is deserving of the greatness of our Nation. It must pass today.

REPUBLICANS HAVE THE RIGHT PRESCRIPTION FOR HEALTH CARE NOT THE FEDERALIZED PROGRAMS

(Ms. FOXX asked and was given permission to address the House for 1 minute.)

Ms. FOXX. Mr. Speaker, despite months of town hall meetings and after millions of Americans voiced their opposition to a government takeover of health care, Democrats in Congress are moving ahead anyway.

Not only does the Pelosi health care plan raise taxes and increase spending, it will vastly grow the size and power of the Federal Government, taking more and more of our freedoms away.

The Pelosi health care plan proposes the creation of more than 110 new bureaucracies, boards, commissions, or programs. More taxes, more spending, and more government is not the plan for reform the people support.

Republicans have a plan that allows us to keep our freedoms and not be dictated to by the Federal Government. It's the right prescription for health care reform.

SAY ‘YES’ TO HEALTH CARE FOR AMERICA

(Mr. PAYNE asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. PAYNE. Mr. Speaker, the American people are counting on us to reform this broken health care system. Health insurance premiums and out-of-pocket costs have risen steadily, and the number of families in trouble over health care continues to grow—48 million uninsured, 50 million under-insured. We simply cannot afford to maintain the status quo.

Those who continue to resist a much-needed change in our health care system are refusing to deal with the problems, and they won't go away if we ignore them.

The health care insurance reforms we espousing will benefit Americans, including those who are already enrolled. No longer will coverage be denied or hikes go for preexisting conditions. Insurance companies will no longer be able to drop insurance when a policyholder becomes sick, just when a patient needs insurance the most.

There will be a positive emphasis on prevention, with vaccinations, mammograms, and colonoscopies that will be covered with no out-of-pocket expenses. In addition, there will be lower premiums for all Americans who will see the doughnut hole go away.

I urge my colleagues to do the right thing and vote for this bill.

FIX WHAT’S BROKEN IN HEALTH CARE

(Mr. SCALISE asked and was given permission to address the House for 1 minute.)

Mr. SCALISE. Mr. Speaker, today is the showdown on a government takeover of health care. And while there are still deals being cut to try to round up the few votes in the dark of night behind these closed doors, what the American people have said is they want transparency, and they don't want a government takeover of health care.

The American people want to fix the problems that are broken like we do in the Republican alternative we will be presenting that actually lowers costs. The CBO score says 10 percent reduction in health care premium, addressing preexisting conditions, and, yes, we actually do real medical liability reform to lower the cost of health care and stop all of these tests that are run just for defensive medicine purposes.

Just a little while ago, one of my friends on the Democratic side said that he wants to redefine freedom. Well, with all due respect, I think the Founding Fathers got it right. We don't need to go and rewrite freedom and have a government takeover of health care.

Let's fix what's broken, but don't break all the things that make medical care work well for so many Americans in this country.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, proceedings will resume on motions to suspend the rules previously postponed.

Votes will be taken in the following order:


The first electronic vote will be conducted as a 15-minute vote. Remaining electronic votes will be conducted as 5-minute votes.

SMALL BUSINESS MICRO LENDING EXPANSION ACT OF 2009

The SPEAKER pro tempore. The unfinished business is the question on suspending the rules and passing the bill, H. R. 3737, as amended.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New York (Ms. VELÁZQUEZ) that the House suspend the rules and pass the bill, H. R. 3737, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. TONKO. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered. The result was taken by electronic device, and there were—yeas 405, nays 23, not voting 6, as follows:

[Roll No. 876]

YEAS—405

Abercrombie  Bishop (NY)  Calvert
Ackerman  Bishop (UT)  Camp
Aderholt  Blackburn
Adler (NJ)  Blumenauer  Cao
Altmire  Blunt  Capito
Alexander  Baucus  Capp
Altmire  Baucus  Capito
Andrews  Baucus  Capp
Arcuri  Barron  Capp
Austria  Benseny  Carson
Baca  Benson  Cason
Bachus  Bono Mack  Cashion
Baier  Boozman  Carnahan
Baird  Burton  Carnes
Baldwin  Burgos  Carney
Baird  Bumgardner  Carson (IN)
Baird  Burwell  Carter
Baldwin  Burr  Cash
Barrett (SC)  Cassidy  Castle
Barrett (GA)  Boyd  Castor (FL)
Barrow  Brady (PA)  Chabot
Barrett (TX)  Brady (TX)  Chandler
Barton (TX)  Bracey (IA)  Chabot
Bean  Bright  Clarke
Bercera  Brown (SC)  Clay
Berkley  Brown, Corrine  Cleaver
Berman  Bryson  Clyburn
Biggert  Buchanan  Cole
Bilirakis  Burton (IN)  Cohen
Bilirakis  Butterfield  Collins (NY)
Bilirakis  Buyer  Connolly (VA)
Ms. FOXX, Messrs. JORDAN of Ohio, JAYAPAL of Washington, and MCHENRY changed their vote from "yea" to "nay." Ms. McCOLLUM changed her vote from "nay" to "yea." (two-thirds being in the affirmative) the rules were suspended and the bill, as amended, was passed.

The motion to reconsider was laid on the table.

| WOMEN'S BUSINESS CENTERS IMPROVEMENTS ACT |

The SPEAKER pro tempore. The unfinished business is the question on suspending the rules and passing the bill, H.R. 1388, as amended.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the motion offered by the gentlewoman from New York (Ms. VELAZQUEZ) that the House suspend the rules and pass the bill, H.R. 1388, as amended.

The question was taken.

Mr. CLEAVER. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—aye[s] 428, noes 4, not voting 2, as follows:

| Roll No. 877 | AYES—428 |

The vote was announced as above recorded.

The motion to suspend the rules and pass the bill, as amended, was agreed to.
Mr. CLEAVER. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. The motion to reconsider was laid on the table.

Mr. FRANKS of Arizona changed his vote from "aye" to "no." So two-thirds being in the affirmative the rules were suspended and the bill, as amended, was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

NATIONAL SCHOOL PSYCHOLOGY WEEK

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Iowa (Mr. LOEBECK) that the House suspend the rules and agree to the resolution, H. Res. 700, as amended.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

RECORDED VOTE

Mr. CONNOLLY of Virginia. Mr. Speaker, I demand a recorded vote.
A recorded vote was ordered.

The SPEAKER pro tempore. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 431, noes 2, not voting 2, as follows:

(Roll No. 879)

AYES—431

Abercrombie          Ackerman          Adam Smith          Adler (NJ)          Akin          Alexander          Altmire          Austria          Arcuri          Bachmann          Bachus          Baird          Balkissoon          Barrett (SC)          Barrow          Basco          Batterman          Black (SC)          Black (NY)          Black (WI)          Black (PA)          Blackshear          Blumenauer          Boehner          Bono Mack

AOB—1

Paul

NOT VOTING—2

Bono Mack Young (AK)

1023

So (two-thirds being in the affirmative) the rules were suspended and the resolution, as amended, was agreed to. The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

EXPRESSIONING SUPPORT FOR CHINESE HUMAN RIGHTS ACTIVISTS HUANG QI AND TAN ZUOREN

The SPEAKER pro tempore. The unfinished business is the question on suspending the rules and agreeing to the resolution, H. Res. 877.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from California (Mr. Beneke) that the rules be suspended and the rules and agree to the resolution, H. Res. 877.

The motion was agreed to.
longer than anyone in America alive today to see this day. I am so happy to see you in the chair. It is an historic day made even more wonderful for us by having you preside.

The SPEAKER pro tempore (Mr. Dingell), the chair that the gentlewoman but observes that there are many here who have worked long and hard to bring us to this day, and the Nation will be grateful to us all. I thank you.

PROVIDING FOR CONSIDERATION OF H.R. 3962, AFFORDABLE HEALTH CARE FOR AMERICA ACT, AND PROVIDING FOR CONSIDERATION OF H.R. 3961, MEDICARE PHYSICIAN PAYMENT REFORM ACT OF 2009

Ms. SLAUGHTER. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 903 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 903
Resolved, That upon the adoption of this resolution it shall be in order to consider in the House the H.R. 3962 to provide affordable, quality health care for all Americans and reduce the growth in health care spending, and for other purposes.

SEC. 1. During consideration of an amendment to the bill, as amended, is waived. The bill, as amended, shall be considered as though under clause 8 of rule XXI.

SEC. 2. During consideration of an amendment to the bill, as amended, is waived. The bill, as amended, shall be considered as though under clause 10 of rule XXI.

SEC. 3. Upon the adoption of this resolution it shall be in order to consider in the House the bill (H.R. 3961) to amend title XVIII of the Social Security Act to reform the Medicare SGR payment system for physicians. All points of order against consideration of the bill are waived except those arising under clause 9 or 10 of rule XXI. The bill shall be considered as read. All points of order against adoption in the bill are waived. The previous question shall be considered as ordered on the bill to final passage without intervening motion except: (1) one hour equally divided and controlled by the chair and ranking minority member of the Committee on Ways and Means; and (2) one motion to recommit.

S C R I P T

Mr. Speaker, in the engrossment of H.R. 3961, the Clerk shall—

(a) add the text of H.R. 2920, as passed by the House, as new matter at the end of H.R. 3961;

(b) conform the title of H.R. 3961 to reflect the addition to the engrossment of the text of H.R. 2920;

(c) assign appropriate designations to provisions within the engrossment; and

(d) conform provisions for short titles within the engrossment.

The SPEAKER pro tempore. The gentlewoman from New York is recognized for 1 hour.

Ms. SLAUGHTER. Mr. Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentleman from Texas (Mr. SESSIONS). All time yielded during consideration of the rule is for debate only.

GENERAL LEAVE

Ms. SLAUGHTER. Mr. Speaker, I ask unanimous consent that all Members have 5 legislative days within which to revise and extend their remarks and to insert extraneous materials into the Record.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from New York?

There was no objection.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining in this vote.

(1045)

So (two-thirds being in the affirmative) the rules were suspended and the resolution voted on.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

RECOGNIZING THE HON. JOHN DINGELL

(Ms. SLAUGHTER asked and was given permission to address the House for 1 minute.)

Ms. SLAUGHTER. Mr. Speaker, I want to say that as the man in this House who has had reform of health care in his blood, who has worked
Ms. SCHAKOWSKY. Mr. Speaker, I rise in support of reform that will allow millions of American women to get the health care they need.

Ms. SLAUGHTER. Mr. Speaker, I yield for a unanimous consent request to the gentlewoman from New York (Mrs. LOWEY).

(Mrs. LOWEY asked and was given permission to revise and extend her remarks.)

Mrs. LOWEY. Mr. Speaker, I support health care that helps senior women afford their medications through Medicare.

Ms. SLAUGHTER. Mr. Speaker, I am pleased to yield for a unanimous consent request to the gentlewoman from California (Mrs. DAVIS).

(Mrs. DAVIS of California asked and was given permission to revise and extend her remarks.)

Mrs. DAVIS of California. Mr. Speaker, I support the Democratic bill because it will keep women and their families healthy—not just take care of them when they are sick.

PARLAMENTARY INQUIRIES

The SPEAKER pro tempore. The gentlewoman from California (Ms. LEE) for a unanimous consent request.

Ms. LEE. Mr. Speaker, I support affordable health care and this Democratic bill so that domestic violence victims can be used ever again as a preexisting condition.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlewoman from Michigan (Ms. KILPATRICK) for a unanimous consent request.

(Ms. KILPATRICK of Michigan asked and was given permission to revise and extend her remarks.)

Ms. KILPATRICK of Michigan. Mr. Speaker, I support our House bill which will let our kids in their 20s get insurance and keep healthy.

Ms. SLAUGHTER. Mr. Speaker, I yield for a unanimous consent request to the gentlewoman from Ohio (Ms. SUTTON).

(Ms. SUTTON asked and was given permission to revise and extend her remarks.)

Ms. SUTTON. Mr. Speaker, I support health care reform that improves the nursing workforce and is endorsed by the American Nursing Association.

Ms. SLAUGHTER. Mr. Speaker, I yield for a unanimous consent request to the gentlewoman from California (Mrs. DAVIS).

(Mrs. DAVIS of California asked and was given permission to revise and extend her remarks.)

Mrs. DAVIS of California. Mr. Speaker, I support the Democratic bill because it will keep women and their families healthy—not just take care of them when they are sick.

PARLAMENTARY INQUIRIES

The SPEAKER pro tempore. The gentlewoman from Georgia (Mrs. PRICE) of Georgia for a parliamentary inquiry.

Ms. PRICE of Georgia. Mr. Speaker, parliamentary inquiry.

The SPEAKER pro tempore. The gentleman may state his parliamentary inquiry.

Mr. PRICE of Georgia. Mr. Speaker, I was just wondering if this was a stall- ing tactic by the majority party on delaying the vote on this important bill which will kill 5.5 million jobs today!

The SPEAKER pro tempore. The Chair will observe that is not a correct parliamentary inquiry. The Chair will observe, on this side of the aisle, I don’t think anybody wants to stall the bill.

Mr. PRICE of Georgia. Mr. Speaker, continuing to reserve the right to object.

The SPEAKER pro tempore. The gentleman is recognized on his reservation.

Mr. PRICE of Georgia. I understand that this may be a train that is rolling, but it appears that the majority side is interested in stalling this bill. Would it be appropriate to ask unanimous consent that all extension and revision of remarks could be done en bloc.

The SPEAKER pro tempore. The Chair will observe that is not a correct parliamentary inquiry. The Chair will observe, on this side of the aisle, I don’t think anybody wants to stall the bill.

Mr. PRICE of Georgia. Mr. Speaker, continuing to reserve the right to object.

The SPEAKER pro tempore. The gentleman is recognized on his reservation.

Ms. PRICE of Georgia. Mr. Speaker, I am pleased to yield to the gentlewoman from California (Ms. WOOLSEY) for a unanimous consent request.

Ms. WOOLSEY. Mr. Speaker, I ask unanimous consent to revise and extend my remarks in support of this bill because it will make health care affordable for women who still earn 77 percent less than men.

Mr. SESSIONS. Mr. Speaker, I observe, on this side of the aisle, I don’t believe that what is occurring is that the facts of the case are that this has gone beyond the rules of the House in the presentation, and I object and would ask for regular order.

The SPEAKER pro tempore. The gentleman from Texas has objected.

Ms. PRICE of Georgia. Mr. Speaker, I am pleased to yield to the gentlewoman from New York (Ms. HIRONO) for a unanimous consent request.

Ms. HIRONO. Mr. Speaker, I ask unanimous consent to revise and extend my remarks because the women in my district cannot wait any longer for meaningful health care reform.

Mr. SESSIONS. Mr. Speaker, I observe, on this side of the aisle, I don’t believe that what is occurring is that the facts of the case are that this has gone beyond the rules of the House in the presentation, and I object and would ask for regular order.

The SPEAKER pro tempore. The gentleman from Texas has objected.

Ms. PRICE of Georgia. Mr. Speaker, I am pleased to yield to the gentlewoman from California (Ms. LEE) for a unanimous consent request.

Ms. LEE. Mr. Speaker, I support affordable health care and this Democratic bill so that domestic violence victims can be used ever again as a preexisting condition.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlewoman from Texas (Ms. EDDIE BERNICE JOHNSON) for a unanimous consent request.

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I support the Democratic bill so that domestic violence victims can be used ever again as a preexisting condition.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlewoman from California (Ms. LEE) for a unanimous consent request.

Ms. LEE. Mr. Speaker, I support affordable health care and this Democratic bill so that domestic violence victims can be used ever again as a preexisting condition.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlewoman from Michigan (Ms. KILPATRICK) for a unanimous consent request.

Ms. KILPATRICK of Michigan. Mr. Speaker, I support our House bill which will let our kids in their 20s get insurance and keep healthy.

Ms. SLAUGHTER. Mr. Speaker, I yield for a unanimous consent request to the gentlewoman from Ohio (Ms. SUTTON).

Ms. SUTTON. Mr. Speaker, I support health care reform that improves the nursing workforce and is endorsed by the American Nursing Association.

Ms. SLAUGHTER. Mr. Speaker, I yield for a unanimous consent request to the gentlewoman from California (Mrs. DAVIS).

(Mrs. DAVIS of California asked and was given permission to revise and extend her remarks.)

Mrs. DAVIS of California. Mr. Speaker, I support the Democratic bill because it will keep women and their families healthy—not just take care of them when they are sick.

PARLAMENTARY INQUIRIES

The SPEAKER pro tempore. The gentlewoman from California (Ms. LEE) for a unanimous consent request.

Ms. LEE. Mr. Speaker, I support affordable health care and this Democratic bill so that domestic violence victims can be used ever again as a preexisting condition.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlewoman from Michigan (Ms. KILPATRICK) for a unanimous consent request.

(Ms. KILPATRICK of Michigan asked and was given permission to revise and extend her remarks.)

Ms. KILPATRICK of Michigan. Mr. Speaker, I support our House bill which will let women and doctors control their health decisions.

Ms. SLAUGHTER. Mr. Speaker, I yield for a unanimous consent request to the gentlewoman from California (Ms. ZOE LOFGREN).

Ms. ZOE LOFGREN of California. Mr. Speaker, I support health care reform that improves the nursing workforce and is endorsed by the American Nursing Association.

Ms. SLAUGHTER. Mr. Speaker, I yield for a unanimous consent request to the gentlewoman from Ohio (Ms. SUTTON).

(Ms. SUTTON asked and was given permission to revise and extend her remarks.)

Ms. SUTTON. Mr. Speaker, I support health care reform that improves the nursing workforce and is endorsed by the American Nursing Association.

The SPEAKER pro tempore. The Chair observes that regular order has been demanded. As such, the gentleman must either object, or withdraw his reservation.

Mr. PRICE of Georgia. Mr. Speaker, I object.

The SPEAKER pro tempore. The Chair hears objection. The Chair would hope the gentleman would not object, but if he does, it will be in the RECORD.

Mr. PRICE of Georgia. Mr. Speaker, continuing to reserve then, if you are not interested in obtaining my objection, continuing to reserve, again it appears that this is a process by which the majority party is interested once again in trying to subvert the rules and expand the debate time on the major- ity side.

Mr. SESSIONS. Parliamentary inquiry.

The SPEAKER pro tempore. Objection was heard. The gentleman from Texas will state his parliamentary inquiry.

Mr. SESSIONS. The question is, could the Speaker please advise us of the time that is being consumed. Does it come off the first 2 hours that would be allowed in the rule for debate by the gentlewoman from New York?

The SPEAKER pro tempore. A Member asking to insert remarks into the RECORD may include a simple declaration of sentiment toward the question under debate but should not embellish the request with extended oratory.

The gentlewoman from New York is recognized.

Ms. SLAUGHTER. Mr. Speaker, I am pleased to yield to the gentlewoman from California (Ms. WOOLSEY) for a unanimous consent request.

Ms. WOOLSEY. Mr. Speaker, I ask unanimous consent to revise and extend my remarks in support of this bill because it will make health care affordable for women who still earn 77 percent less than men.

Mr. SESSIONS. Mr. Speaker, I reserve the right to object.

The SPEAKER pro tempore. The Chair recognizes the gentleman from Texas on his reservation.

Mr. SESSIONS. Mr. Speaker, I believe that what is occurring is that the facts of the case are that this has gone beyond the rules of the House in the presentation, and I object and would ask for regular order.

The SPEAKER pro tempore. The gentleman from Texas has objected.

Ms. PRICE of Georgia. Mr. Speaker, I am pleased to yield to the gentlewoman from Hawaii (Ms. HIRONO) for a unanimous consent request.

Ms. HIRONO. Mr. Speaker, I ask unanimous consent to revise and extend my remarks because the women in my district cannot wait any longer for meaningful health care reform.

Mr. SESSIONS. Mr. Speaker, I reserve the right to object.

The SPEAKER pro tempore. The gentlewoman from Texas is recognized on his reservation.
Mr. SESSIONS. Mr. Speaker, I believe what is occurring now is not only opposed to the House rules but is containing further comment, which was not allowed in the rule nor in the general provisions of the House.

The SPEAKER pro tempore. The Chair will entertain the ruling that the Chair made earlier.

A Member asking to insert remarks may include a simple declaration of sentiment towards the question under debate but should not embelish the request with extended oratory.

The Chair has heard nothing which contravenes that, and the Chair makes the statement to my good friend that we will continue as we have in allowing each Member—

Mr. SESSIONS. Mr. Speaker, parliamentary inquiry.

The SPEAKER pro tempore. The gentleman is out of order. The Chair is busy ruling.

Mr. SESSIONS. Could the Speaker please advise me about the time that is presently being consumed?

The SPEAKER pro tempore. The gentleman is out of order. The Chair is busy ruling.

The Chair recognizes the distinguished gentlewoman from New York.

Ms. ROYBAL-ALLARD. Mr. Speaker, I am pleased to yield for a unanimous consent request to the gentlewoman from California (Ms. ROYBAL-ALLARD).

(Ms. ROYBAL-ALLARD asked and was given permission to revise and extend her remarks.)

□ 1100

Ms. ROYBAL-ALLARD. Mr. Speaker, I rise in support of the Democratic bill because it will help women with breast cancer pay for chemotherapy.

Mr. PRICE of Georgia. Mr. Speaker, reserving the right to object.

The SPEAKER pro tempore. The unanimous consent request has been entered. That is the business of the House.

Ms. SLAUGHTER. Mr. Speaker, reservation.

The SPEAKER pro tempore. The unanimous consent request has been entered. That is the business of the House.

Mr. PRICE of Georgia. Further inquiry, Mr. Speaker.

The SPEAKER pro tempore. The gentleman will state his parliamentary inquiry.

Mr. PRICE of Georgia. Is it not appropriate for a Member of the House to be able to reserve a right to object on a unanimous consent request?

The SPEAKER pro tempore. Mr. Speaker, the Chair is going to instruct the gentleman to assert timely objections.

Mr. PRICE of Georgia. Parliametary inquiry.

The SPEAKER pro tempore. The gentleman will state his inquiry.

Mr. PRICE of Georgia. At the time that a unanimous consent request is made, the Speaker has apparently determined that the statement, as soon as it is completed, does not allow for a reservation. Is it not, under the rules of the House, appropriate for a Member of the House to reserve a right to object based upon a unanimous consent request?

The SPEAKER pro tempore. The Chair is going to instruct the gentleman lightly upon the rules of the House by observing that reservations must be made in a timely fashion.

The Chair will protect the rights of the gentleman to assert timely objections or to proceed in an appropriate manner under the rules.

The Chair now recognizes the gentlewoman from New York.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlelady from California (Mrs. NAPOLITANO) for a unanimous consent request.

(Mrs. NAPOLITANO asked and was given permission to revise and extend her remarks.)

Mrs. NAPOLITANO. Mr. Speaker, I rise in support of health care reform that eliminates out-of-pocket costs for osteoporosis screenings.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlelady from Ohio (Ms. KILROY) for a unanimous consent request.

Ms. KILROY. Mr. Speaker, I thank the gentlelady from Ohio.

Mr. Speaker, I ask unanimous consent to revise and extend my remarks in support of the Democratic bill.

Mr. SESSIONS. Mr. Speaker, parliamentary inquiry.

Ms. KILROY. Mr. Speaker, I have already yielded to the gentlelady from Ohio (Ms. KILROY).

Mr. DREIER. Mr. Speaker, I reserve the right to object. Mr. Speaker, I reserve the right to object and wish to be heard on my reservation.

The SPEAKER pro tempore. The Chair rules that out of order.

The Chair makes the observation that since a demand for the regular order has been made, reservations may no longer be raised. Perceiving that the gentleman from California has withdrawn his reservation, the Chair recognizes now, again, the gentlewoman from New York, who controls the time at this moment.

Ms. SLAUGHTER. Mr. Speaker, I have already yielded to the gentlelady from Ohio (Ms. KILROY).

Ms. KILROY. I thank the gentlelady from New York.

Mr. Speaker, I ask unanimous consent to revise and extend my remarks in support of the Democratic bill.

Mr. SESSIONS. Mr. Speaker, I object.
Ms. SLAUGHTER. Mr. Speaker, I would inquire of Ms. KIRKHOFF, have you had time to raise your objection?

Ms. KIRKHOFF. I ask unanimous consent to revise and extend my remarks in support of the Democratic bill.

The SPEAKER pro tempore. Objection is heard.

Ms. KIRKHOFF. I rise in support of this Democratic bill because it won't force women into a bare bones policy, high deductible, and high cost plan.

The SPEAKER pro tempore. Objection has been heard.

Mr. SESSIONS. Mr. Speaker, I would ask to be heard.

Mr. Speaker, the Republicans are asking for an extension of 1 hour on both sides under the rule that will equally allow both sides 39 additional minutes to be heard, because it's obvious that Members of Congress need to be heard and this rule does not provide the amount of time necessary, and the people who are here is an example of why we want to work hard on this.

The SPEAKER pro tempore. The gentleman from Texas has not yet been recognized for debate. The gentleman will resume his seat and we will proceed with the business of the House.

The Chair continues to recognize the gentlewoman from New York.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlelady from Wisconsin (Ms. BALDWIN) for a unanimous consent request.

Ms. BALDWIN. Mr. Speaker, because it is time to protect older women by closing the doughnut hole, I ask unanimous consent to revise and extend my remarks in support of this bill.

Mrs. BACHMANN. I object.

The SPEAKER pro tempore. Objection is heard.

The Chair has a comment to make here. The Chair is going to request the Members on both sides of the aisle to respect the rights of other Members. Members have the right, under the rules, to a unanimous consent. If Members on one side of the aisle want their right protected, the Chair observes that they should then respect the rights of Members on the other side of the aisle. It will be the purpose of the Chair to try and avoid that all Members are heard at the proper time and fashion and to see that the rules are carried out. The Chair will also try to see that the debate is conducted with a measure of comity and grace and decency, and the Chair would request my friends on both sides of the aisle to respect that.

PARLIAMENTARY INQUIRIES

Mr. CULBERSON. Parliamentary inquiry, Mr. Speaker.

The SPEAKER pro tempore. The gentleman will state it.

Mr. CULBERSON. Mr. Speaker, to fulfill your proper admonition of the House that we proceed with comity and respect and allow the voices on both sides to be heard, my parliamentary inquiry, Mr. Speaker, is to ask that we would—and we are prepared to do so with a unanimous consent—agree to expand the debate by 1 hour to allow other Members of the House on both sides—could we have a unanimous consent request, Mr. Speaker, to expand the debate?

The SPEAKER pro tempore. The Chair will observe that my friend has not stated a proper parliamentary inquiry.

The Chair simply wants to make this observation. We can spend a long time here on this particular wrangle or we can allow the proceedings to go forward. Everybody will have a chance to be heard as long as the House is presided over by this particular Member.

The Chair just requests my friends on both sides of the aisle to respect the rights of other Members. And the Chair asks the Members not to make that any more difficult than they must.

The Chair continues to recognize the gentlewoman from New York.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlelady from New York (Ms. ESHOO) for a unanimous consent request.

Ms. ESHOO. Mr. Speaker, is it not correct procedure in what disorderly House, that the request is not in order.

The gentlewoman from New York continues to be recognized.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlelady from California (Ms. ESposito) for an unanimous consent request.

Ms. ESposito. Because women shouldn't have to buy a separate policy for maternity care, Mr. Speaker, I ask unanimous consent to revise and extend my remarks on this bill which will limit age ratings that make coverage unaffordable for older women.

Mrs. BACHMANN. I object, Mr. Speaker.

The SPEAKER pro tempore. Objection is heard.

The gentlewoman from New York continues to be recognized.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlelady from Massachusetts (Ms. TSongas) for an unanimous consent request.

Ms. TSongas. Because women have had time to raise your objection?

The SPEAKER pro tempore. The Chair observes that that can only be done at this time by the gentlewoman from New York yielding for the purpose of that kind of unanimous consent request.

Mr. CULBERSON. Will the gentlelady from New York yield to expand the debate by 1 hour so that everyone can speak.

Ms. SLAUGHTER. I am calling for regular order. I would like to really get on with this bill.

The SPEAKER pro tempore. The Chair observes that the gentlewoman from New York has not yielded for that purpose and that, therefore, the request is not in order.

The gentlewoman from New York continues to be recognized.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlelady from California (Ms. ESposito) for an unanimous consent request.

Ms. ESposito. Mr. Speaker, I ask unanimous consent to revise and extend my remarks on this bill which will limit age ratings that make coverage unaffordable for older women.

Mrs. BACHMANN. I object, Mr. Speaker.

The SPEAKER pro tempore. Objection is heard.

The gentlewoman from New York continues to be recognized.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlelady from Massachusetts (Ms. TSongas) for an unanimous consent request.

Ms. TSongas. Because women should have to buy a separate policy for maternity care, Mr. Speaker, I ask unanimous consent to revise and extend my remarks in support of the Democratic bill.

Mrs. BACHMANN. I object, Mr. Speaker.

The SPEAKER pro tempore. Objection is heard.

The gentlewoman from New York continues to be recognized.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlelady from Massachusetts (Ms. TSongas) for an unanimous consent request.

Ms. TSongas. Because women should have to buy a separate policy for maternity care, Mr. Speaker, I ask unanimous consent to revise and extend my remarks in support of the Democratic bill.

Mrs. BACHMANN. I object, Mr. Speaker.

The SPEAKER pro tempore. Objection is heard.

The gentlewoman from New York continues to be recognized.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlelady from California (Ms. ESposito) for an unanimous consent request.

Ms. ESposito. Because women should have to buy a separate policy for maternity care, Mr. Speaker, I ask unanimous consent to revise and extend my remarks in support of the Democratic bill.

Mrs. BACHMANN. I object, Mr. Speaker.

The SPEAKER pro tempore. Objection is heard.

The gentlewoman from New York continues to be recognized.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlelady from Massachusetts (Ms. TSongas) for an unanimous consent request.

Ms. TSongas. Because women should have to buy a separate policy for maternity care, Mr. Speaker, I ask unanimous consent to revise and extend my remarks in support of the Democratic bill.

Mrs. BACHMANN. I object, Mr. Speaker.

The SPEAKER pro tempore. Objection is heard.

The gentlewoman from New York continues to be recognized.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlelady from California (Ms. ESposito) for an unanimous consent request.

Ms. ESposito. Because women should have to buy a separate policy for maternity care, Mr. Speaker, I ask unanimous consent to revise and extend my remarks in support of the Democratic bill.

Mrs. BACHMANN. I object, Mr. Speaker.

The SPEAKER pro tempore. Objection is heard.

The gentlewoman from New York continues to be recognized.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlelady from Massachusetts (Ms. TSongas) for an unanimous consent request.

Ms. TSongas. Because women should have to buy a separate policy for maternity care, Mr. Speaker, I ask unanimous consent to revise and extend my remarks in support of the Democratic bill.

Mrs. BACHMANN. I object, Mr. Speaker.

The SPEAKER pro tempore. Objection is heard.

The gentlewoman from New York continues to be recognized.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlelady from California (Ms. ESposito) for an unanimous consent request.

Ms. ESposito. Because women should have to buy a separate policy for maternity care, Mr. Speaker, I ask unanimous consent to revise and extend my remarks in support of the Democratic bill.

Mrs. BACHMANN. I object, Mr. Speaker.

The SPEAKER pro tempore. Objection is heard.

The gentlewoman from New York continues to be recognized.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentlelady from Massachusetts (Ms. TSongas) for an unanimous consent request.

Ms. TSongas. Because women should have to buy a separate policy for maternity care, Mr. Speaker, I ask unanimous consent to revise and extend my remarks in support of the Democratic bill.

Mrs. BACHMANN. I object, Mr. Speaker.

The SPEAKER pro tempore. Objection is heard.

The gentlewoman from New York continues to be recognized.
Mr. PRICE of Georgia. Does the rule not provide on a unanimous consent request that there be no significant embellishment of remarks, and in fact the majority party has continued to embellish their remarks upon your UC request?

The SPEAKER pro tempore. The Chair is kind of wearing out this ruling, but the Chair will respond again for the benefit of my good friend by observing:

A Member asking to insert remarks may include a simple declaration of sentiment on the question under debate, but should not embellish the requests with extended oratory. The Chair is going to try and enforce that, and the Chair would suggest to all Members that we respect each other’s rights and, on this side, that Members observe the rule and on that side that the Members permit the Members on this side to observe the rule and to make their necessary points. The Chair will try and enforce these rules in a fair and proper way.

The Chair observes that the proceedings will proceed more speedily if the Members will assist the Chair in this particular way.

Ms. SLAUGHTER. I am pleased to yield to the gentlewoman from Nevada (Ms. TITUS) for a unanimous consent request.

Ms. TITUS. Mr. Speaker, because the Democratic bill covers the preventative services that women need to stay healthy and the Chair understands the concerns of the people over here to do the same.

Mr. BURTON of Indiana. Mr. Speaker, you have just ruled that you cannot embellish, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been heard, if an objection has been hearing the requests over and over for a very long time.

The Chair is going to now make a further admonition to the House. The Chair will advise Members that, as indicated by previous occupants of the Chair going a long way back, although a unanimous consent request to insert remarks in debate may comprise a simple declaration of statement of the Member’s attitude toward the pending measure, it is improper for a Member to embellish such requests with other oratory and that it can become an imposition on the time of the Member who yielded for that purpose.

Then the Chair will entertain as many requests to make insertions by unanimous consent as may be necessary to accommodate the Members, but the Chair also asks the Members to cooperate by confining such remarks to the proper form.

Ms. SLAUGHTER. Mr. Speaker, I am pleased to yield to the gentlewoman from California (Ms. LORETTA SANCHEZ) for a unanimous consent request.

Ms. LORETTA SANCHEZ of California. Mr. Speaker, I support health care reform, as it will provide assurance for maternity and well-child care.

Ms. SLAUGHTER. Mr. Speaker, I am in support of health care reform, as it will provide assurance for maternity and well-child care.

Ms. SLAUGHTER. Mr. Speaker, I am pleased to yield to the gentlewoman from California (Ms. LORETTA SANCHEZ) for a unanimous consent request.

Ms. LORETTA SANCHEZ of California. Mr. Speaker, I support health care reform, as it will provide assurance for maternity and well-child care.

The SPEAKER pro tempore. The Chair is going to now make a further admonition to the House. The Chair will advise Members that, as indicated by previous occupants of the Chair going a long way back, although a unanimous consent request to insert remarks in debate may comprise a simple declaration of statement of the Member’s attitude toward the pending measure, it is improper for a Member to embellish such requests with other oratory and that it can become an imposition on the time of the Member who yielded for that purpose.

Mr. GOHMERT. Mr. Speaker, a parliamentary inquiry.

The SPEAKER pro tempore. Mr. Speaker, a parliamentary inquiry.

Mr. GOHMERT. Mr. Speaker, a parliamentary inquiry.

The SPEAKER pro tempore. The gentlewoman from Indiana. I object.

Mr. GOHMERT. Mr. Speaker, a parliamentary inquiry.

The SPEAKER pro tempore. The gentlewoman from Indiana. I object.

Mr. GOHMERT. Mr. Speaker, a parliamentary inquiry.

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Mr. GOHMERT. Mr. Speaker, a parliamentary inquiry.

The SPEAKER pro tempore. The gentlewoman from Indiana. I object.

Mr. GOHMERT. Mr. Speaker, a parliamentary inquiry.

The SPEAKER pro tempore. The gentlewoman from Indiana. I object.
Mr. SESSIONS. Mr. Speaker, I appreciate that.

Mr. Speaker, at this time, I would like to yield to the gentlewoman from Ohio (Mrs. SCHMIDT) for a unanimous consent request.

(Mrs. SCHMIDT asked and was given permission to revise and extend her remarks.)

Mrs. SCHMIDT. Mr. Speaker, I rise in opposition to this job-killing bill before us.

Mr. SESSIONS. Mr. Speaker, I would like to yield to the gentlewoman from Oklahoma (Ms. FALLIN) for a unanimous consent request.

(Ms. FALLIN asked and was given permission to revise and extend her remarks.)

Ms. FALLIN. Mr. Speaker, I rise in opposition against this freedom-killing, constitutional affront, job-killing bill, health care bill.

Mr. SESSIONS. Mr. Speaker, I yield to the gentlewoman from Tennessee (Mrs. BLACKBURN) for a unanimous consent request.

(Mrs. BLACKBURN asked and was given permission to revise and extend her remarks.)

Mrs. BLACKBURN. Mr. Speaker, I rise in opposition on this record-killing, job-killing bill that is going to cut Medicare and pile debt on our children, our precious grandchildren and raise health care costs and taxes on the American people.

The SPEAKER pro tempore. The Chair is going to observe, the rules are going to be observed on both sides of the aisle.

For the benefit of my colleagues, the Chair will simply observe that Members asking to insert remarks may include a simple declaration of sentiment towards the question under debate but should not embellish the request with extended oratory.

The gentleman from Texas continues to be recognized.

Mr. SESSIONS. Mr. Speaker, I yield to the gentlewoman from California (Mrs. BONO MACK) for a unanimous consent request.

(Mrs. BONO MACK asked and was given permission to revise and extend her remarks.)

Mrs. BONO MACK. Mr. Speaker, I would like to yield to the gentlewoman from Wisconsin (Ms. GREY-VOORDE) for a unanimous consent request.

(Ms. GREY-VOORDE asked and was given permission to revise and extend her remarks.)

Ms. GREY-VOORDE. Mr. Speaker, I rise in opposition against this job-killing bill that raises taxes on the American people.

Mr. SESSIONS. Mr. Speaker, I yield to the gentlewoman from Florida (Ms. ROS-LEHTINEN) for a unanimous consent request.

(Ms. ROS-LEHTINEN asked and was given permission to revise and extend her remarks.)

Ms. ROS-LEHTINEN. Mr. Speaker, I rise in opposition to this job-killing bill because it piles on debt on my brand-new 3-month-old grandbaby.

We agree that real healthcare reform is a necessity. We must provide uninsured Americans with meaningful healthcare reform.

But the trillion dollar Pelosi bill is not the answer.
The Pelosi bill will drive already hurting hardworking families and seniors further into debt.

My home state of Florida is suffering with 11.2% unemployment.

This is not the right time to burden families with increased debt.

Also, with over 162 billion dollars in harmful cuts to Medicare Advantage, the Pelosi plan will force millions of seniors to lose their current health coverage.

And Medicare prescription drug premiums will likely rise by 20 percent.

The trillion dollar Pelosi bill makes it tougher on seniors to get the coverage and treatment they deserve after a lifetime of hard work and sacrifice.

There is a disconnect between Congress and reality when we think creating bureaucracies is the same as creating solutions.

Mr. SESSIONS. Mr. Speaker, I yield to the gentlewoman from Michigan (Mrs. MILLER) for a unanimous consent request.

(Mrs. MILLER of Michigan asked and was given permission to revise and extend her remarks.)

Mrs. MILLER of Michigan. Mr. Speaker, I rise in opposition to this job-killing, deficit-exploding government takeover of our health care system.

Mr. SESSIONS. Mr. Speaker, I yield to the gentlewoman from the State of Washington (Mrs. MC MORRIS RODGERS) for a unanimous consent request.

(Mrs. MC MORRIS RODGERS asked and was given permission to revise and extend her remarks.)

Mrs. MC MORRIS RODGERS. Mr. Speaker, I rise in opposition because this bill will take away the ability of women, the chief health officer in 85 percent of American households, for making the best decisions for their families.

Mr. SESSIONS. Mr. Speaker, I yield to the gentlewoman from West Virginia (Mrs. CAPITO) for a unanimous consent request.

(Mrs. CAPITO asked and was given permission to revise and extend her remarks.)

Mrs. CAPITO. Mr. Speaker, I rise in opposition because this bill puts crushing debt on everyone and puts the government between a woman and her doctor.

Mr. SESSIONS. Mr. Speaker, I yield to the gentlewoman from Illinois (Ms. BIGGERT) for a unanimous consent request.

(Ms. BIGGERT asked and was given permission to revise and extend her remarks.)

Mrs. BIGGERT. Mr. Speaker, I rise in opposition to this bill which raises health care costs and taxes.

Mr. SESSIONS. Mr. Speaker, I yield to the gentlewoman from Minnesota (Mrs. BACHMANN) for a unanimous consent request.

(Mrs. BACHMANN asked and was given permission to revise and extend her remarks.)

Mrs. BACHMANN. Mr. Speaker, I rise in opposition to this job-killing bill that will cut $500 million from Medicare and potentially collapse the economic economy.

Mr. SESSIONS. Mr. Speaker, I yield to the gentlewoman from Kansas (Ms. JENKINS) for a unanimous consent request.

(Ms. JENKINS asked and was given permission to revise and extend her remarks.)

Ms. JENKINS. Mr. Speaker, I rise in opposition because this bill kills jobs, cuts Medicare, piles on debt, increases costs and raises taxes.

While there are many reasons why I’m opposed to Speaker Pelosi’s health care bill, there is one that has been highlighted in today’s headlines.

JOBS

Americans from coast to coast are struggling to make ends meet and many are looking for work.

Yet on the day unemployment in our nation hit 10.2 percent, the highest level since 1983, the Democrat Party continues to move forward with yet another job-killing bill.

According to a model used by President Obama’s own economic advisors, Speaker Pelosi’s health care plan would kill another 5.5 million jobs.

That is downright criminal.

Before voting on Speaker Pelosi’s plan later this weekend, I urge my colleagues to respond to the needs of the American people by supporting solutions to create jobs, not kill them.

I yield back the remainder of my time.

The SPEAKER pro tempore. The Chair is going to宣布 again the rules of the House as they affect this part of our proceedings.

A Member asking to insert remarks may include a simple declaration of sentiment towards the question under debate but should not embelish their requests with extended oratory.

Mr. SESSIONS. Mr. Speaker, I yield to the gentlewoman from Wyoming (Mrs. LUMMIS) for a unanimous consent request.

(Mrs. LUMMIS asked and was given permission to revise and extend her remarks.)

Mrs. LUMMIS. Mr. Speaker, I rise in opposition to this job-killing bill at a time when our Nation has 10.2 percent unemployment that cuts Medicare, piles debt on our children, and raises health care costs.

Mr. SESSIONS. Mr. Speaker, I yield to the gentlewoman from Florida (Ms. GINNY BROWN-WAITE) for a unanimous consent request.

(Ms. GINNY BROWN-WAITE of Florida asked and was given permission to revise and extend her remarks.)

Ms. GINNY BROWN-WAITE of Florida. Mr. Speaker, I rise in opposition to this job-killing bill that’s estimated to cut 5.5 million jobs in America. It’s not going to help health care, and the bottom line is Medicare is imperiled as a result of it.

The SPEAKER pro tempore. The Chair will ask for a simple declaration of sentiment, or the gentleman from Texas will be charged for the time just like the gentlewoman from New York.

Mr. SESSIONS. Mr. Speaker, I yield to the gentleman from North Carolina (Ms. FOXX) for a unanimous consent request.

(Ms. FOXX asked and was given permission to revise and extend her remarks.)

Ms. FOXX. Mr. Speaker, I rise in opposition to this exercise of tyranny of the majority that our Founders so feared on this job-killing bill that cuts Medicare, piles debt on our children, increases health care costs, and raises taxes on the American people.

The SPEAKER pro tempore. The Chair observes that the gentleman from Texas is being charged for the time now being used.

Mr. SESSIONS. Mr. Speaker, I yield to the gentleman from Kansas (Ms. JENKINS) for a unanimous consent request.

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Mr. SESSIONS. Mr. Speaker, I yield to the gentlewoman from Florida (Ms. GINNY BROWN-WAITE) for a unanimous consent request.

(Ms. GINNY BROWN-WAITE of Florida asked and was given permission to revise and extend her remarks.)

Ms. GINNY BROWN-WAITE of Florida. Mr. Speaker, I rise in opposition to this job-killing bill that’s estimated to cut 5.5 million jobs in America. It’s not going to help health care, and the bottom line is Medicare is imperiled as a result of it.

The SPEAKER pro tempore. The Chair will ask for a simple declaration of sentiment, or the gentleman from Texas will be charged for the time just like the gentlewoman from New York.

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(Ms. FOXX asked and was given permission to revise and extend her remarks.)

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(Mrs. LUMMIS asked and was given permission to revise and extend her remarks.)

Mrs. LUMMIS. Mr. Speaker, I rise in opposition to this job-killing bill at a time when our Nation has 10.2 percent unemployment that cuts Medicare, piles debt on our children, and raises health care costs.

Mr. SESSIONS. Mr. Speaker, I yield to the gentlewoman from Florida (Ms. GINNY BROWN-WAITE) for a unanimous consent request.

(Ms. GINNY BROWN-WAITE of Florida asked and was given permission to revise and extend her remarks.)

Ms. GINNY BROWN-WAITE of Florida. Mr. Speaker, I rise in opposition to this job-killing bill that’s estimated to cut 5.5 million jobs in America. It’s not going to help health care, and the bottom line is Medicare is imperiled as a result of it.

The SPEAKER pro tempore. The Chair will ask for a simple declaration of sentiment, or the gentleman from Texas will be charged for the time just like the gentlewoman from New York.
Mr. SESSIONS. Mr. Speaker, at this time I would like to inquire upon the time that is left on both sides, please, sir.

The SPEAKER pro tempore. The gentleman from Texas is charged with the time.

Mr. SESSIONS. Mr. Speaker, I yield to the gentleman from Illinois (Mr. ROSKAM) for a unanimous consent request.

(Mr. ROSKAM asked and was given permission to revise and extend his remarks.)

Mr. ROSKAM. Mr. Speaker, I rise in opposition to this bill that would lead to possible jail time if you don’t comply.

Mr. SESSIONS. Mr. Speaker, I would like to yield to the gentleman from Colorado (Mr. COFFMAN) for a unanimous consent request.

(Mr. COFFMAN asked and was given permission to revise and extend his remarks.)

Mr. COFFMAN of Colorado. Mr. Speaker, I rise in opposition as this bill is punitive to both small businesses and seniors.

Mr. SESSIONS. Mr. Speaker, I would like to yield to the gentleman from Illinois (Mr. SHIMKUS) for a unanimous consent request.

(Mr. SHIMKUS asked and was given permission to revise and extend his remarks.)

Mr. SHIMKUS. Mr. Speaker, I rise in opposition because this bill’s main intent is government control of health care.

Mr. SESSIONS. Mr. Speaker, I yield to the gentleman from Arizona (Mr. FLAKE) for a unanimous consent request.

(Mr. FLAKE asked and was given permission to revise and extend his remarks.)

Mr. FLAKE. Mr. Speaker, I rise in opposition to this bill. When there is 10 percent unemployment, you stop digging.

Mr. SESSIONS. Mr. Speaker, I yield to the gentleman from Indiana (Mr. BURTON) for a unanimous consent request.

(Mr. BURTON of Indiana asked and was given permission to revise and extend his remarks.)

Mr. BURTON of Indiana. I hope I don’t get a hernia, Mr. Speaker, and say to all my colleagues, if you haven’t read this thing, it’s going to cost billions and billions of dollars and hurt the economy. I would just like to say that I hope before we vote on this thing you will read it.

The SPEAKER pro tempore. The gentleman from Texas will be charged with the time.
gets no break on providing insurance for their employees.

And now this year we have literally thousands of organizations on our side favoring the bill. From AARP, who would never go for any bill that in any way would diminish health care because that is their life’s work, the Consumers Union, the American Cancer Society and the American Medical Association, they have all joined in this cause.

The reason we are here at this moment is because of the leadership of our Speaker, Ms. PELOSI, who is a powerful leader, a compassionate woman, and an inclusive colleague who deserves all the credit for bringing us here to this momentous event that we face today, the most momentous in the history of America.

Before we vote, it is also fitting that we recall the words of the late Senator Kennedy, who spoke as far back as 1978 about the lack of health care coverage in this country. Senator Kennedy said, “One of the most shameful things about modern America is that in our unbelievably rich land, the quality of health care available to many of our people is unbelievably poor, and the cost is unbelievably high.”

I agreed with Senator Kennedy. We cannot afford not to pass this legislation.

Now is our chance to fix our health care system, improve the lives of millions of Americans, and make more corporations in America competitive in a global economy.

With great heartfelt thanks to our great Speaker pro tempore this morning, Mr. DINGELL, I reserve the balance of my time.

Mr. SESSIONS. Mr. Speaker, at this time I would like to yield to the gentlewoman from Texas (Ms. GRANGER) for a unanimous consent request.

(Ms. GRANGER asked and was given permission to revise and extend her remarks.)

Ms. GRANGER. Mr. Speaker, I rise in opposition on behalf of District 12 on this job-killing bill that cuts Medicare, piles debts on our children, raises health care costs, and raises taxes on the American people.

The SPEAKER pro tempore. The gentleman from Utah (Mr. BISHOP) for a unanimous consent request.

(Mr. BISHOP of Utah asked and was given permission to revise and extend his remarks.)

Mr. BISHOP of Utah. Mr. Speaker, I rise to illustrate how this bill will stop health care reform already instituted by the States.

This may seem hard to believe, but over 200 years ago the Founding Fathers forewarned the health care problems we have today and they proposed a solution. We call it federalism. See, if something has to be done the same way, at the same time by everybody, only the federal government can do it. The feds are good at one-size-fits all solutions. But if you want creativity, innovation or justice, and consideration for unique circumstances, states are, as Louis Brandeis once called them, the true laboratories of democracy.

The Founding Fathers understood the Federal Government should be limited, not just for the fun of it, but the federal government has limitations to its effectiveness. In Federalist Number 45 James Madison said, “Powers delegated by the several states to an agency of the federal government must be as well defined and limited as possible.”

He wasn’t speaking about health reform specifically, but if there ever was a bill that sought to concentrate power as an expedient solution to the crisis of the day, it’s Speaker PELOSI’s health care bill.

If we were to pass it, we would be losing sight of the structure the Founders put in place to ensure reforms were done at the most appropriate and helpful level, and power wasn’t concentrated.

Balance is key, and the Pelosi bill would be a permanent shift of power to the federal government to control our daily lives and our health care decisions. You see, that as why the Constitution was designed with this balance in mind. James Madison said, “Parchment barriers, a few luminous words on paper, would not keep ambitious men from exercising undue power—freedom can be preserved not by glooming statements but by the balance of real forces.”

Our health care system needs reform and costs need to be lowered. Hey, in 2000, 54% of all firms offered health benefits today only about 44% of them do. But the reforms needed for the state of California are not the reforms needed for the state of Massachusetts or the state of Utah. Massachusetts has their program; it’s expensive, but they appear to like it; but it won’t work in Utah. What Utah is trying to do wouldn’t fly in Boston. Like every state, Utah’s demographics are unique.

We have a very young population that predominantly works for smaller firms. In Utah, 32 percent of small businesses offer insurance, but that is 10 percent less than the national average. Where the feds are good at one-size-fits all solutions, businesses with stables costs, workers have affordable, portable options, and it’s tailored for our demographics. If the Pelosi bill were to pass, though, that state innovation is stopped. That would be the true health care tragedy.

You know, we can’t solve every issue by getting all the experts in a room in DC. All the creativity and intelligence is not just here in this city. Creative solutions can happen throughout the country when the federal government gets off the backs of individuals and businesses with their mandates and regulations, and out of their pockets with their taxes and then allows real people the ability to find real solutions.

The Pelosi bill seeks to dramatically alter the healthcare landscape for the U.S. and Utah forever. For example, prohibits the sale of private individual health insurance policies, beginning in 2013, forcing individuals and businesses to purchase coverage through the federal government.

PG 49—provides a huge liability loophole for (large) insurance companies, and I bet not more than 10 people know about it.

Small business will be hit with a mandate to provide insurance, with penalties for not providing insurance . . . and a surtax of 5.4% on small business owners. It is estimated that fifty five hundred (5,500) businesses in Utah will be hit with this additional tax. This is devasating for small business owners, already sick and tired of being nickel and dimed by the federal government.

Tort reform, allowing interstate insurance competition and block grants to states for high risk pooling are things the federal government to drive change are common sense changes that won’t damage the work states are doing to provide what their citizens need.

Individual merits of the bill notwithstanding, the biggest problem is the idea that health care decisions can be dictated by Washington, DC bureaucrats—a health care czar.

To paraphrase PJ O’Rourke, the Pelosi bill would have the same effect as giving alcohol and keys to the car to a teenage boy.

The federal government can play a role, but real health reform must happen on the state level. We . . . you and I, know what our unique healthcare needs are, and frankly what types of treatment or access we require to live the healthiest possible life. Despite the fanciful rhetoric coming from both sides of the aisle, our ability to choose will be lost if we fail to allow individual states to address their unique and diverse needs.

Mr. SESSIONS. I would like to yield to the gentleman from California (Mr. HERGER) for a unanimous consent request.

(Mr. HERGER asked and was given permission to revise and extend his remarks.)

Mr. HERGER. Mr. Speaker, I rise to say this job-killing bill would cause as many as 112 million Americans to lose their current health care insurance.

The SPEAKER pro tempore. The gentleman from Texas (Mr. LEE) for a unanimous consent request.

(Mr. LEE of New York. I rise to say this job-killing bill cuts Medicare, piles debt on our children, and does nothing to address the issue of medical liability reform.

Medical liability reform would decrease the need for physicians to practice defensive medicine and could save $54 billion, according to the CBO.
As we all know, the majority refused virtually all amendments to the underlying bill. An amendment that I proposed would play a meaningful role in reforming medical liability laws.

My amendment would administer a pilot program in five states in which a three-member panel—a judge, a physician and a lawyer—would hold a hearing to determine if the facts of an alleged medical malpractice case are sufficient to raise a question of liability. This will lower costs and help eliminate defensive medicine.

Modeled after a Massachusetts program, all cases can proceed past this panel and go to trial regardless of whether the panel believes the defendant was at fault. However, if the panel believes that the case is frivolous, the person who files the case would have to file bond in an amount, determined by the judge, payable to the defendant for costs should the plaintiff not prevail in the final judgment. The pilot program would look at the changes in the cost of malpractice insurance, the number of physicians practicing, number of liability carriers, and the amount of pay-outs from liability carriers with respect to lawsuits. In states with 2,000 pages there is not one meaningful piece that will address the issue of medical liability reform.

This pilot program would show Congress and the American people how meaningful reforming medical liability will be, and that is the only reason I can assume the majority did not allow it to proceed.

The SPEAKER pro tempore. The gentleman from Texas is again charged to allow it to proceed.

Mr. SESSIONS. I would like to yield to the gentleman from Florida (Mr. Posey) for a unanimous consent request.

Mr. POSEY asked and was given permission to revise and extend his remarks.

Mr. POSEY. Mr. Speaker, I rise in opposition to this job-killing bill that the overwhelming majority of Americans don't want and don't need.

Madam Chair, I rise to express my deep concern about the specific provisions in the bill before us, but over the lack of transparency and openness throughout this process.

In just a few short hours, the U.S. House of Representatives will vote on the most sweeping changes ever in our nation's health care system. The final version of this bill, including last minute amendments, was made available to Members of Congress just a few short hours ago. The final text of this bill has not been made available to the public or Members of Congress for at least 72 hours.

I believe that when the Congress considers changes of this magnitude which will affect 17 percent of our entire economy, we should have more transparency and openness. I will be voting against H.R. 3962, not only because of the specific provisions I find objectionable, but also because of the lack of transparency about what it is specifically that we are voting on.

The House should not be considering or passing this 2,000-page bill which has not even been subjected to a single committee hearing. Over 200 amendments were filed to this 2,000-page bill. Sadly, out of these 200 amendments, only 1 is allowed to be offered.

Now, let me turn to some specific concerns with the bill. H.R. 3962 is the wrong prescription for our economy. Yesterday, the Department of Labor reported that the national unemployment rate hit a 26-year record high of 10.2 percent. Florida’s unemployment rate is 12.9 percent. Furthermore, as reported in this morning's New York Times, the broadest measure of underemployment and unemployment reaches 17.5 percent, which is higher than the record 17.1 percent reached at the height of the 1981 recession.

This is the wrong time to be considering legislation that will cost us jobs. The hundreds of billions of dollars of higher taxes and the un-funded mandates that H.R. 3962 places on small businesses will result in the elimination of between 4 and 5 million American jobs. That is the estimated job loss as measured using a formula developed by President Obama's own Chief Economic Advisor, Kathleen Romer. This would be in addition to the estimated 2.5 million jobs that would be lost if the Cap and Trade National Energy Tax legislation is enacted into law. (Estimated job loss by the Heritage Foundation.)

Small businesses across America create nearly 65 percent of all new jobs and this bill's 8 percent employer health care tax is only going to make it much harder for small businesses to create jobs. The H.R. 3962 provision to impose a $50,000 fine for inadvertent error will only serve to bankrupt many small businesses.

America cannot afford this bill. They cannot afford more legislation that will lead to higher unemployment. The American people need legislation that promotes job creation, not legislation that stifle the creation of American jobs.

H.R. 3962 is excessively costly and completely unaffordable. Washington just ended the year with a record $1.4 trillion debt. The Congressional Budget Office, CBO, estimates trillion dollar deficits as far as the eye can see. Our Nation's debt is so serious that in May the Secretary of the U.S. Treasury had to fly to China to ensure that the Chinese would continue to purchase our Treasury notes and to assure them that Washington would get serious about getting its fiscal house in order.

Sadly, this health care bill creates a new unaffordable entitlement program that we cannot afford and will indebted future generations of Americans for decades to come. CBO says of H.R. 3962 that it "would put into effect (or leave in effect) a number of procedures that might be difficult to maintain over a long period of time." In other words, this bill creates serious long-term budget problems for our Nation.

The President said in his September address to Congress and the Nation that health care reform legislation would not exceed more than $900 billion. Unfortunately, when you assemble all of the pieces of this health care agenda together, you come up with a price tag of nearly $1.6 trillion for the first 10 years of this bill—56 percent above the $900 billion cap. This includes CBO's $1.05 trillion cost estimate for H.R. 3962 and the $209 billion for the Medicare doctor fix. Further increasing the cost is the administration's proposed Medi- care+Choice program. This would cost more than $200 billion in discretionary spending required in the future as a result of H.R. 3962, and more than $34 billion in unfunded Medicaid mandates on the States ($1 billion for Florida as estimated by the State).

Furthermore, when you consider that the costs of H.R. 3962 begin to significantly increase in 2014, thus a more accurate 10 year cost estimate for the bill (2014-2024) shows a cost of $2.4 trillion. H.R. 3962 sets us up for serious budget challenges for 2020 and will indebted our children for decades to come.

H.R. 3962 will have an adverse impact on Medicare recipients. I am very concerned about the nearly $500 billion in cuts that H.R. 3962 makes to Medicare. This, I believe will have a long-term negative impact on Medicare. Taking the money out of Medicare only makes the challenge of averting Medicare's projected 2017 insolveney more difficult. Furthermore, those hardest hit are likely to be seniors enrolled in Medicare Advantage, MA, plans, including over 42,000 seniors in my congressional district who are enrolled in MA plans. Many of these seniors would lose their current Medicare plan and be forced back into the traditional Medicare fee-for-service plan, which will cost them more money and less coordination of their care.

Failure to buy government approved plan can result in lines and jail time. A November letter from the Joint Committee on Taxation affirmed that if an American citizen fails to purchase a government approved health care plan or pay the mandatory 2.5 percent national health care tax, they will be subject to Federal penalties which may include up to 5 years and a fine of up to $25,000. It is simply unthinkable that Washington would enact legislation carrying such mandates and penalties, but that is what H.R. 3962 would do. Such coercion is wrong and quite frankly runs counter to the freedoms and liberties that have made this Nation what it is today.

The American people should be allowed to choose whatever health care plan they want. They should not be restricted to only buying health insurance that Congress or an unelected group of bureaucrats say you can buy.

The word "shall" is included more than 3,400 times throughout H.R. 3962. Shall is a term used in legislative language to mandate what can or cannot be done. With the use of the word "shall" more than 3,400 times, the choices and liberties of people to choose what they want are clearly undermined. Clearly, these mandates seriously undermine and change the health care that 80 percent of Americans have today and want to keep.

Illegal Immigrants Covered Under H.R. 3962. It is wrong to use taxpayer dollars to subsidize the enrollment of illegal immigrants into this new government plan. While H.R. 3962 includes language stating that funding cannot be used to enroll illegal immigrants in the national health care plan, the nonpartisan Congressional Research Service, CBO, and the Social Security Administration all agree that the provisions in H.R. 3962 are insufficient to actually prevent their enrollment. Subsidies for illegal immigrants will receive taxpayer subsidies for enrollment in subsidized health care plans.

Other Concerns. The American people were warned earlier this year that health care reform legislation would lower their average health care costs by about $2,500. H.R. 3962 does just the opposite. Estimates by the Joint Committee on Taxation, the CBO, and six other
studies show that imposing new taxes on insurance policies, as H.R. 3962 does, will drive up the cost of medical coverage.

We were told that health care reform was needed in order to lower the overall amount of spending on health care. However, according to the CBO, during the decade following the 10-year budget window, the bill would increase both federal outlays for health care and the federal budgetary commitment to health care, relative to amounts under current law. So, H.R. 3962 will actually result in more spending on health care rather than less.

I opposed H.R. 3962 in H.R. 3962, which would use taxpayer dollars to pay for elective abortions and subsidize enrollment in health insurance plans that pay for elective abortions. H.R. 3962 would for the first time use taxpayer dollars to subsidize elective abortions and expand mandate that insurance coverage of elective abortion be expanded to every jurisdiction in the country. I oppose this mandate, but I am supportive of the Stupak/Smith amendment, which will remove from this bill any expansion of taxpayer funding for abortions.

Health Care Solutions. I was greatly disappointed that the debate in the House was so severely restricted as only 1 of more than 200 amendments was allowed. This is truly a sad day for the American people as constructive options to health care reform have been silenced.

We should focus on creating more choices for the American people, not less. Rather than move in the direction of more choices and increased competition, H.R. 3962 undermines choice in many ways. By creating a national Health Benefits Advisory Committee, HBAC, H.R. 3962 creates a one-size-fits-all set of benefits with which every health plan in America must conform. Estimates are that millions of Americans will be moved into this new government health care plan, losing the coverage that they currently have and want to keep.

There are steps that can be taken—without reducing these choices—to address the concerns of those who lack coverage or who have difficulties paying for the coverage they want. We should move in the direction of greater deductibility of health insurance for all Americans. Refundable health care tax credits of $2,500 for an individual or $5,500 for a family will enable working Americans to secure affordable health care coverage and empower them to choose the type of coverage that meets their needs.

Enactment of Association Health Plan, AHP, legislation would make it easier for small businesses to pool together and negotiate with insurance providers for the purchase of more affordable insurance for their employees. Simplicity, choice, and the deductibility of health insurance for all Americans. Refundable health care tax credits of $2,500 for an individual or $5,500 for a family will enable working Americans to secure affordable health care coverage and empower them to choose the type of coverage that meets their needs.

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My Republican friends see things differently. Their prescription for health care is “take two tax breaks and call me in the morning.” It is the same-old same-old. For 12 years, Republicans had their chance to improve health care in America, and for 12 years they let the Affordable Health Care for America Act stall, before the sistrocket, while letting the insurance companies make money hand-over-fist.

Those who vote against this bill are on the wrong side of history. With the passage of this bill, we stand for the real people. Vote “yes” on this rule. Vote “yes” on this bill. Let’s deliver real health insurance reform for the American people.

Mr. Speaker, this is an historic moment. I urge my colleagues to stand with the people of this great country: not with the insurance companies and not with the special interests, but with the real people. Vote “yes” on this rule. Vote “yes” on this bill. Let’s deliver real health insurance reform for the American people.

Mr. Speaker, this is a remarkable, historic moment. Passage of health insurance reform is a “Franklin Roosevelt” moment, right up there with the creation of Social Security.

We have debated this issue for almost 100 years, since Teddy Roosevelt ran on the Bull Moose Party. This year alone, House and Senate have spent the better part of 100 hours in hearings on health reform. They have heard from 181 witnesses, spent 83 hours in committee markups, and considered 239 amendments. The Rules Committee spent almost 12 hours hearing testimony last night. This has been a very thorough and thoughtful process. The time for talk has come to an end. Now is the time for action.

The need for reform is clear. Since 2000, employer-sponsored health insurance premiums for American families have more than doubled. Because of crushing health care costs, small businesses are losing their ability to compete in the global marketplace.

The state is experiencing major budget difficulties without having to fund additional federal mandates. The budget for the current fiscal year was reduced before FY’10 budget. A severe revenue shortfall has forced us to further reduce agency budgets for FY’11 by another 5%. If revenue does not improve, a larger cut may be required. We will have a better idea when October revenue data becomes available later this week. A large cut may be called for in order to keep from overspending from the Rainy Day Fund as well. This proposal leaves a $150 million budget gap in FY’11 from Rainy Day alone.

The state will most likely face a continued reduction in revenues in FY’11. The FY’11 budget assumptions most likely will include spreading the last of the Education and Medicaid Stimulus funds as well as Rainy Day funds in order to maintain current levels of services.

The FY’12 outlook is even more dire as the absence of Stimulus and Rainy Day funds will have a significant impact on the budget. The absence of stimulus funds will be most apparent in the Medicaid program, where over $400 million was used in FY’10 and over $500 million will be used just to maintain current services in FY’11.

Unfortunately, this comes with a price for state governments.

As your representative in the Fourth District of Oklahoma, I take very seriously your input when it comes to matters involving unfunded mandates and other policy shifts. Before I vote on this legislation, I would appreciate your insight on some important issues.

It would seem from the text of this bill and the CBO report that it creates an unfunded mandate in the amount of $39 billion from 2010-2019 by increasing Medicaid costs to the States. I am concerned that this might present some budgetary challenges for the State of Oklahoma, and I am therefore turning to you to ask your assistance in answering the following questions:

Can Oklahoma afford these unfunded mandates in the current fiscally constrained environment?

Should the House version of health care reform pass, what are your plans for fully funding the unfunded mandate that will be transferred to Oklahoma?

Would new taxes on the citizens of Oklahoma be necessary to cover the increased costs of Medicaid?

What do you believe the actual cost would be to Oklahoma?
just our state, but for every state in the nation. Certainly, there will be no good answers for state leaders facing these unfunded mandates. As a former state senator yourself, I know as well as anyone the fiscal crisis facing the states in today’s economy. No state in the nation can sustain the financial hit they are about to experience. Fortunately, you take a lead conservative and are aware of the practices we engage in here in Oklahoma, our situation, while dire, may not be as severe as many other states, but that’s small comfort, with the realities we face today. Indeed, factoring in the added load of Federal legislation further burdening our economy, I fear for the long-term future for the hard-working taxpayers of our state.

We will be watching with great interest as you fight the good fight in Washington. Please, let’s keep the lines of communication open as this process unfolds.

With best regards,

GLENN COFFEE,
President Pro Tempore,
Oklahoma State Senate.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,

Hon. CHRIS COLE,
Speaker of the House of Representatives, State Capitol, Oklahoma City, OK.

DEAR SPEAKER BENGE: As you know, yesterday, Speaker Nancy Pelosi and Majority Leader Steny Hoyer, and Representative John Dingell introduced H.R. 3962, the “Affordable Health Care for America Act”. This 900 page bill is an attempt to reorganize the entire health care system in the United States to cover more Americans. Unfortunately this comes with a price for state governments.

As your representative in the Fourth District of Oklahoma, I take very seriously your input when it comes to matters involving unfunded mandates and other policy shifts. Before I vote on this legislation, I would appreciate your insight on some important issues.

It would seem from the text of this bill and the CBO report that it creates an unfunded mandate in the amount of $34 billion from 2015-2019 by increasing Medicaid costs to the States. I understand that there may present some budgetary challenges for the State of Oklahoma, and I am therefore turning to you for your assistance in answering the following questions:

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Should the House version of health care reform pass, what are your plans for fully funding the unfunded mandate that will be transferred to Oklahoma?

Would new taxes on the citizens of Oklahoma be necessary to cover the increased costs of Medicaid?

What do you believe the actual cost would be to Oklahoma?

Before we begin final consideration of this legislation, your thoughts on these matters would be extremely helpful to me. Unfortunately, the scheduling of this legislation is dynamic, and a vote on it could come as early as Thursday. All indications lead me to believe you will have no opportunity to offer amendments to this legislation.

Therefore, before I vote on this legislation, I would ask for your insight on these matters.

Sincerely,

TOM COLE,
Member of Congress.

Hon. TOM COLE,
Member of Congress, Rayburn House Office Building, Washington, DC.

DEAR CONGRESSMAN COLE: Thank you for the opportunity to share my insights regarding the Medicaid expansions contained in the “Affordable Health Care for America Act” (H.R. 3962). Not surprised, these expansions would represent significant unfunded mandates on the state of Oklahoma.

The Oklahoma Health Care Authority, which is in charge of administering the state’s Medicaid program, has estimated a preliminary amount of $128 million if the federal health care legislation becomes law. This estimate does not account for decreased federal support of the Medicaid expansions in later years, which inevitably will shift an increasing financial burden to this state as well as others. Oklahoma already is experiencing difficulty funding its current Medicaid program due to revenue shortfalls as a result of the national recession and decreased natural gas prices. Revenue collections to the state in the first quarter of FY-10 trailed last year’s collection by 29.5 percent. State agencies, on average, experienced an initial budget reduction of 7 percent when compared to FY-09. Agencies are expected to see 5 percent cuts in their monthly allocations for the remainder of the fiscal year. Even deeper cuts may be necessary if future revenue streams continue to fall.

In the current economic environment, Oklahoma is struggling to maintain core services for its citizens. And that is before the ramifications of this federal health care policy and its unfunded mandates are even considered.

American Reinvestment and Recovery Act (ARRA) federal stimulus funds have been employed and are budgeted to offset declining revenue in FY-10 and FY-11. These funds will no longer be available for FY-12 and beyond. Though some economic indicators suggest that revenues may be stabilizing, no firm indicators signal that state revenue can be expected to improve in the near future. Without economic growth, Oklahoma is left with two options to replace current stimulus funds: raise revenue through tax increases or institute deep budget cuts.

Like you, I find the idea of tax increases, even if they weren’t incredibly difficult to pass under our state’s Constitution, in an economic downturn. In tough economic times, increasing taxes on work and productivity is counterproductive and takes more money out of the hands of Oklahomans and Americans when they need it the most. So with tax increases off the table, we will have no choice but to drastically cut government services to free up funds to pay for the unfunded mandates passed onto us from the federal government.

Our state is already experiencing significant budget challenges and the added burden of ARRA unfunded federal mandate would lead to further budget cuts, jeopardizing existing state programs and services developed for Oklahomans by Oklahomans.

In Oklahoma, we have put in place market and consumer driven reforms that are working to lower state’s uninsured costs for private insurance, all while improving access to affordable health care for all of our citizens. I urge Washington to give states the maximum amount of flexibility possible to craft a health care plan that best meets individual state needs. A one-size-fits-all health care policy is not the answer for Oklahoma, or our country as a whole. I know we have an advocate in you and your fellow federal delegates, but I would like to urge you to vote ‘no’ not only on behalf of what this legislation may do to our country, but the disastrous financial burden it will also place on our state.

Sincerely,

CHRIS BENGE,
Speaker, Oklahoma House of Representatives.

The SPEAKER pro tempore. The gentleman from Texas (Mr. MILLER) for a unanimous consent request.

Mr. MILLER of Florida asked and was given permission to revise and extend his remarks.

Mr. MILLER of Florida, Mr. Speaker, this job-killing bill cuts Medicare, piles debt on our children, raises health care costs, and raises taxes on the American people.

The SPEAKER pro tempore. The gentleman from Texas is again charged time.

Mr. SESSIONS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, we are here on the floor today to debate the greatest job-kill takeover of health care in America. We understand that this bill is about a massive tax increase, $740 billion. We understand it is about deep Medicare cuts, some $150 billion. We also understand that millions of jobs will be lost and that mandates for purchasing insurance will cost an incredible $1.2 trillion, and there will be 118 new Federal bureaucracies created by this legislation.

The gentleman from Massachusetts came down and talked about the evil insurance companies. Well, the fact of the matter is that the largest six insurance companies in this country made about $6 billion 2 years ago, but the Federal Government in their mismanagement lost $90 billion. Mr. Speaker, we know who can best take care of the health care for our country.
up before Rules last night. He admitted to the Rules Committee that he had not asked the CBO or any other independent source for employment implications of this bill. Yet Republicans, using the same economic forecasts and economic projections, found the White House projections, we find that there would be between 4 and 5 million free enterprise-system jobs that would be lost.

During a time of recession where every single American is trying to make ends meet, do we find that we find $730 billion in new taxes that are on this bill. Taxes on small businesses, taxes on health savings accounts, and the worst part is that this will surely lead to a double dip in the recession. This is a problem not only for employers, but it will be a problem for people who want to find jobs.

Mr. Speaker, this is a hard mandate on business, and it means that the free enterprise system will simply not employ more Americans. We’re concerned about this. We Republicans are on the floor today, and we’re going to stand and say “no” to what is happening.

Mr. Speaker, the bottom line is that this is the health care debate about for health care what the stimulus did for jobs, the diminishment of employment in America.

I reserve the balance of my time.

Mr. Speaker, I yield 2 minutes to the gentleman from Florida (Mr. HASTINGS), a member of the Rules Committee.

Mr. HASTINGS of Florida. Distinguished chairwoman and distinguished spokesperson so that our country’s senior states learned about for health care what the stimulus did for jobs, the diminishment of employment in America.

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not include the fatal flaw in the Democratic bill—massive tax increases on small businesses; tax increases and regulations that will kill jobs.

The Republican alternative allows small businesses to pool together, allows people to buy insurance across State lines. According to the Congressional Budget Office, it actually brings down the cost of health care premiums.

The Democrats’ bill will raise taxes, according to CBO by over $750 billion and cut Medicare by approximately $500 billion. It will make much worse our economic situation, increase unemployment, take the country in the wrong direction at a time when unemployment is already over 10 percent.

Especially, Mr. Speaker, when you consider that there is a bipartisan consensus in this Nation on the need to increase access to health insurance to those who do not have it today; it is sad that this destructive legislative product is being brought to the floor.

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes to the gentlewoman from Maine (Ms. PINGREE), a member of the Rules Committee.

Ms. PINGREE of Maine. Mr. Speaker. I am honored to be here in your presence today and to be here with my colleagues; I thank the gentlewoman from New York for allowing me this time. I am so proud to be here casting the vote that so many of my constituents have waited way too long for. There has been a lot of hard work, a lot of facts and figures that have gone into the discussion of this important piece of legislation before us, and certainly over the last 10 months that I’ve been here. I want to spend my time talking about the story that is always on my mind when I’m talking about health care and is certainly on my mind today.

As a young father, my brother was diagnosed with malignant melanoma, a disease that I hope no one else ever has to face or face in a loved one. He had recent history to stay away from us, and certainly over the last 10 months that I’ve been here. I want to spend my time talking about the story that is always on my mind when I’m talking about health care and is certainly on my mind today.

That would be a very sad story if it had been 2 years ago, but in fact, my brother’s death was 20 years ago, and back then we talked about the importance of making sure that no one was ever denied insurance because they had a preexisting condition. We talked about the fact that no one should have to go into personal bankruptcy or be poor because they don’t have health care insurance.

I am here today, looking forward to casting my “yes” vote on this rule, on this health care bill, in the memory of my brother and of so many of my constituents and their families who have suffered through exactly the same thing, because I believe that this bill moves us much closer to a time when no one can be denied health care coverage because of a preexisting condition; no one can be told you can’t have health care coverage; no one will have to go into personal bankruptcy. I am here in the memory of my brother.

There can be no more delay.

Mr. SESSums, Speaker, I appreciate the gentlewoman’s story. The other side of the story is that it will be $730 billion worth of taxes, that we will have a health care system where you will not be able to choose your own physician, where you will have to call someone to then find out which doctor you go to, and perhaps worst of all, the gentlewoman also needs to know—because we heard in the Rules Committee last night—if you willingly make the decision that you do not want to participate and you do not pay the tax to the IRS, there is a penalty and a fine that is a criminal penalty of up to 5 years in prison and up to a $250,000 fine. That is not freedom.

Criminalizing this issue is a bad way. Mr. Speaker, the Democrats have it on the floor today. It is not in the Senate bill. It is in this bill. So to glorify this bill which has criminal felony penalties is a difficult way to have enforcement.

Mr. Speaker, at this time I would like to yield 1 minute to the gentlewoman from Miami Township, Mrs. SCHMIDT.

Mrs. SCHMIDT. Mr. Speaker, the Democrats’ bill will raise taxes, and they do not include the fatal flaw in the Democratic bill, a better bill, a bill that avoids a government takeover of health care, a bill that costs less and reduces the budget deficit by $100 billion. A bill that we can be proud of.

We fought to protect Medicare, and we’re giving our seniors a bill that immediately closes the Medicare Part D doughnut hole and strengthens Medicare.

I personally took on the cause of small businesses, the economic engine of the American economy and job growth, many of which can’t afford to provide coverage today. These businesses are the entrepreneurs and innovators on which the future of our economy depends.

I’m happy to say this new bill raises the threshold for the surcharge to a million dollars in income for most small businesses, significantly reducing any impact while giving small businesses access to the exchange which provides them the same buying power that large corporations enjoy. I remain hopeful that through the conference process, we can further reduce or eliminate the small business surcharge while preserving the savings for individuals and small businesses.

My constituents said to include tort reform and interstate competition, and their voices have been heard. And I’m proud to say this bill provides for insurance companies competing across State lines through interstate compacts and includes reforms to reduce defensive medicine.

This summer Americans in every district in this country spoke out about the crisis. We listened. We took their ideas to heart and brought them to Washington. This bill was written by patriots across our great Nation, and I urge my fellow Members to join me in proud support of this bill.

Mr. Speaker, at this time I yield 1 minute to the distinguished gentleman from Fullerton, California (Mr. ROYCE).

Mr. ROYCE. Mr. Speaker, I think all in this Chamber agree that health care costs continue to weigh heavily on Americans. But, unfortunately, this trillion dollar government takeover will make matters worse.
Medicine will be rationed via politics under this act. The cost of private insurance for those not getting the government subsidy will undoubtedly skyrocket. It’s going to potentially double for a lot of people.

Economists of all political affiliations will tell you that the greater government’s thumb, the greater government’s role in health care, the more the bureaucracy that’s going to come out of it, the higher it’s going to drive costs. And this bill would create a costly new entitlement dominating the market and it’s about an unsustainable debt that’s added to the future.

We can take steps to bring greater choice and competition to health care. But, this bill is about government intervention dominated by government decision making.

Today’s vote will mark an epic turn- on job growth, economic efficiency, and lowering the rates of disability.

We’ve heard how long our country has waited to get a bill like this. We’ve heard it’s been too long for the 14,000 Americans a day who lose their health care coverage. Too long for the millions of us who are deemed uninsurable because we have a preexisting condition.

Our bill will provide assistance to small businesses. Small businesses in my district have asked over and over again for help with the crushing cost of insurance and for solutions of their health problems that small groups have in obtaining insurance. Small businesses will see a great deal of help and support in this bill, and large businesses as well because they will be able to contain the costs of their health premiums, which over the years, as employers know, keep increasing at double-digit rates of inflation.

Our bill has features that will improve efficiency in the labor market, improve workplace productivity, and lower the rates of disability.

Today’s vote will mark an epic turn-on job growth, economic efficiency, and the budget deficit.

This bill will: eliminate the insurance company practice of denying coverage based on pre-existing conditions; close the prescription drug donut hole and save money for our seniors; cap out-of-pocket expenses; and make insurance more affordable and accessible.

I was an early supporter of this bill placed too much of the financial burden on families and small businesses in my district. I also heard from my constituents that it did not do enough to contain costs.

I have appreciated the opportunity to weigh in with those concerns, and I am pleased to see them addressed in the bill we have before us today. The thresholds for the income surcharge have more than doubled, saving thousands of working families and small businesses in Northern Virginia and elsewhere from higher taxes.

The legislation before us today will provide insurance coverage to 96 percent of all Americans, reduce long-term premium costs for families and small businesses, and bring down the federal deficit by more than $100 billion. I will support legislation that does those things. I voted for this bill.

Mr. Speaker, I rise today in opposition to this rule and the underlying bill. Small businesses have struggled for years to obtain affordable health insurance for their employees. However, rather than embrace solutions that enjoy the unanimous support of the small business community, this bill takes a government-heavy approach that falls in its goal to make health insurance more affordable. What is more unfortunate is that the bulk of the funding for the health care bill is balanced on the backs of small business owners and their families.

I offered an amendment to the Rules Committee to provide relief to these job creators by striking the mandate and tax on employers, but my fight fell on deaf ears.

The tax increases included in this bill are job killers, plain and simple. At a time when our Nation’s unemployment rate exceeds 10 percent for the first time in 26 years, the first goal of this body should be improving the economy and creating jobs.

Real solutions exist to the problem of affordable health care. This bill is not that solution, and I would urge my colleagues to vote against the rule and this bill.

Mr. Speaker, after months of spirited debate in thousands of meetings, letters, phone calls, and e-mails with my constituents, I am proud to stand here today and pledge my support for meaningful health insurance reform that will improve the quality of care and quality of life for virtually every family in my district, while reducing the deficit by more than $100 billion.

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Ms. Slaughter. Mr. Speaker, I yield 2 minutes to the gentlewoman from Ohio (Ms. Kilroy).

Ms. Kilroy. Mr. Speaker, I rise to address some of the claims made by the other side of the aisle that the Democratic health care bill will cost our economy jobs. In fact, as noted in the June 2009 Council of Economic Advisers’ report, our legislation will most likely have a positive impact on job growth, economic efficiency, standards of living, and the budget deficit.

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Our bill will provide assistance to small businesses. Small businesses in my district have asked over and over again for help with the crushing cost of insurance and for solutions of their health problems that small groups have in obtaining insurance. Small businesses will see a great deal of help and support in this bill, and large businesses as well because they will be able to contain the costs of their health premiums, which over the years, as employers know, keep increasing at double-digit rates of inflation.

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Our bill has features that will improve efficiency in the labor market, improve workplace productivity, and lower the rates of disability.
Mr. HEINRICH. Mr. Speaker, during the past few months, we have seen a vigorous and at times emotionally charged debate about how to fix our broken health care system. I spent the last several months conducting an aggressive and thorough health care listening tour across the First Congressional District of New Mexico. Just last week I held a telephone town hall with nearly 10,000 seniors in my district to discuss how reforming the health care system strengthens Medicare.

Six principles have guided my work and determined my vote on this legislation: health insurance reform must create stability, contain costs, guarantee choice, improve quality, cover everyone, and include a strong public option.

The Affordable Health Care for America Act delivers on each of these principles, and it does so without adding a penny to the deficit. This bill will provide greater competition for insurance companies, give Americans affordable coverage, choice, and stability that they can count on.

I urge my colleagues to vote in favor of H.R. 3962.

Mr. SESSIONS. Mr. Speaker, I know that Republicans in our districts are also telling seniors and other people that there will be a $700 billion tax increase to pay for this massive government takeover of health care.

Mr. Speaker, at this time I yield 1 minute to the gentleman from Marietta, Georgia (Dr. GINGREY).

Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, I rise in opposition to the rule and unequivocal opposition to the underlying government takeover of the American people's health care. When I appeared before the Rules Committee last night, I heard the chairman designee say that the changes to bring us these 2,000 pages that were enacted in the middle of the night will be minimis changing. Going from a thousand pages to 2,000 pages is hardly de minimis. And what I noted, of course, was of the 20 Republican amendments that had been approved in committee, only five remained and none of mine.

So, Mr. Speaker, I've brought forth amendments that the American public has told me that they want, such as that every Member of Congress, if the government option is so good, they ought to join it; amendments such as medical liability reform, and the CBO has told us, Mr. Speaker, that it would save $54 billion; amendments such as no cuts to Medicare unless you keep that money in the Medicare system, which has a $35 trillion unfunded mandate; and finally no individual mandates on our young people who can ill afford it. It is unconstitutional.

Ms. SLAUGHTER. Mr. Speaker, I reserve the balance of my time.

Mr. Speaker, at this time I would like to yield 1 minute to the star of the Texas delegation from Dallas, Texas (Mr. HENSARLING).

Mr. HENSARLING. Mr. Speaker, since the President and the Democrats took control of Congress, they have passed a $1.1 trillion stimulus plan, a $410 billion omnibus spending plan, they have passed appropriations bills that have increased spending 10, 20, 30 percent. They have remaining in their first trillion-dollar deficit in our Nation's history. They passed a budget that will triple—triple—the national debt in the next 10 years. And now today, a $1.3 trillion government takeover of our health care system.

Mr. Speaker, you cannot improve the health of a nation by bankrupting its children. There are a trillion reasons, a trillion reasons, to defeat this government takeover of our health care system. Let me give you one more: government control is the rationing of our health care.

Think about your loved ones. Think about your constituents. Think about anybody you know. Reject this trillion-dollar takeover of our government health care.

Ms. SLAUGHTER. Mr. Speaker, may I inquire of my colleague how many speakers he has remaining?

Mr. SESSIONS. Mr. Speaker, I appreciate the chairman of the Rules Committee asking about our further speakers. We have several speakers left before I would close.

Ms. SLAUGHTER. Then I will continue to reserve.

Mr. Speaker, this bill is a tragedy, and to be talking about how to fix our broken health care system last night were de minimis changing. Going to the gentleman from Roanoke, Virginia (Mr. GOODLATTE).

Mr. GOODLATTE. Mr. Speaker, I rise in strong opposition to this unfair rule and the underlying bill, and in support of the Republican substitute.

This bill is so wrong that it's going to be taking it up a day after the unemployment figures were released that showed 10.2 percent, 15.5 million Americans out of work, the highest number in American history, and when you add in those who are underemployed, one out of every six Americans is looking for more work.

That means that the average American can look out from their home, their neighbor to their left, their neighbor to their right, and nearly everyone in their own home, and they will see at least one person who is looking for more work or who is completely unemployed. And the same day a report came out showing that this legislation will cost up to 5.5 million more jobs. It is an outrage and why this legislation should be opposed.

Don't let this 2,000-page, 400,000-word, job-killing, tax-increasing, bureaucratic legislation fall on your job.

Ms. SLAUGHTER. Mr. Speaker, I continue to reserve.

Mr. SESSIONS. Mr. Speaker, at this time I would like to yield 1 minute to the gentleman from Savannah, Georgia (Mr. KINGSTON).

Mr. KINGSTON. Mr. Speaker, in January, with 8.5 percent unemployment rates, Speaker PELOSI passed an $800 billion pork-laden stimulus bill. In May, unemployment goes to 9.5 percent and we get a 2% property tax of $1,500 per household. Now, November, unemployment is over 10 percent and we are about to pass a $1 trillion government takeover of health care. It raises premiums, it raises taxes. It cuts Medicare.

Mr. Speaker, America does not need a government takeover of health care; we need jobs. If your kitchen sink is leaking, you fix the sink; you don't take a wrecking ball to the entire kitchen. This bill is a wrecking ball to the entire economy.

We need targeted, specific reforms to help people who have fallen through the health care cracks, and we have a lot of bipartisan support for that, and I urge my colleagues to vote in strong opposition to this unfair rule and the underlying bill. We have against this monstrosity Vote “no.” Let's start all over and do it right.

Ms. SLAUGHTER. Mr. Speaker, I continue to reserve.

Mr. SESSIONS. Mr. Speaker, I continue to reserve.

Mr. KINGSTON. Mr. Speaker, there is so much wrong with this bill it is impossible to cover in 90 seconds, so let me focus on one aspect.

Yesterday we learned that unemployment has reached 10 percent in this country. Can you imagine being a small businessman and deciding whether or not you are going to hire new employees when you face the prospect of an 8 percent tax if you are not providing the kind of health care coverage that this bill envisions. An 8 percent tax. And depending on the kind of business you have, if you are a Sub S corporation, for example, you could face an additional 5.4 percent surtax on top of that. Are you going to hire more people? Not a chance. Unemployment will get worse.

We are in a deep economic hole, Mr. Speaker, and the first rule should be, stop digging. Yet here we have doubled down, and we are trading in our shovel for a backhoe, and we are saying we are going to dig faster and deeper. To what end? What are we saying to people out there? That jobs aren't important? That we don't care because we just have to pass this legislation?

We ought to have more responsibility than that.

Ms. SLAUGHTER. I continue to reserve.

Mr. SESSIONS. Mr. Speaker, the gentleman from Arizona is correct. This bill is as much about health care as the stimulus package was about jobs. It is to bust the free enterprise system, and for all of the control of health care to go to the Federal Government. I get it, and I assure you, the American people get it, also. And we
will give our friends, the Democrats, all of the credit for what they are doing. Mr. Speaker, at this time I yield 1 minute to the distinguished gentleman from Florida (Mr. STEARNS).

Mr. STEARNS. Mr. Speaker, let me ask the Democrats, why did you do this in a health care bill? In section 340N, called Public Health Workforce Loan Repayment Program, it is going to cost the government taxpayers $283 million over 5 years because you are forgiving loans for veterinarians. So the real question I have for you folks: Why are veterinarians part of this health care bill?

When you go to section 555, Second Generation Biofuel Producer Credit, you remove the eligibility for tax credits for biofuels. My question again: What do biofuels have to do with health care? I would like the gentlelady from New York to answer why veterinarians are included in this bill in terms of loan forgiveness and why you are creating a brand new tax on biofuels when it is not necessary. In fact, this is a gift for the biofuel producers.

Are you happy with the health care system the way it is? You won’t be happy with the new Health Care Czar described in this bill. This is a bad bill for the American people. Vote against the rule.

Ms. SLAUGHTER. Mr. Speaker, I am going to yield myself 30 seconds because I need to answer Mr. STEARNS.

Mr. STEARNS asks why are the veterinarians covered. Have you ever heard of swine flu? Have you ever heard about food safety? Have you ever heard that the majority of all antibiotics produced in the United States are given to cattle and poultry even though they are not ill? But swine flu should make you worry a little bit, don’t you think?

I want to spend the rest of my 30 seconds saying this morning we have heard all kinds of nonsense about the things that will happen from this bill. This bill does not add one cent to the deficit certified by the CBO. In fact, it reduces it.

Mr. SESSIONS. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from Nashville, Tennessee (Mrs. BLACKBURN) a member of the Energy and Commerce Committee.

Mrs. BLACKBURN. Mr. Speaker, I thank the gentleman from Texas and I rise in opposition to this rule, and I encourage my colleagues to stand in opposition to this rule.

The reason is this is not what the American people want to see in health care reform. It is not what my constituents want to see in health care reform. There are some very, very tangible reasons. This is a wrong step for America. This bill costs too much. It is too expensive to afford.

Look at what happened to my home State of Tennessee with the test case for public option health care. The cost not only doubled, not only tripled—it bankrupted. It nearly broke the State. Our State is on the verge of bankruptcy. We had a 4-year battle over a State income tax to pay for this. Who do you think is going to pay for this bill? This is too expensive to afford. What you are doing is fundamentally changing the future of our children, our grandchildren, and our great-grandchildren to pay, to pay for federalizing, nationalizing government control of health care.

Let’s oppose the rule and take it down.

Ms. SLAUGHTER. Mr. Speaker, 68 percent of Americans want this bill very seriously, and I am pleased to yield 1 minute to the gentleman from Wisconsin (Mr. KAGEN).

Mr. KAGEN. Mr. Speaker, I thank Chairwoman SLAUGHTER for this opportunity to speak on behalf of this rule, a rule that will guarantee that we will get an opportunity to pass legislation to help everyone in Wisconsin that I represent. This rule that will help everybody that I have cared for as a physician for the past 33 years.

What are we doing? We are fixing what is broken, we are improving on what we already have, and making certain that all of us can afford to pay. We are putting patients first. We are putting patients first so no longer will a family lose their home and go bankrupt simply because their children become sick and they can’t afford their health care bills.

We are putting patients first by reforming the rules, reforming the rules by making sure that we are going to close the doughnut hole in Medicare part D, and making certain that we are going to have mandatory practice rules to guarantee that patients and their doctors can decide their decisions amongst themselves. We are putting people first because people are more important than corporate profits.

Mr. SESSIONS. Mr. Speaker, I would like to yield 1 minute to the distinguished gentleman from Beaumont, Texas (Mr. POE).

Mr. POE of Texas. Mr. Speaker, we debate the public option legislation about health care, but we forget the obvious. This massive government takeover of our health care still allows the 20 million people in this country that are illegally here to get one of those fake Social Security cards without benefit of even a photo ID and get some of that free government health care that everybody else has to pay for.

We need to fix that problem, and we need to fix some other problems, but don’t turn the Federal Government loose on the health care of America. This bill costs too much, $700 billion in new taxes, and citizens and legal immigrants are going to get stuck with the bill with poor health quality and health care.

And that’s the way it is. Ms. SLAUGHTER. Mr. Speaker, that’s not the way it is. There are no illegal aliens in this bill who get anything at all.

I am pleased to yield 30 seconds to the gentleman from Georgia (Mr. JOHNSON).

Mr. JOHNSON of Georgia. Mr. Speaker, I rise today to support the rule and the underlying legislation. I want everybody to look into their heart of hearts, their conscience, the loneliness of the recesses of their consciousness, and in that moment you know that all Americans deserve health care, not just the rich and wealthy. What we are doing today is giving that to the average American.

I support the rule and the underlying legislation.

Mr. JOHNSON of Georgia. Mr. Speaker, I rise today to support the rule and the underlying legislation, H.R. 3962, the Affordable Health Care for America Act. I would like to thank Chairman RANGEL and Chairman WAXMAN, for their leadership and hard work in bringing this important legislation swiftly to the floor. Your efforts are commendable and will benefit all Americans.

Mr. Speaker, today I and many of my colleagues will take a historic step in favor of extending quality affordable health insurance to millions of Americans. This is a moral question as well as a financial question. When this bill becomes law, 96 percent of Americans will have access to primary care doctors, prescription drugs, and preventive services. When this bill becomes law 96 percent of Americans will no longer have to worry about choosing between their or their children’s health and other essentials like food and shelter. If that were not enough then I remind my colleagues that the Congressional Budget Office says that this bill will reduce the national debt. The status quo is no longer acceptable.

I urge my colleagues to stand today on the right side of history as this Congress takes the first step in bringing the security of affordable health insurance to millions of people. Congress and the public have had ample opportunity to review, comment on, and improve upon the health reform legislation that we will vote on today. During the month of August, many Members of Congress, including myself, held town hall meetings. During my town hall meetings I heard testimony from constituents across the Fourth District and from across the political spectrum. I considered the views of everyone who wishes to speak their opinion and to the consideration that the thousands of my constituents—and the millions of Americans—without health insurance could no longer wait. I ran for Congress on a pledge to take care of home and I believe that there is no better way to take care of home than to ensure that all of my constituents and all Americans have access to quality affordable health care.

I have advocated—consistently and strongly—for the inclusion of a public option in health reform legislation. While my preference remains the more robust version of the public option, H.R. 3962 contains a public option that will create competition in the insurance market to drive down costs for everyone, including the Federal Government.
Mr. KING of Iowa. I thank the gentleman from Texas for yielding. 

Mr. Speaker, I would first say, as the gentleman from Georgia stated, all Americans deserve the benefit that all Americans have health care, every single one. Eighty-five percent of us are insured and 85 percent of us are happy with the policy that we have.

The President has made two arguments in favor of the public option. One is that the public option would ensure that all Americans have health care, America costs too much money.

What’s your solution? Spend another $1.5 trillion. Too much money, throw another $1.5 trillion at it. That’s upside down. What is the simplest part of logic that you don’t understand?

Second thing, too many people in America are uninsured, 47 million. Well, subtract from that 47 million illegal aliens which will be funded under this bill, immigrants, those that qualify for Medicaid and other government programs, and you’ve got people that make over $75,000 a year, now you’re down to really only 12.1 million Americans who are without affordable options. That is less than 4 percent of America. And for that you would throw out the liberty of America, destroy the baby with the bathwater of the best health insurance industry in the world, the best health care delivery system in the world, destroyed by a desire to create a dependency society to steal our freedom.

Ms. SLAUGHTER. Mr. Speaker, I yield to the gentleman from New York for a unanimous consent request.

Mr. ACKERMAN asked and was given permission to revise and extend his remarks.

Mr. ACKERMAN. Mr. Speaker, I rise in support of the rule and in strong support of the bill.

Mr. Speaker, I rise on this historic day in strong support of the Affordable Health Care for America Act, H.R. 3962. One of the reasons I voted for the baby folks, that’s why we’re here. We must provide health care for all Americans, uninsured, other government programs, those that qualify for Medicaid and other government programs, and you’ve got people that make over $75,000 a year, now you’re down to really only 12.1 million Americans who are without affordable options. That is less than 4 percent of America. And for that you would throw out the liberty of America, destroy the baby with the bathwater of the best health insurance industry in the world, the best health care delivery system in the world, destroyed by a desire to create a dependency society to steal our freedom.

Mr. Speaker, I support this landmark legislation because it changes the way that insurance companies ration medical care: The measure would require all plans to eliminate coverage denials because of a pre-existing condition, eliminate dropping coverage when individuals become sick, eliminate annual and lifetime caps on how much can be spent on care, and eliminate exorbitant out-of-pocket expenses. All Americans deserve these basic protections from their health-insurance plans, and these important changes will improve the coverage for nearly all those who already have insurance—even those Americans who are extremely satisfied with their current plans.
The act starts with what works well in today’s health care system and fixes the parts that are broken. No one has to discard the health care they enjoy today—everyone can keep their current health plan, doctors and hospitals. A new marketplace will allow individuals to shop among a large number of private plans and get a government-legible price. For the first time ever, American families—even those who keep their current health insurance—will benefit from no longer having to worry about losing health coverage because of a new or lost job. The bill finally brings the type of health insurance reform that Americans need and deserve.

I also strongly support this bill because the 47 million uninsured Americans, the 2.6 million uninsured New Yorkers and the 78,000 uninsured neighbors in my congressional district will have access to affordable, secure and quality health-care coverage instead of having to rely on the local hospital emergency room. Most recent administrations never acknowledged the moral or economic costs we pay every day to fix this problem. Fortunately, President Obama has made comprehensive health-insurance reform his top priority. I am proud to be voting today to make sure that health-care reform contains costs and is affordable; puts our country on a clear path to fiscal solvency; provides affordable coverage; ensures choice of physicians and health plans; promotes prevention and wellness; improves the quality of care, and is fiscally sustainable over the long-term. Putting these principles into action is not only doable; it is absolutely essential.

So, Mr. Speaker, I urge all my colleagues to support the Affordable Health Care for America Act so that all Americans will have access to health care.

MRS. SLAUGHTER. Mr. Speaker, I yield 1½ minutes to the gentleman from Oregon (Mr. DeFazio).

Mr. DEFAZIO. I thank the gentleman.

The Republican record defies their rhetoric. Remember their so-called “prescription drug benefit” for seniors passed in the dark of the night, no one read the bill, didn’t know what was in it? It cost $700 billion because that was subsidizing the pharmaceutical and insurance industry. But now they’re worried about costs that gave the seniors a doughnut hole. Now their concern is about costs that gave the seniors a doughnut hole. Now their concern is not about what they’re stating; it’s about their patrons in the insurance industry.

This bill has real reforms of the worst abuses of the insurance industry. It takes away their unfair antitrust community so they can no longer collude to drive up premium prices for restrict coverage. The Republicans would continue the antitrust exemption.

This bill outlaws the unfair pre-existing condition restriction. The Republicans would continue that for the insurance industry.

This bill would not allow the industry to cancel your policy even though you’ve been paying your premiums when you get sick. It’s called rescission. The Republicans allow that abuse to continue.

This bill on our side outlaws the small print that limits your lifetime coverage which bankrupts families every day in America. The Republicans allow it to continue.

And that’s not enough. They open up a new loophole, their so-called “national plan.” A company would only be regulated by the laws of the State in which it is headquartered. If it sold you a policy. If you live in Oregon but you bought a policy that was written in—oh, and by the way, they expand the definition of States to include the territories and the Marianna Islands. So if you’ve got a problem, call the Mariana Islands. If you’ve got a problem, call the Mariana Islands insurance commissioner. That’s the Republican plan: Profits for the insurance industry.

Mr. SESSIONS. Mr. Speaker, I yield to the gentleman from Texas (Mr. NEUGEBAUER) for a unanimous consent request.

Mr. NEUGEBAUER. asked and was given permission to revise and extend his remarks.

Mr. NEUGEBAUER. Mr. Speaker, I rise in opposition to this job-killing bill that cuts Medicare, piles debt on our children, raises health care costs, and raises taxes on the American people.

Last week, Speaker Pelosi introduced the long-awaited final draft of her health care reform bill. H.R. 3962, combined with the 42-page manager’s amendment, comes in at over 2,000 pages.

A preliminary analysis by the nonpartisan Congressional Budget Office estimates that the true cost of the bill is $1.3 trillion. Buried within this bill are details that would add massive federal involvement in the health care of every American, including the following: creation of a government-run insurance program that could cause as many as 114 million Americans to lose their current coverage; elimination of the private market for individual health insurance; taxes on all Americans who purchase insurance, individuals who don’t purchase insurance, and millions of small businesses; and cuts to Medicare Advantage plans that will result in higher premiums. Yet, with all these taxes, mandates and cuts, the majority party still maintain somehow this bill will lower the cost of health care to Americans.

For months, Americans have been telling Congress they want real solutions for the health care crisis in America but they are also telling us there is a big difference between the right and wrong way to reform health care. Republicans listened to the American people and have produced a commonsense, fiscally responsible health care reform proposal—not Speaker Nancy Pelosi’s 2,000-page government takeover of one-sixth of our Nation’s economy.

Republicans’ alternative solution focuses on lowering health care premiums for families and small businesses, increasing access to affordable, high-quality care, and promoting healthier lifestyles—without adding to the crushing debt Washington has placed on our children and grandchildren. Even the nonpartisan Congressional Budget Office, CBO, confirmed that the Republican health care plan would lower health care premiums up to 10 percent and save the government $68 billion over 10 years without imposing tax increases on families and small businesses. The Republican alternative contains no tax increases, no cuts to Medicare, no health care rationing, no deficit spending, and no huge intrusion of government into your personal health care choices. Instead, our plan recognizes that health care reform must be based on competition, preserving the relationship between doctors and patients, and reducing health care costs for American families without a massive government intrusion.

Health care solutions are badly needed in this country, but we need to get it done right. Republicans have listened to the American people and put forth commonsense health care legislation that reduces the deficit, lowers premiums, and improves coverage options for those with preexisting conditions.

GROUPS KEY VOTING “NO”

American Bakers Association; American Consensus Union; American Council of Engineering Companies; American Hotel and Lodging Association; American Dental Association; American Federation of State, County and Municipal Employees; American Hotel and Lodging Association; American Medical Association; American Petroleum Institute; American Society of General Surgeons; American Society of Neurological Surgeons; American Trucking Associations; Associated General Contractors of America; Automotive Recyclers Association; Brick Industry Association; Club for Growth; Compliance Women for McCain; Consumer Federation of Citizens Against Government Waste; Family Research Council; FreedomWorks.

Independent Electrical Contractors; International Foodservice Distributors Association; International Franchise Association; National Association of Manufacturers; National Association of Wholesale-Distributors; National Federation of Independent Business (NFIB); National Lumber and Building Material Dealers Association; National Ready Mix Concrete Association; National Retail Federation; National Taxpayers Union; North American Die Casting Association; Printing Industries of America; Small Business & Entrepreneurship Council; U.S. Chamber of Commerce.

GROUPS OPPOSING H.R. 3962

Aeronautical Repair Station Association; Air Conditioning Contractors of America; American Academy of Facial Plastic and Reconstructive Surgery; Apparel & Footwear Association; American Architectural Manufacturers Association; American Association of Neurological Surgeons; American Benetton Council; American Center for Law and Justice; American Electric Power; American Family Insurance; American Farm Bureau Federation; American Foundry Society; American International Automobile Dealer Association (AIDA); American Petroleum Institute; American Society of General
Mr. Speaker, I yield 1 minute to the gentleman from Michigan (Mr. STUPAK).

Mr. STUPAK. Mr. Speaker, the rule being debated makes in order the Stu-
pak-Ellsworth-Smith-Kaptur-Dahlkemper-pro-life amendment that would apply the longstanding Hyde amendment, which states no public funding for abortion.

I appreciate the willingness of Speaker PELOSI to work with all Democrats through the day and night Friday to reach an agreement on language. Ulti-
mately, the agreement we reached fell apart, and the only appropriate consid-
eration was to make our amendment in order.

The Speaker recognizes that Mem-
bers deserve the chance to vote their conscience and have their voices heard on this most important matter.

There are a number of critical re-
fills in this bill, such as a repeal to the health insurance industry’s anti-
competition to price discrimination into the industry, a prohibition on in-
surance companies discriminating against people with preexisting condi-
tions, elimination of the practice of re-
pricing, and a transition to a health care reim-
bursement system that addresses geo-
graphic disparities and rewards quality of care over quantity of procedures per-
formed.

Mr. Speaker, the time to pass health care reform and provide quality, affordable health care for all Americans. I urge my colleagues to support the rule and to support the Stupak amendment later today.

I thank the gentlewoman for yield-
ing.

Mr. SESSIONS. Mr. Speaker, I re-
sulte the balance of my time.

Ms. SLAUGHTER. Mr. Speaker, I yield 30 seconds to the gentleman from Rhode Island (Mr. LANGEVIN).

Mr. LANGEVIN. Mr. Speaker, I rise today in strong support of this rule and the underlying bill which finally puts us on the path to solving our Nation’s health care crisis.

As an exception to Congress, I have heard from countless constituents in Rhode Island struggling with the fail-
ures of our health care system. I have heard from constituents forced to make unconscionable choices between saving their mortgage or losing their cover-
age, and families facing bankruptcy due to catastrophic medical costs.
The tax for inaction is over. This bill represents an historic opportunity to enact reforms that will allow constituents who lose their jobs to keep their health care coverage, eliminates preexisting conditions, and protects people by abolishing lifetime insurance caps.

Every American deserves the promise of quality affordable health care, and this is our moment to fulfill that promise.

Mr. SESSIONS. Mr. Speaker, I spoke just a second ago about the mandates that would be criminal penalties. I would like to enter a letter from the gentleman, Mr. CAMP, that is from the Joint Committee on Taxation that outlines this part of the law.

Dear Mr. CAMP: This is in response to your request for information relating to enforcement of the individual mandate (Internal Revenue Code ("Code") of the individual mandate of H.R. 3962, as amended, the "Affordable Health Care for America Act." You specifically inquired about penalties for a willful failure to comply.

**CIVIL PENALTIES**

Section 6662(a)—an accuracy related penalty of 20 percent of the underpayment attributable to health care tax law, based on negligence or failure to make a reasonable attempt at compliance. The failure of a reasonable attempt lack of a reasonable attempt to comply and the latter includes any intentional disregard of rules or regulations) or substantial understatement, the understatement of tax is sufficiently large.

Section 6656—a fraud penalty of 75 percent of the underpayment, if the government can prove fraudulent failure to pay by clear and convincing evidence.

Section 6702—a $5,000 penalty for taking a frivolous position on a tax return, if the underpayment is delayed or if the tax administration and the return on its face indicates that the self-assessment is substantially incorrect.

Section 6662(c)—an 1% per month penalty of 0.5 percent of the underpayment, each month, up to a maximum of 25 percent of the underpayment.

**CRIMINAL PENALTIES**

Prosecution is authorized under the Code for a variety of offenses. Depending on the level of the noncompliance, the following penalties could apply to an individual:

Section 7201—felony willful evasion is punishable by a fine of up to $250,000 and/or imprisonment of up to one year.

Section 7202—filing false statements is punishable by a fine of up to $25,000 and/or imprisonment of up to five years.

**APPLICATION OF PENALTIES UNDER CURRENT PRACTICE**

The IRS attempts to collect most unpaid liabilities through the civil procedures described above. A number of factors distinguish civil from criminal penalties, in addition to the potential for incarceration if found guilty of a crime. Unlike the standard in civil cases, successful criminal prosecution requires that the government bear the burden of proof beyond a reasonable doubt of all elements of the criminal offenses. Criminal offenses require proof that the offense was willful, which is a degree of culpability greater than that required in a civil penalty cases. For example, a prosecution for willful failure to pay under section 7203 requires proof beyond a reasonable doubt both that the taxpayer intentionally violated a known legal duty and that the taxpayer had the ability to pay. In contrast, in applying the civil penalty for failure to pay under section 6651, the burden is on the taxpayer: the penalty cannot be assessed unless the IRS has determined that the taxpayer had the ability to pay. In contrast, in applying the civil penalty for failure to pay under section 6651, the burden is on the taxpayer: the penalty cannot be assessed unless the IRS has determined that the taxpayer had the ability to pay. In contrast, in applying the civil penalty for failure to pay under section 6651, the burden is on the taxpayer: the penalty cannot be assessed unless the IRS has determined that the taxpayer had the ability to pay.

Mr. Speaker, to increase accessibility. We all want to do that. Well, I believe very fervently that increasing affordability will increase accessibility. If we can
make health insurance more affordable, more people in this country will have access to quality health insurance. The substitute that we have offered does just that. It says that the opportunity to have access to the best quality product at the lowest possible price is something that every American should have. They are denied that today by virtue of the fact that they can’t buy insurance across State lines.

If you look at our goal of trying to bring about meaningful liability reform, the interests today engage in, as we all know, defensive medicine. They recommend a wide range of tests simply because of their fear of being sued. In my State of California, we have a very, very viable package that deals with that. If we were to take the California model and apply it here at the Federal level, the Congressional Budget Office has estimated that we will save $54 billion. $54 billion will be saved.

I believe that we need to do everything in our power to allow small businesses and individuals to come together so that they can, in fact, as large entities do, get lower insurance rates. And, Mr. Speaker, I believe that we can also ensure that we address the challenge of preexisting conditions so that Americans with those preexisting conditions are not denied access to quality health insurance and health care. We can do that, and that is exactly what our substitute does.

Unfortunately, Mr. Speaker, we have continued to have this characterization that if we don’t support this measure, if we don’t support this measure which takes control of one-sixth of our Nation’s economy, we are not committed to reform. That is outrageous. We believe that a step-by-step approach is the proper route for us to take.

I like very much what our friend from North Carolina earlier said: We don’t need a complete overhaul. We need a system to ensure that every single American does have access to quality, affordable health care.

Vote “no” on this rule. We can do better.

It is truly unfortunate that the healthcare debate has come to be cast as a fight between those who favor and those who oppose reform. There is not a single Member of this House who does not support the idea of improving the accessibility and the quality of healthcare in America. We all want to expand access so that all Americans will have the ability to band together, to achieve the economies of scale that large corporations and labor unions have. Small businesses and individuals should also be able to purchase insurance across State lines. And we can provide tax incentives to make coverage more accessible. Finally, we must eliminate the rampant waste, fraud, and abuse that are dramatically and needlessly driving up costs.

Each of these proposals would significantly reduce costs for individuals and families without diminishing the quality of care. In fact, they would enhance the quality of healthcare in this country. Greater competition and greater accountability in the healthcare industry would provide Americans with more choices—and better choices.

Some have made the very dubious claim that expanding options for consumers would somehow diminish the quality of our healthcare. They have said that reforms such as giving small businesses and individuals the flexibility to purchase insurance across State lines, would spark a race to the bottom. But increasing competition and accountability would have precisely the opposite effect. When patients have more choices and more flexibility, the result will be higher-quality care. And by addressing the root issue of affordability, we can effectively expand access for all, including those with pre-existing conditions.

The commonsense reform measures we are proposing would accomplish this without raising taxes or diminishing coverage for a single American. And we would expand access while allowing those who are happy with their current health coverage to keep it. Certainly the reforms that we have seen are not something that are widely supported by the American people.

So it is extremely unfortunate that the Democratic Majority has chosen to put forward a divisive, unworkable, enormously expensive proposal that will improve neither accessibility nor the quality of health care—substantially more inefficient, wasteful than the current system—already in need of reform. This legislation would accomplish precisely the opposite of its stated goals. A dramatic expansion of the government role in our healthcare system is an utterly nonsensical way to try to enhance efficiency, cut costs or improve quality. Furthermore, government is the last people that Americans want to have making their healthcare decisions for them.

Our national unemployment rate sailed past 10 percent last month, as we just found out on Friday, while California’s is at 12.2 percent. As our economy continues to struggle on its road to recovery, now is the worst possible time to impose significant new taxes on the American people. And with the announcement of the Democratic Majority’s $1.4 trillion deficit, we simply cannot afford to enact more than a trillion in new government spending—an estimated figure that would be sure to balloon if implemented.

The Democratic Majority’s so-called reform bill is a fiscal disaster that will make our healthcare system—already in need of reform—substantially more inefficient, wasteful and costly, and make quality care even less accessible. Today’s vote is not a vote to reject or support healthcare reform. Today’s vote is about the path we will choose as a nation to pursue better and more affordable healthcare. Republicans have put forward proposals that will cut costs while improving care, and we can achieve this without raising taxes or further crippling our nation with even more debt.

The Democrats have put forth a proposal that would take us in precisely the opposite direction—higher costs, lower-quality care, new taxes. And a bigger deficit. And urge my colleagues to support real reform.

Ms. SLAUGHTER. Mr. Speaker, this is a wonderful, exciting day for us and the culmination of nearly 100 years of work that we will join the community of nations that believe that the people who live within them are deserving of decent health care, all of them, regardless of their financial situation.
This is such a step that I am proud that my life has brought me to this moment today; and I am sure, Mr. Speaker, that you share with every fiber of your being the same idea that we have finally reached the day when we will all brace ourselves to meet the duty and say to the future that this was our finest hour.

I request a “yes” vote on the previous question.

Mr. ACKERMAN. Mr. Speaker, I rise on this historic day in strong support of H. Res. 903—the rule providing for consideration of H.R. 3962—the Affordable Health Care for America Act.

Let me be absolutely clear: every single American should have access to affordable and quality health-care coverage. For too many years, drastically needed health-insurance reform has been delayed. I’m happy to say the long overdue reform of our health-care insurance system has finally begun. The status quo is unsustainable and costly: Without health insurance, the premium for an average family is expected to rise from $11,000 to $24,000 in less than a decade. Americans want reduced costs and more choices.

Mr. Speaker, I support this landmark legislation because it changes the way that insurance companies ration medical care: The measure would require all plans to eliminate coverage denials because of a pre-existing condition, eliminate dropping coverage when individuals become sick, eliminate annual and lifetime limits on how much can be spent on care, and eliminate exorbitant out-of-pocket expenses. All Americans deserve these basic protections from their health-insurance plans, and these important guarantees will improve the coverage for nearly all those who already have insurance—even those Americans who are extremely satisfied with their current plans.

The Act starts with what works well in today’s health care system and fixes the parts that are broken. No one has to discard the health care they enjoy today—everyone can keep their current health plan, doctors and hospitals. A new marketplace will allow individuals to shop among a large number of private plans or choose a public insurance option. For the first time ever, American families—even those who keep their current health insurance—will benefit from no longer having to worry about losing health coverage because of a new or lost job. The bill finally brings the coverage for nearly all those who already have insurance—even those Americans who are extremely satisfied with their current plans.

The wrong way is to raise taxes even higher and dig our debt even deeper to pay for more wasteful programs that don’t work. This health care overhaul bill will likely make Cash for Clunkers look like a Black Friday door buster item! Before we raise taxes to pay for yet another program, we owe it to our constituents to cut out the waste, fraud, and abuse of government programs.

One size does not fit all when it comes to health care. A patient and their physician should be in charge of their health care decisions, not politicians.

I too, give it a thumbs down. Mrs. BIGGERT. Mr. Speaker, I rise in strong opposition to this rule and the underlying bill. Over the month of August, I spoke with over 20,000 of my constituents about health care, and one subject in particular kept surfacing over and over—skyrocketing costs of insurance premiums. In fact, a recent survey filled out by over six thousand residents of the 13th District showed that, at nearly 47 percent, rising costs were far and away the number one concern when it comes to health care. Families in my district simply cannot keep pace with rising health care bills. And it’s no wonder when over the past year, health care costs rose at twice the rate of inflation.

Unfortunately, this bill would do absolutely nothing to address this pressing concern. Instead, it cuts seniors’ Medicare benefits, taxes small businesses struggling to stay afloat, and places government bureaucracy between you and your doctor.

Fortunately, we’re offering a better, commonsense alternative to increase competition, improve portability for those between jobs, and expand coverage for pre-existing conditions—without job-threatening tax increases.

That is why I am very pleased that according to experts at the nonpartisan Congressional Budget Office, or CBO, our Republican alternative will reduce your premiums by as much as 10 percent. In addition, the bill would save the government $58 billion. You heard that right—it would save the government—your tax dollars—money.

And this bill doesn’t have any complicated budgetary gimmicks that will inflate numbers or circumvent accurate analysis. This bill has it all, it expands choice and portability, it takes as a starting point what small businesses need, allowing the purchase of health insurance across state lines, and medical malpractice reform.

In addition, the bill would change current law to ensure that insurance companies can’t drop Americans who play by the rules just because they get sick. And no one can be denied treatment because of annual or lifetime benefit caps.

Mr. Speaker, we need reform, not revolution. I urge my colleagues to join me in supporting an alternative that will provide real help to struggling Americans.

Ms. SLAUGHTER. I yield back the balance of my time, and I move the previous question on the resolution. The SPEAKER pro tempore. The question is on ordering the previous question.

The question was taken; and the Speaker pro tempore announced that the ayes had appeared to have it.

RECORDED VOTE

Ms. SLAUGHTER. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. Pursuant to clause 8 and clause 9 of rule XX, this 15-minute vote on ordering the previous question will be followed by a 15-minute vote on adoption of House Resolution 903, if ordered, and a 5-minute vote on the motion to suspend the rules on House Resolution 892, if ordered.

The vote was taken by electronic device, and there were—yeses 247, noes 187, not voting 6.

[A roll No. 881]

AYES—247

Abacrombie, David (HI)         Hooley, Joseph (MA)
Acker, David (NY)            Isakson, Johnny (GA)
Adler, Nicki (IL)            Jackson (IL)
Altmire, Jason (PA)         Jackson-Lee, Sheila (TX)
Andrews, Donna (GA)         Delaury, Sylvia (MD)
Arcuri, Michael (NJ)         Hicks, Daniel (IL)
Baca, G. K. (CA)            Dingell, John (MI)
Baird, Dave (WA)            Doggett, Lloyd (TX)
Barrow, Sanford (GA)        Donnelly (IN)
Bean, Bruce (IL)            Doyle, Patrick (NY)
Berman, Lloyd (CA)          Doyle, Stephen (CT)
Bishop, John (GA)           Doyle, Thomas (NY)
Bilirakis, Michael (FL)     Doyle, Tom (NJ)
Bischoped, Jamie (OK)       Edwards (TX)
Boswell, Frank (TX)         Edwards, Gary (CA)
Boucher, Bill (CA)          Eshoo, Zachary (CA)
Boyce, Tom (CO)             Etheridge, Jim (NC)
Brady (PA)                  Farr, Tony (CA)
Brady (FL)                  Fattah, Chaka (PA)
Brady (LA)                  Filner, G. K. (CA)
Brown, Corrine                 Garamendi, Mike (CA)
Brown, Tammy (PA)          Giffords, Phil (CT)
Brown, Warren (MA)         Giffords, Scott (IN)
Browner, James             Gonzalez, Barney (CA)
Browning, Mark (NV)        Gordon (TN)         Lipinski
Buchanan, Carol (NY)      Gorton, Thomas (WA)
Carnahan, Frances (MI)    Grayson, Al (FL)
Carney, Howard (OH)        Green, Don (FL)
Carson (IN)                 Granger, Diane (IN)
Carson (FL)                 Grayson, Robert (FL)
Chandler, Brad (NY)        Green, Jim (FL)
Chapman,itre (TX)           Grijalva, Ann (AZ)
Clarke, Robert             Gutierrez, Henry (TX)
Clay, Emanuel              Hall (NC)
Clay, Frank                 Halloran, Patrick (NY)
Clyburn, G. K.             Hare, Jerry (PA)
Cohen, Howard (NY)        Harkin, Gary (IA)
Cohen, Steve (NJ)         Hartzler, Todd (MO)
Coffman (VA)                Hatch, Mitt (UT)
Conyers (TN)               Hatfield, Andy (TX)
Conyers, Charles          Hayden, Constance (NY)
Cooper, Morgan             Himes, Jim (CT)
Costello, Frank            Hinchey, Tim (IL)
Courter, Elizabeth (CT)    Hinshaw, Steve (CA)
CQF: Finger, John (NV)      Hirono (HI)
Currie, Mark (MI)         Himes, Jeff (CT)
Cuellar, Henry                 Holt, Ike (TX)
Cummings, John            Honda, Daniel (FL)
Dahlekepner, Tom          Holden, John (CA)
Davis (CA)                  Holland (MI)

RECORDED VOTE

Mr. ACKERMAN. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. Pursuant to clause 8 and clause 9 of rule XX, this 15-minute vote on ordering the previous question will be followed by a 15-minute vote on adoption of House Resolution 903, if ordered, and a 5-minute vote on the motion to suspend the rules on House Resolution 892, if ordered.

The vote was taken by electronic device, and there were—yeses 247, noes 187, not voting 6.
Messrs. LUCAS and LAMBORN changed their votes from "aye" to "no." 

The result of the vote was announced as above recorded.

RECORDED VOTE
Mr. SR. MISS, Mr. Speaker, I demand a recorded vote.

The vote was taken by electronic device and there were—ayes 242, noes 192, not voting 0, as follows:

[Roll No. 982]

AYES—242

NOES—192

SO THE RESOLUTION WAS AGREED TO.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.
rule. There were some of us for it and some of us who were against it, but I know that all of us, all 434 of his colleagues, are honored to serve with the longest-serving Member of this House, who has committed himself to health care throughout his life, as did his father. We honor him for the service he has given to our country.

Ladies and gentlemen, let us stand in honor of JOHN DINGELL.

RECOGNIZING 20TH ANNIVERSARY OF THE ENDING OF THE COLD WAR

The SPEAKER pro tempore. The UNFINISHED BUSINESS is the question on suspending the rules and agreeing to the resolution, H. Res. 892.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from California (Mr. Berman) that the House suspend the rules and agree to the resolution, H. Res. 892.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

RECORDED VOTE

Mr. HASTINGS of Florida. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 431, noes 1, voting not 2, as follows:

Rolle No. 883

AYES—431

Noes—1

So (two-thirds being in the affirmative) the rules were suspended and the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

AFFORDABLE HEALTH CARE FOR AMERICA ACT

Mr. WAXMAN. Mr. Speaker, pursuant to House Resolution 903, I call up the bill (H.R. 3962) to provide affordable, quality health care for all Americans and reduce the growth in health care spending, and for other purposes, and ask for its immediate consideration in the House.

The Clerk read the title of the bill. The SPEAKER pro tempore. Pursuant to House Resolution 903, the amendment printed in part A of House Report 111–330, perfected by the modification printed in part B of the report adopted and the bill, as amended, is considered read.

The text of the bill, as amended, is as follows:

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF DIVISIONS, TITLES, AND SUBTITLES.—(a) Short Title.—This Act may be cited as the “Affordable Health Care for America Act.”

(b) Table of Divisions, Titles, and Subtitles.—This Act is divided into divisions, titles, and subtitles as follows:

DIVISION A—AFFORDABLE HEALTH CARE CHOICES
DIVISION I—IMPROVING HEALTH CARE VALUE
Subtitle A—Provisions related to Medicare part A
Subtitle B—Provisions Related to Part B
Subtitle C—Provisions Related to Medicare Parts A and B
Subtitle D—Medicare Advantage Reforms
Subtitle E—Improvements to Medicare Part D
Subtitle F—Medicare Rural Access Protections

DIVISION II—MEDICARE BENEFICIARY IMPROVEMENTS
Subtitle A—Improving and Simplifying Financial Assistance for Low Income Medicare Beneficiaries
Subtitle B—Reducing Medicare Disparities
Subtitle C—Miscellaneous Improvements

DIVISION III—PROMOTING PRIMARY CARE, MENTAL HEALTH SERVICES, AND COORDINATED CARE

DIVISION IV—QUALITY
Subtitle A—Comparative Effectiveness Research
Subtitle B—Nursing Home Transparency
Subtitle C—Quality Measurements
Subtitle D—Physician Payments Sunshine Provision
Subtitle E—Public Reporting on Health Care-Associated Infections

DIVISION V—MEDICARE GRADUATE MEDICAL EDUCATION

DIVISION VI—PROGRAM INTEGRITY
Subtitle A—Increased funding to fight waste, fraud, and abuse
Subtitle B—Enhanced penalties for fraud and abuse
Subtitle C—Enhanced Program and Provider Protections
Subtitle D—Access to Information Needed to Prevent Fraud, Waste, and Abuse

DIVISION VII—MEDICAID AND CHIP
Subtitle A—Medicaid and Health Reform
Subtitle B—Prevention
Subtitle C—Access
Subtitle D—Coverage
Subtitle E—Financing
Subtitle F—Waste, Fraud, and Abuse
Subtitle G—Puerto Rico and the Territories
Subtitle H—Miscellaneous

DIVISION VIII—REVENUE-RELATED PROVISIONS

DIVISION IX—MISCELLANEOUS PROVISIONS

DIVISION X—PUBLIC HEALTH AND WORKFORCE DEVELOPMENT

DIVISION XI—COMMUNITY HEALTH CENTERS

DIVISION XII—WORKFORCE DEVELOPMENT
Subtitle A—Primary Care Workforce
Subtitle B—Nursing Workforce
Subtitle C—Public Health Workforce
Subtitle D—Adapting Workforce to Evolving Health System Needs

DIVISION XIII—PREVENTION AND WELLNESS

DIVISION XIV—QUALITY AND SURVEILLANCE

DIVISION V—OTHER PROVISIONS
Subtitle A—Drug Discount for Rural and Other Hospitals; 340B Program
Subtitle B—Programs
Subtitle C—Food and Drug Administration

Subtitle D—Community Living Assistance Services and Supports
Subtitle E—Miscellaneous

DIVISION D—INDIAN HEALTH CARE IMPROVEMENT
TITLE I—AMENDMENTS TO INDIAN LAWS
TITLE II—IMPROVEMENT OF INDIAN HEALTH CARE PROVIDED UNDER THE SOCIAL SECURITY ACT

DIVISION A—AFFORDABLE HEALTH CARE CHOICES
SEC. 100. PURPOSE; TABLE OF CONTENTS OF DIVISION; GENERAL DEFINITIONS.
(a) PURPOSE.
(1) IN GENERAL.—The purpose of this division is to provide affordable, quality health care for all Americans and reduce the growth in health care spending.

(2) BUILDING ON CURRENT SYSTEM.—This division achieves this purpose by building on what works in today's health care system, while reorienting high-risk pool programs.

(b) INSURANCE REFORMS.—This division:
(A) enacts strong insurance market reforms;
(B) creates a new Health Insurance Exchange, with a public health insurance option alongside private plans;
(C) includes sliding scale affordability credits; and
(D) initiates shared responsibility among workers, employers, and the Government; so that all Americans have coverage of essential health benefits.

(4) HEALTH DELIVERY REFORM.—This division institutes health delivery system reforms both to increase quality and to reduce growth in health spending so that health care becomes more affordable for businesses, families, and Government.

(b) TABLE OF CONTENTS OF DIVISION.—The table of contents of this division is as follows:
Sec. 100. Purpose; table of contents of division; general definitions.

TITLE I—IMMEDIATE REFORMS

Sec. 101. National high-risk pool program.
Sec. 102. Ensuring value and lower premiums.
Sec. 103. Ending health insurance rescissions.
Sec. 104. Sunshine on price gouging by health insurance issuers.
Sec. 105. Requiring the option of extension of dependent coverage for uninsured young adults.
Sec. 106. Limitations on preexisting condition exclusions.

Sec. 102. Protecting the choice to keep current coverage.
Sec. 105. Requiring the option of extension of dependent coverage for uninsured young adults.
Sec. 106. Limitations on preexisting condition exclusions.
Sec. 101. National high-risk pool program.
Sec. 102. Ensuring value and lower premiums.
Sec. 103. Ending health insurance rescissions.
Sec. 104. Sunshine on price gouging by health insurance issuers.
Sec. 105. Requiring the option of extension of dependent coverage for uninsured young adults.
Sec. 106. Limitations on preexisting condition exclusions.

Sec. 202. Protecting the choice to keep current coverage.
Sec. 205. Requiring the option of extension of dependent coverage for uninsured young adults.
Sec. 206. Limitations on preexisting condition exclusions.
Sec. 201. National high-risk pool program.
Sec. 202. Ensuring value and lower premiums.
Sec. 203. Ending health insurance rescissions.
Sec. 204. Sunshine on price gouging by health insurance issuers.
Sec. 205. Requiring the option of extension of dependent coverage for uninsured young adults.
Sec. 206. Limitations on preexisting condition exclusions.

Sec. 212. Guaranteed issue and renewal for insured plans and prohibiting rescissions.
Sec. 211. Prohibiting preexisting condition exclusions.

Sec. 215. Ensuring adequacy of provider networks.
Sec. 216. Requiring the option of extension of dependent coverage for uninsured young adults.
Sec. 217. Consistency of costs and coverage under qualified health benefits plans during plan year.

Subtitle C—Standards Guaranteeing Access to Essential Benefits
Sec. 221. Coverage of essential benefits package.

Subtitle D—Additional Consumer Protections
Sec. 231. Requiring fair marketing practices by health insurers.
Sec. 232. Requiring fair grievance and appeals mechanisms.

Sec. 233. Requiring information transparency and open enrollment.
Sec. 234. Application to qualified health benefits plans not offered through the Health Insurance Exchange.

Sec. 235. Timely payment of claims.
Sec. 236. Standardized rules for coordination and subrogation of benefits.

Sec. 237. Application of administrative simplification.
Sec. 238. State prohibitions on discrimination against health care providers.
Sec. 239. Protection of physician prescriber information.

Sec. 240. Dissemination of advance care planning information.

Subtitle E—Governance
Sec. 242. Duties and authority of Commissioner.

Sec. 243. Coordination and coordination.
Sec. 244. Health Insurance Ombudsman.
Subtitle F—Relation to Other Requirements; Miscellaneous

Sec. 251. Relation to other requirements.
Sec. 252. Prohibiting discrimination in health care.
Sec. 253. Whistleblower protection.
Sec. 254. Construction regarding collective bargaining.
Sec. 255. Severability.

Sec. 256. Treatment of Hawaii Prepaid Health Care Act.
Sec. 257. Actions by State attorneys general.
Sec. 258. Application of State and Federal laws regarding abortion.

Sec. 259. Nondiscrimination in health care.
Sec. 261. Construction regarding standard of care.

Sec. 262. Restoring application of antitrust laws to health sector insurers.
Sec. 263. Study and report on methods to increase EHR use by small health care providers.
Sec. 264. Performance Assessment and Accountability: Application of GPRA

Sec. 269. Other functions.

Sec. 270. Health Insurance Exchange Trust Fund.

Sec. 271. Optional operation of State-based health insurance exchanges.

Sec. 272. Interstate health insurance compacts.

Sec. 273. Health insurance cooperatives.

Sec. 274. Retention of DOD and VA authority.

Subtitle B—Public Health Insurance Option

Sec. 275. Establishment and administration of a public health insurance option.

Sec. 276. Exchange-eligible individuals and employers.

Sec. 277. Premiums and financing.

Sec. 278. Payment rates for items and services.

Sec. 279. Modernized payment initiatives and delivery system reform.

Sec. 280. Prizes for participation.

Sec. 281. Application of fraud and abuse provisions.

Sec. 282. Application of HIPAA insurance requirements.

Sec. 283. Application of health information privacy, security, and electronic transaction requirements.

Sec. 284. Enrollment in public health insurance option or voluntary.

Sec. 285. Enrollment in public health insurance option by Members of Congress.

Sec. 286. Reimbursement of Secretary of Veterans Affairs.

Subtitle C—Individual Affordability Credits

Sec. 287. Availability through Health Insurance Exchange.

Sec. 288. Affordable credit eligible individual.

Sec. 289. Affordability premium credit.

Sec. 290. Affordability cost-sharing credit.

Sec. 291. Income determinations.

Sec. 292. Special rules for application to territories.

Sec. 293. No Federal payment for undocumented aliens.

TTITLE IV—SHARED RESPONSIBILITY

Subtitle A—Individual Responsibility

Sec. 294. Individual responsibility.

Subtitle B—Employer Responsibility

PART I—HEALTH COVERAGE PARTICIPATION REQUIREMENTS

Sec. 295. Health coverage participation requirements.

Sec. 296. Employer responsibility to contribute toward employee and dependent coverage.

Sec. 297. Employer contributions in lieu of coverage.

Sec. 298. Authority related to improper contributions.

Sec. 299. Impact study on employer responsibility requirements.

Sec. 300. Study on employer hardship exemption.

PART II—SATISFACTION OF HEALTH COVERAGE PARTICIPATION REQUIREMENTS


Sec. 302. Satisfaction of health coverage participation requirements under the Internal Revenue Code of 1986.

Sec. 303. Additional rules relating to health coverage participation requirements.

TTITLE V—AMENDMENTS TO INTERNAL REVENUE CODE OF 1986

Subtitle A—Provisions Relating to Health Care Reform

PART I—SHARED RESPONSIBILITY

Sec. 304. Tax on individuals without acceptable health care coverage.

PART II—EMPLOYER RESPONSIBILITY

Sec. 305. Election to satisfy health coverage participation requirements.

Sec. 306. Health care contributions of non-electing employers.

PART III—LIMITATIONS ON HEALTH CARE RELATED EXPENDITURES

Sec. 307. Distributions for medicine qualified only if for prescribed drug or insulin.

Sec. 308. Limitation on health flexible spending arrangements under cafeteria plans.

Sec. 309. Increase in penalty for nonqualified distributions from health savings accounts.

Sec. 310. Denial of deduction for federal subsidies for prescription drug plans which have been excluded from gross income.

PART IV—OTHER PROVISIONS TO CARRY OUT HEALTH INSURANCE REFORM

Sec. 311. Disclosures to carry out health insurance exchange subsidies.

Sec. 312. Offering of exchange-participating health benefits plans through cafeteria plans.

Sec. 313. Exclusion from gross income of payments made under reinsurance program for retirees.

Sec. 314. CLASS program treated in same manner as long-term care insurance.

Sec. 315. Exclusion from gross income for medical care provided for Indians.

Sec. 316. Codification of economic substance doctrine; penalties.

Sec. 317. Certain large or publicly traded persons made subject to a more likely than not standard for avoiding penalties on underpayments.

PART III—PARTY IN HEALTH BENEFITS

Sec. 318. Certain health related benefits applicable to health and dependents extended to eligible beneficiaries.

(c) GENERAL DEFINITIONS.—Except as otherwise provided, in this division:

(1) ACCEPTABLE COVERAGE.—The term “acceptable coverage” has the meaning given such term in section 362(d)(2)(C).

(2) BASIC PLAN.—The term “basic plan” has the meaning given such term in section 362(c).

(3) COMMISSIONER.—The term “Commissioner” means the Health Choices Commissioner established under section 241.

(4) COST-SHARING.—The term “cost-sharing” includes deductibles, coinsurance, copayments, and similar charges, but does not include premiums, balance billing amounts for non-network providers, or spending for non-covered services.

(5) DEPENDENT.—The term “dependent” has the meaning given such term by the Commissioner and includes a spouse.

(6) EMPLOYMENT-BASED HEALTH PLAN.—The term “employment-based health plan”—

(A) means a group health plan (as defined in section 733(a)(1) of the Employee Retirement Income Security Act of 1974); and

(B) includes coverage described in section 362(d)(2)(E) (relating to TRICARE).

(7) ENHANCED PLAN.—The term “enhanced plan” has the meaning given such term in section 303(c).

(8) ESSENTIAL BENEFITS PACKAGE.—The term “essential benefits package” is defined in section 222(a).

(9) EXCHANGE-PARTICIPATING HEALTH BENEFITS PLAN.—The term “exchange-participating health benefits plan” means a qualified health benefits plan that is offered through the Health Insurance Exchange and may be purchased directly from the entity offering the plan or through enrollment agents and brokers.

(10) FAMILY.—The term “family” means an individual and includes the individual’s dependents.

(11) FEDERAL POVERTY LEVEL; FPL.—The terms “Federal poverty level” and “FPL” have the meaning given the term “poverty line” in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

(12) HEALTH BENEFITS PLAN.—The term “health benefits plan” means health insurance coverage and any employment-based health plan and includes the public health insurance option.

(13) HEALTH INSURANCE COVERAGE.—The term “health insurance coverage” has the meaning given such term in section 2791 of the Public Health Service Act, but does not include coverage in relation to its provision of exceptions benefits—

(A) described in paragraph (1) of such subsection; or
(B) described in paragraph (2), (3), or (4) of such subsection if the benefits are provided under a separate policy, certificate, or contract of insurance.

(14) HEALTH INSURANCE ISSUER.—The term "health insurance issuer" has the meaning given such term in section 2791(b)(2) of the Public Health Service Act.

(15) HEALTH INSURANCE EXCHANGE.—The term "Health Insurance Exchange" means the Health Insurance Exchange established under section 301.

(16) INDIAN.—The term "Indian" has the meaning given such term in section 4 of the Indian Health Care Improvement Act (24 U.S.C. 1603).

(17) INDIAN HEALTH CARE PROVIDER.—The term "Indian health care provider" means a health care program operated by the Indian Health Service, an Indian tribe, tribal organization, or urban Indian organization as such term is defined in section 2791(d) of the Public Health Service Act.

(18) MEDICAID.—The term "Medicaid" means a plan implemented under subsection (a) of section 1902 of the Social Security Act (whether or not the plan is operating under a waiver under section 1115 of such Act).

(19) MEDICAID ELIGIBLE INDIVIDUAL.—The term "Medicaid eligible individual" means an individual who is eligible for medical assistance under Medicaid.

(20) MEDICARE.—The term "Medicare" means the health insurance programs under title XVIII of the Social Security Act.

(21) PLAN.—The term "plan" has the meaning given such term in section 3901(b) of the Employee Retirement Income Security Act of 1974.

(22) PLAN YEAR.—The term "plan year" means—

(a) with respect to an employment-based health plan, a plan year as specified under such plan; or

(b) with respect to a health benefit plan other than an employment-based health plan, a 12-month period as specified by the Commissioner.

(23) PREMIUM PLAN; PREMIUM-PLUS PLAN.—The terms "premium plan" and "premium-plus plan" have the meanings given such terms in section 303(c).

(24) QHP OFFERING ENTITY.—The terms "QHP offering entity" means, with respect to a health benefits plan that is—

(a) a group health plan (as defined, subject to subsection (d), in section 733(a)(1) of the Employee Retirement Income Security Act of 1974), the plan sponsor in relation to such group health plan, except that, in the case of a plan maintained jointly by 1 or more employers and 1 or more employee organizations and with respect to which an employer is the primary source of financing, such term means such employer;

(b) health insurance coverage, the health insurance issuer offering the coverage;

(c) the public health insurance option, the Secretary of Health and Human Services;

(d) a non-Federal governmental plan (as defined in section 2791(d) of the Public Health Service Act), the State or political subdivision of a State (or agency or instrumentality of such State or subdivision) which establishes or maintains such plan; or

(E) a Federal governmental plan (as defined in section 2791(d) of the Public Health Service Act), the appropriate Federal official.

(25) QUALIFIED HEALTH BENEFITS PLAN.—The term "qualified health benefits plan" means a health benefits plan that—

(a) meets the requirements for such a plan under title II and includes the public health insurance option; and

(b) is offered by a QHP offering entity that meets the applicable requirements of such title with respect to such plan.

(26) PUBLIC HEALTH INSURANCE OPTION.—The term "public health insurance option" means the public health insurance option as provided under subtitle B of title III.

(27) SERVICE AREA; PREMIUM RATING AREA.—The term "service area" and "premium rating area" mean with respect to health insurance coverage—

(A) offered other than through the Health Insurance Exchange, such an area as established by the QHP offering entity of such coverage in accordance with applicable State law; and

(B) offered through the Health Insurance Exchange, such an area as established by such entity in accordance with applicable State law and applicable rules of the Commissioner for Exchange-participating health benefits plans.

(28) STATE.—The term "State" means the 50 States and the District of Columbia and includes—

(A) for purposes of title I, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands; and

(B) for purposes of titles II and III, as elected under and subject to section 346, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(29) STATE MEDICAID AGENCY.—The term "State Medicaid agency" means, with respect to a Medicaid plan, the single State agency responsible for administering such plan under title XIX of the Social Security Act.

(30) Y1, Y2, ETC.—The terms "Y1", "Y2", "Y3", "Y4", "Y5", and similar subsequently numbered terms, mean 2013 and subsequent years, respectively.

TITLE I—IMMEDIATE REFORMS

SEC. 101. NATIONAL HIGH-RISK POOL PROGRAM.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish a temporary national high-risk pool program (in this section referred to as the "program") to provide health benefits to eligible individuals during the period beginning on January 1, 2010, and, subject to subsection (b)(3)(B), ending on the date on which the Health Insurance Exchange is established.

(b) Administration.—The Secretary may carry out this section directly or, pursuant to agreements, grants, or contracts with States, through high risk pool programs provided that the requirements of this section are met. For a State without a high risk pool program, the Secretary may work with the State to coordinate with other forms of coverage expansions, such as State public-private partnerships.

(c) Eligibility.—For purposes of this section, the term "eligible individual" means an individual who meets the requirements of subsection (1)(1)".

(1) who—

(A) is not eligible for—

(i) benefits under title XVIII, XIX, or XXI of the Social Security Act; or

(ii) coverage under an employment-based health plan (not including coverage under a COBRA continuation provision, as defined in section 107(d)(1)); and

(B) was offered coverage under such section if the benefits are provided under such section if the benefits are provided under such section if the benefits are provided under such section if the benefits are provided under such section.

(iii) premium rate for high risk pool coverage, reasonable in relation to the nature and source of such coverage and reasons for its discontinuance.

(3) who has not had health insurance coverage or coverage under an employment-based health plan for at least the 6-month period immediately preceding the date of the individual's application for high-risk pool coverage under this section; or

(4) who on or after October 29, 2009, had employment-based retiree health coverage (as defined in subsection (b)) and a decrease in premiums for such individual under such coverage (for any coverage period beginning on or after such date) exceeds such excessive percentage as the Secretary shall specify.

For purposes of paragraph (1)(A)(iii), a person is defined by the term "Medicaid eligible individual" defined in section 2701(b)(4) of the Public Health Service Act shall not be considered to be eligible for coverage under an employment-based health plan.

(d) MEDICALLY ELIGIBLE REQUIREMENTS.—For purposes of subsection (c)(1)(B)(ii), an individual described in this subsection is an individual—

(1) who, during the 6-month period ending on the date the individual applies for high-risk pool coverage under this section, was offered individual health insurance coverage at a premium rate for high risk pool coverage that was above the premium rate for high risk pool coverage available to such individual;

(A) was not offered such coverage because of a preexisting condition or was offered such coverage at a premium rate that was above the premium rate for high risk pool coverage available to such individual;

(B) was offered such coverage—

(i) under terms that limit the coverage for a preexisting condition; or

(ii) at a premium rate above the premium rate for high risk pool coverage available to such individual;

or

(C) who has an eligible medical condition as defined by the Secretary.

In making a determination under paragraph (1) of whether an individual was offered individual health insurance coverage at a premium rate above the premium rate for high risk pool coverage, the Secretary shall make adjustments to offset differences in premium rates that are attributable solely to differences in age rating.

(e) ENROLLMENT.—To enroll in coverage in the program, an individual shall—

(1) submit to the Secretary an application for participation in the program, at such time, in such manner, and containing such information as the Secretary shall require for such application.

(2) meet all of the requirements of subsection (a)(1)(B).

(3) if the individual had other prior health insurance coverage or coverage under an employment-based health plan, meet the requirements of subsection (b) if the individual is determined to have prior health insurance coverage.

(4) if the individual was offered such coverage under another health care program in the 12 months prior to the date of application for participation in the program, meet the requirements of subsection (a)(1)(A)(ii).

(5) PROTECTION AGAINST DUMPING RISKS BY INSURERS.—

(1) IN GENERAL.—The Secretary shall establish criteria for determining whether health insurance issuers and employment-based health plans have discouraged an individual from remaining enrolled in prior coverage based on that individual's health status.

Sanctions.—If the Secretary finds that a health insurance issuer or an employment-based health plan shall be responsible for reimbursing the program for the medical expenses incurred by the program for an individual who, based on criteria established by the Secretary, the Secretary finds was encouraged by the issuer to disenroll from a health benefits plan, the Secretary shall determine if the individual is eligible for enrollment in the program.

The criteria shall include at least the following circumstances:

(A) In the case of prior coverage obtained through an employer, employment-based or other forms of coverage expansions, such as State public-private partnerships.

(B) Whether the person was offered coverage in the program.

(C) Such insurance issuer is responsible for such individual.

(d) Protection Against Dumping Risks by Insurers.—

(1) IN GENERAL.—The Secretary shall establish criteria for determining whether health insurance issuers and employment-based health plans have discouraged an individual from remaining enrolled in prior coverage based on that individual's health status.

Sanctions.—If the Secretary finds that a health insurance issuer or an employment-based health plan shall be responsible for reimbursing the program for the medical expenses incurred by the program for an individual who, based on criteria established by the Secretary, the Secretary finds was encouraged by the issuer to disenroll from a health benefits plan, the Secretary shall determine if the individual is eligible for enrollment in the program.

The criteria shall include at least the following circumstances:

(A) In the case of prior coverage obtained through an employer, employment-based or other forms of coverage expansions, such as State public-private partnerships.

(B) Whether the person was offered coverage in the program.

(C) Such insurance issuer is responsible for such individual.
(i) the provision by the issuer or plan of money or other financial consideration for disenrolling from the coverage; or
(ii) in the case of an individual whose premium for the prior coverage exceeded the premium required by the program (adjusted based on the age factors applied to the prior coverage).

(ii) the prior coverage is a policy for which duration, pre-existing condition, or health status factors are that can be considered in determining premiums at renewal.

(ii) the prior coverage is a policy for which duration, pre-existing condition, or health status factors are that can be considered in determining premiums at renewal.

(iv) the prior coverage is a policy for which duration, pre-existing condition, or health status factors are that can be considered in determining premiums at renewal.

(iii) the prior coverage is a policy for which duration, pre-existing condition, or health status factors are that can be considered in determining premiums at renewal.

(ii) the prior coverage is a policy for which duration, pre-existing condition, or health status factors are that can be considered in determining premiums at renewal.

(iii) the prior coverage is a policy for which duration, pre-existing condition, or health status factors are that can be considered in determining premiums at renewal.

(ii) the prior coverage is a policy for which duration, pre-existing condition, or health status factors are that can be considered in determining premiums at renewal.

(iii) the prior coverage is a policy for which duration, pre-existing condition, or health status factors are that can be considered in determining premiums at renewal.

(ii) the prior coverage is a policy for which duration, pre-existing condition, or health status factors are that can be considered in determining premiums at renewal.

(iii) the prior coverage is a policy for which duration, pre-existing condition, or health status factors are that can be considered in determining premiums at renewal.
Secretary under section 2742(f).''.

(4) UNITED STATES IN GENERAL.—Such title is further amended by adding at the end the following:

"(f) RESCISSION.—A health insurance issuer may rescind individual health insurance coverage only upon clear and convincing evidence of fraud described in subsection (b)(2), under procedures that provide for independent, external third-party review.

(5) GUIDANCE.—The Secretary of Health and Human Services shall issue guidance implementing the amendments made by paragraphs (1) and (2), including procedures for independent, external third-party review.

(6) OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD-PARTY REVIEW IN CERTAIN CASES.—

"(a) NOTICE AND REVIEW RIGHT.—If a health insurance issuer determines to rescind health insurance coverage for an individual in the individual market, before such rescission may take effect the issuer shall provide the individual with notice of such proposed rescission of such determination by an independent, external third-party under procedures specified by the Secretary under section 2742(f).

"(b) INDEPENDENT DETERMINATION.—If the individual requests such review by an independent, external third-party of a rescission of such determination by the health insurance issuer, the coverage shall remain in effect until such third party determines that the coverage may be rescinded under the guidance issued by the Secretary under section 2742(f).

(7) APPLICATION TO GROUP HEALTH INSURANCE.—Such title is further amended by adding after section 2702 the following new section:

"SEC. 2706. OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD-PARTY REVIEW IN CASES OF RESCISSION.

"(a) NOTICE AND REVIEW.—(1) In general.—The Secretary shall, in conjunction with States, establish a process for the annual review, beginning in 2010 and subject to subsection (b), for the review of all premium increases in health insurance coverage.

"(2) Consideration.—In determining under paragraph (1) whether to allow additional premium increases, the Secretary shall take into account the rate of growth of the Consumer Price Index (as defined in subsection (b)) of the participant.

"(3) Grants.—The Secretary shall make available to States grants during 2010 through 2014, and thereafter, to States for review of premium increases.

"(b) Allocation.—The Secretary shall ensure the public disclosure of information on such increase and justifications for all health insurance issuers.

"(c) ALLOCATION.—The Secretary shall establish a formula for determining the amount of any grant to a State under this subsection.

"(7) OPPORTUNITY FOR EXTENSION OF DEPENDENT COVERAGE FOR UNINSURED YOUNG ADULTS.

"(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance in connection with a group health plan, that provides coverage for dependent children shall make available such coverage, at the option of the participant involved, for one or more qualified children as defined in subsection (b) of the participant.

"(b) QUALIFIED CHILD DEFINED.—In this section, the term 'qualified child' means, with respect to a participant in a group health plan or group health insurance coverage, an individual who (but for age) would be treated as a dependent child of the participant under such plan or coverage and who—

"(1) is under 27 years of age; and

"(2) is not enrolled as a participant, beneficiary, or enrollee (other than as an eligible child) under such plan or coverage.

"(c) PREMIUMS.—Nothing in this section shall be construed as preventing a group health plan or health insurance issuer with respect to group health insurance coverage from increasing the premiums otherwise required for coverage provided under this section consistent with standards established by the Secretary based upon family size.

"SEC. 2707. REQUIRING THE OPTION OF EXTENSION OF DEPENDENT COVERAGE FOR UNINSURE.
(1) REDUCTION IN LOOK-BACK PERIOD.—Section 701(a)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(a)(1)) is amended by striking “6-month period” and inserting “9 months”. (2) REDUCTION IN PERMITTED PREEXISTING CONDITION LIMITATION PERIOD.—Section 701(a)(2) of such Act (29 U.S.C. 1181(a)(2)) is amended by striking “12 months” and inserting “9 months”. (3) SUNSET OF INTERIM LIMITATION.—Section 701 of such Act is amended by striking “9 months” and inserting “9 months”. (b) AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.—(1) REDUCTION IN LOOK-BACK PERIOD.—Section 9801(a)(1) of the Internal Revenue Code of 1986 is amended by striking “6-month period” and inserting “30-day period”. (2) REDUCTION IN PERMITTED PREEXISTING CONDITION LIMITATION PERIOD.—Section 9801(a)(2) of such Code is amended by striking “12 months” and inserting “3 months”, and by striking “18 months” and inserting “9 months”. (3) SUNSET OF INTERIM LIMITATION.—Section 9801 of such Code is amended by adding at the end the following new subsection: “(b) TERMINATION.—This section shall cease to apply to any group health plan as of the date that such plan becomes subject to the requirements of section 211 of the (relating to prohibiting preexisting condition exclusions)”. (c) AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.—(1) REDUCTION IN LOOK-BACK PERIOD.—Section 2701(a)(1) of the Public Health Service Act (42 U.S.C. 300gg(a)(1)) is amended by striking “6-month period” and inserting “30-day period”. (2) REDUCTION IN PERMITTED PREEXISTING CONDITION LIMITATION PERIOD.—Section 2701(a)(2) of such Act (42 U.S.C. 300gg(a)(2)) is amended by striking “12 months” and inserting “3 months”, and by striking “18 months” and inserting “9 months”. (3) SUNSET OF INTERIM LIMITATION.—Section 2701 of such Act (42 U.S.C. 300gg) is amended by adding at the end the following new subsection: “(b) TERMINATION.—This section shall cease to apply to any group health plan as of the date that such plan becomes subject to the requirements of section 211 of the (relating to prohibiting preexisting condition exclusions).” (4) MISCELLANEOUS TECHNICAL AMENDMENT.—Section 2702 of such Act (42 U.S.C. 300gg-1) is amended by striking “701” and inserting “701(a)”. (d) EFFECTIVE DATES.—(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this subsection shall apply with respect to group health plans for plan years beginning on or after January 1, 2010. (2) SPECIAL RULE FOR COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of the enactment of this Act, the amendments made by this section shall not apply to plan years beginning before the earlier of— (A) the date that such collective bargaining agreements relating to the plan terminates (determined without regard

to any extension thereof agreed to after the date of the enactment of this Act); (B) 3 years after the date of the enactment of this Act. SEC. 107. PROHIBITING ACTS OF DOMESTIC VIOLENCE FROM BEING TREATED AS PREEXISTING CONDITIONS. (a) ERISA.—Section 701(d)(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(a)(3)) is amended— (1) in the heading, by inserting “OR DOMESTIC VIOLENCE” after “PREGNANCY”, and (2) by inserting “OR DOMESTIC VIOLENCE” after “relating to pregnancy”. (b) PHSA.—(1) GROUP MARKET.—Section 2701(d)(3) of the Public Health Service Act (42 U.S.C. 300gg(d)(3)) is amended— (A) in the heading, by inserting “OR DOMESTIC VIOLENCE” after “PREGNANCY”, and (B) by inserting “OR DOMESTIC VIOLENCE” after “relating to pregnancy”. (2) INDIVIDUAL MARKET.—Title XXVII of such Act is amended by inserting after section 2701(d)(3) the following new section: “SEC. 2754. PROHIBITION ON DOMESTIC VIOLENCE AS PREEXISTING CONDITION. “A health insurance issuer offering health insurance coverage in the individual market on or after the effective date, or health insurance issuers offering group health insurance coverage for plan years beginning on or after such date, shall not, on the basis of domestic violence, impose any preexisting condition exclusion (as defined in section 2701(b)(1)(A)) with respect to such coverage.” (c) IRC.—Section 9801(d)(3) of the Internal Revenue Code of 1986 is amended— (1) in the heading, by inserting “OR DOMESTIC VIOLENCE” after “PREGNANCY”; and (2) by inserting “OR DOMESTIC VIOLENCE” after “relating to pregnancy”. (d) EFFECTIVE DATES.—(1) Except as otherwise provided in this subsection, the amendments made by this section shall apply with respect to group health plans and health insurance issuers offering group health insurance coverage for plan years beginning on or after January 1, 2010. (2) The amendments made by subsection (b) shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after such date. SEC. 108. ENDING HEALTH INSURANCE DENIALS AND EXCLUSIONS BASED ON THE EXISTENCE OF A PREEXISTING CONDITION. (a) AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—(1) IN GENERAL.—Subpart B of part 7 of subchapter C of chapter 71 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181 et seq.) is amended by— (A) in the heading, by inserting “OR DOMESTIC VIOLENCE” after “PREGNANCY”, and (B) by inserting “OR DOMESTIC VIOLENCE” after “relating to pregnancy”. (2) AMENDMENTS TO THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.—(A) IN GENERAL.—Title XXVII of the Employee Retirement Income Security Act, as inserted by subsection (b), is amended by— (1) by adding the following new section: ‘‘Sec. 704. Requiring the option of extension consistent with standards established by the Secretary based upon family size.’’. (2) by amending section 2701(a)(1) of such Act (42 U.S.C. 300gg-1) with respect to such coverage.” (3) by amending section 2701(a)(3) of such Act (42 U.S.C. 300gg-3) with respect to such coverage.” (b) ERISA.—Section 701(d)(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1181(a)(3)) is amended— (1) in the heading, by inserting “OR DOMESTIC VIOLENCE” after “PREGNANCY”; and (2) by inserting “OR DOMESTIC VIOLENCE” after “relating to pregnancy”. (c) IRC.—Section 9801(d)(3) of the Internal Revenue Code of 1986 is amended— (1) in the heading, by inserting “OR DOMESTIC VIOLENCE” after “PREGNANCY”; and (2) by inserting “OR DOMESTIC VIOLENCE” after “relating to pregnancy”. (d) EFFECTIVE DATES.—(1) Except as otherwise provided in this subsection, the amendments made by this section shall apply with respect to group health plans and health insurance issuers offering group health insurance coverage for plan years beginning on or after January 1, 2010. (2) The amendments made by subsection (b) shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after such date.
“(i) procedures that do not materially affect the function of the body part being treated; and

(ii) procedures for secondary conditions and follow-up treatment.

(B) EXCEPTION.—Such term does not include cosmetic surgery performed to reshape normal structures of the body to improve appearance or self-esteem.

(C) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of such Code is amended by adding at the end the following new item:

"SEC. 715. Standards relating to benefits for minor child’s congenital or developmental deformity or disorder.

(a) REQUIREMENTS FOR TREATMENT FOR CHILDREN WITH DEFORMITIES.—A group health plan that provides coverage for surgical benefits shall provide coverage for outpatient and inpatient diagnosis and treatment of a minor child’s congenital or developmental deformity, disease, or injury. A minor child shall include any individual who is 21 years of age or younger.

(b) NOTICE.—A group health plan under this part shall comply with the notice requirement under section 713(b) (other than paragraphs (i), (ii), and (iii) with respect to the requirements of this section)."

(2) CONFORMING AMENDMENT.—

(A) Subsection (c) of section 731 of such Act is amended by striking "section 711" and inserting "sections 711 and 715".

(B) The table of contents in section 1 of such Act is amended by inserting after the item relating to section 714 the following new item:

"Sec. 715. Standards relating to benefits for minor child’s congenital or developmental deformity or disorder.

(b) AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1986.—

(1) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"SEC. 8914. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD’S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

(a) REQUIREMENTS FOR TREATMENT FOR CHILDREN WITH DEFORMITIES.—A group health plan that provides coverage for surgical benefits shall provide coverage for outpatient and inpatient diagnosis and treatment of a minor child’s congenital or developmental deformity, disease, or injury. A minor child shall include any individual who is 21 years of age or younger.

(b) NOTICE.—A group health plan under this part shall comply with the notice requirement under section 713(b) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of this section as if such section applied to such plan.

(2) INDIVIDUAL HEALTH INSURANCE.—Subpart 2 of part B of title XXVII of the Public Health Service Act, as amended by section 161(b), is further amended by adding at the end the following:

"SEC. 2755. STANDARDS RELATING TO BENEFITS FOR MINOR CHILD’S CONGENITAL OR DEVELOPMENTAL DEFORMITY OR DISORDER.

The provisions of section 2708 shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as such provisions apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

(c) CONFORMING AMENDMENTS.—

(A) Section 2723(c) of such Act (42 U.S.C. 300gg–23(c)) is amended by striking "section 2704" and inserting "sections 2704 and 2708".

(B) Section 2762(b)(2) of such Act (42 U.S.C. 300gg–62(b)(2)) is amended by striking "section 2751" and inserting "sections 2751 and 2755".

(d) EFFECTIVE DATES.—

(1) The amendments made by this section shall apply with respect to group health plans (and health insurance issuers offering group health insurance coverage) for plan years beginning on or after January 1, 2010.

(2) The amendment made by subsection (c)(2) shall apply with respect to health insurance coverage offered in connection with a group health plan, a dollar limitation on the total amount that may be paid under health insurance coverage with respect to benefits under the plan with respect to an individual or other coverage unit on a lifetime basis.

(3) CONFORMING AMENDMENTS.—

(A) Section 108(c)(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.), is amended by striking 

"(the dollar lifetime limit with respect to benefits under a group health plan or health insurance coverage offered in connection with a group health plan, a dollar limitation on the total amount that may be paid under health insurance coverage with respect to benefits under the plan with respect to an individual or other coverage unit on a lifetime basis)

and follow-up treatment.

(C) AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.—

(1) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–4 et seq.) is amended by adding at the end the following:

"SEC. 2709. ELIMINATION OF LIFETIME AGGREGATE LIMITS.

(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not impose an aggregate dollar lifetime limit with respect to benefits payable under the plan.

(b) DEFINITION.—In this section, the term ‘aggregate dollar lifetime limit’ means, with respect to benefits under a group health plan or health insurance coverage offered in connection with a group health plan, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit on a lifetime basis.’’.

(2) CLERICAL AMENDMENT.—The table of sections for subchapter B of chapter 100 of such Code, as amended by section 108(b), is amended by adding at the end the following:

"Sec. 9854. Standards relating to benefits for minor child’s congenital or developmental deformity or disorder.

(c) AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT RELATING TO THE GROUP MARKET.—

(1) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–4 et seq.) is amended by adding at the end the following:

"SEC. 2709. ELIMINATION OF LIFETIME AGGREGATE LIMITS.

(a) IN GENERAL.—A group health plan and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not impose an aggregate dollar lifetime limit with respect to benefits payable under the plan.

(b) DEFINITION.—In this section, the term ‘aggregate dollar lifetime limit’ means, with respect to benefits under a group health plan or health insurance coverage offered in connection with a group health plan, a dollar limitation on the total amount that may be paid under health insurance coverage with respect to benefits under the plan or health insurance coverage with respect to an individual or other coverage unit on a lifetime basis.

(2) INDIVIDUAL MARKET.—Subpart 2 of part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–62 et seq.) is amended by adding at the end the following:

"SEC. 2756. ELIMINATION OF LIFETIME AGGREGATE LIMITS.

The provisions of section 2709 shall apply to health insurance coverage offered by a health insurance issuer in the individual market."
market in the same manner as they apply to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group markets, except that the reduction in benefits (and health insurance issuers offering group health insurance coverage) for plan years beginning on or after January 1, 2010.

(2) Amendment made by subsection (c)(2) shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after such date.

SEC. 110. PROHIBITION AGAINST POSTRETIREMENT REDUCTIONS OF RETIREE HEALTH BENEFITS BY GROUP HEALTH PLANS.

(a) In General.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by sections 108 and 109, is amended by inserting after section 716 the following new section:

“SEC. 717. PROTECTION AGAINST POSTRETIREMENT REDUCTION OF RETIREE HEALTH BENEFITS.

“(a) In General.—Every group health plan shall—(1) establish a plan which bars the plan, or any fiduciary of the plan, from reducing the benefits provided under the plan to a Retiree, or beneficiary of a Retiree, unless such reduction affects the benefits provided to the participant or beneficiary as of the date the participant or beneficiary is no longer a participant or beneficiary of the plan; (2) with respect to a group health plan in the small or large group market (as defined in part III of subchapter C of chapter 70 of title 5) as a contract of insurance, the group health plan in the small or large group market (as defined in part III of subchapter C of chapter 70 of title 5) as a contract of insurance; and (3) with respect to other cost-sharing and benefit reduction in benefits—(i) is—(I) maintained by one or more employers (including without limitation any State or political subdivision thereof, or any agency or instrumentality of any of the foregoing), former employers or employee organizations or associations in the group health plan, or any employer, or participating employment-based plan, or any agency or instrumentality of any of the foregoing, or (II) is not an active employee of any participating employment-based plan.
(ii) LIMITATION TO AVAILABLE FUNDS.—The Secretary has the authority to stop taking applications for participation in the program or take such other steps in reducing expenditures under a wellness program in order to ensure that expenditures under the reimbursement program do not exceed the funds available under this subsection.

SEC. 112. WELLNESS PROGRAM GRANTS.

(a) ALLOWANCE OF GRANT.—

(1) IN GENERAL.—For purposes of this section, the Secretaries of Health and Human Services and Labor shall jointly award wellness program grants under this section. Wellness program grants shall be awarded to small employers (as defined by the Secretary of Labor) any plan year in an amount equal to 50 percent of the funds paid or incurred by such employers in connection with a qualified wellness program during the plan year. For purposes of the preceding sentence, in the case of any qualified wellness program offered as part of an employment-based health plan, only costs attributable to the qualified wellness program and not to the health plan, or health insurance coverage offered in connection with such a plan, may be taken into account.

(b) LIMITATION OF GRANT.—

(A) In general.—A wellness grant awarded to an employer under this section shall be for up to 3 years.

(B) Amount.—The amount of the grant under paragraph (1) for an employer shall not exceed—

(1) the product of $150 and the number of employees of the employer for any plan year; and

(2) $50,000 for the entire period of the grant.

(c) QUALIFIED WELLNESS PROGRAM.—For purposes of this section:

(1) QUALIFIED WELLNESS PROGRAM.—The term “qualified wellness program” means a program that—

(A) includes any 3 wellness components described in subsection (c); and

(B) is to be certified jointly by the Secretary of Health and Human Services and the Secretary of Labor, in coordination with the Director of the Centers for Disease Control and Prevention, as a qualified wellness program under this section.

(2) PROGRAMS MUST BE CONSISTENT WITH RESEARCH AND BEST PRACTICES.—

(A) IN GENERAL.—The Secretary of Health and Human Services and the Secretary of Labor shall not certify a program as a qualified wellness program unless the program—

(i) is consistent with evidence-based research and best practices, as identified by persons with expertise in employer health promotion and wellness programs;

(ii) includes multiple, evidence-based strategies which are based on the existing and emerging research and careful scientific reviews, including the Guide to Community Preventive Services, the Guide to Clinical Preventive Services, and the National Registry for Effective Programs, and

(iii) includes strategies which focus on prevention and support for employee population health outcomes.

(B) PERIODIC UPDATING AND REVIEW.—The Secretaries of Health and Human Services and Labor, in consultation with other appropriate agencies, shall—

(i) monitor and periodically evaluate such programs and the evidence on which they are based; and

(ii) revise the criteria for certification under this section as necessary.

(c) HEALTH LITERACY AND ACCESSIBILITY.—

The Secretary of Health and Human Services and Labor shall jointly, as part of the certification process—

(A) ensure that employers make the program content and materials physically accessible (including for individuals with disabilities), and appropriate to the health literacy needs of the employees covered by the programs;

(B) require a health literacy component to provide special assistance and materials to employees with literacy skills, limited English and from underserved populations; and

(C) require the Secretaries to compile and disseminate to employer health plan administrators information on model health literacy curricula, instructional programs, and effective intervention strategies.

(d) WELLNESS PROGRAM COMPONENTS.—For purposes of this section, the wellness program components described in this subsection are the following:

(1) HEALTH AWARENESS COMPONENT.—A health awareness component which provides for the following:

(A) HEALTH EDUCATION.—The dissemination of health information which addresses the specific needs and health risks of employees. (B) HEALTH SCREENINGS.—The opportunity for periodic screenings for health problems and referrals for appropriate follow-up measures.

(2) EMPLOYEE ENGAGEMENT COMPONENT.—An employee engagement component which provides for an active engagement of employees in worksite wellness programs through worksite assessments and program planning, onsite delivery, evaluation, and improvement efforts.

(3) BEHAVIORAL CHANGE COMPONENT.—A behavioral change component which encourages healthy living through counseling, seminars, self-help manuals, online tools, or other programs which provide technical assistance and problem solving skills. Such component may include programs relating to—

(A) tobacco use;

(B) obesity;

(C) stress management;

(D) physical fitness;

(E) nutrition;

(F) substance abuse;

(G) depression; and

(H) mental health promotion.

(4) SUPPORTIVE ENVIRONMENT COMPONENT.—A supportive environment component which includes the following:

(A) On-site educational programs—Policies and services at the worksite which promote a healthy lifestyle, including policies relating to—

(i) tobacco use at the worksite;

(ii) the availability of healthy foods at the worksite through cafeterias and vending options;

(iii) minimizing stress and promoting positive mental health; and

(iv) the encouragement of physical activity before, during, and after work hours.

(b) PARTICIPATION REQUIREMENT.—No grant shall be awarded under subsection (a) unless the Secretaries of Health and Human Services and Labor, in consultation with other appropriate agencies, jointly certify, as a part of any certification described in subsection (b), that each wellness program component of the qualified wellness program—

(1) shall be available to all employees of the employer;

(2) shall not mandate participation by employees; and

(3) may provide a financial reward for participation of an individual in such program as long as such reward is not tied to the premium or cost-sharing of the individual under the health benefits plan.

(e) PHASEOUT PROTECTIONS.—Data gathered for purposes of the employer wellness program may be used solely for the purposes of administering the program. The Secretaries of Health and Human Services and Labor shall develop standards to ensure that such data remain confidential and are not used for purposes beyond those for administering the program.

(f) CERTAIN COSTS NOT INCLUDED.—For purposes of this section, costs paid or incurred by an employer for food or health insurance coverage of COBRA continuation coverage shall not be taken into account under subsection (a).

(g) OUTREACH.—The Secretaries of Health and Human Services and Labor, in conjunction with other appropriate agencies and members of the business community, shall institute an outreach program to inform businesses about the availability of the wellness program grant as well as to educate businesses on how to develop programs acceptable to employees, recognize best practices and on how to measure the success of implemented programs.

(2) EFFECTIVE DATE.—This section shall take effect on July 1, 2010.

(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

SEC. 113. EXTENSION OF COBRA CONTINUATION COVERAGE.

(a) EXTENSION OF CURRENT PERIODS OF CONTINUATION COVERAGE.—

(1) In general.—In the case of any individual who is, under a COBRA continuation coverage provision, entitled to COBRA continuation coverage on or after the date of the enactment of this Act, the required period of any such coverage which has not subsequently terminated pursuant to any provision for any reason other than the expiration of a period of specified number of months shall, notwithstanding such provision and subject to subsection (b), extend to the earlier of the date on which such individual becomes eligible for acceptable coverage or the date on which such individual becomes eligible for health insurance coverage through the Health Insurance Exchange (or a State-based Health Insurance Exchange operating in a State or group of States).

(2) Notice.—As soon as practicable after the date of the enactment of this Act, the Secretary of Labor, in consultation with the Secretary of the Treasury and the Secretary of Health and Human Services, shall, in consultation with administrators of the group health plans (or other entities) that provide COBRA continuation coverage involvement, provide rules setting forth the form and manner in which prompt notice to individuals of the continued availability of COBRA continuation coverage to such individuals under paragraph (1).

(b) CONTINUOUS EFFECT OF OTHER TERMINATING EVENTS.—Notwithstanding section (a), any required period of COBRA continuation coverage which is extended under this subsection shall cease upon the occurrence, prior to the date of termination otherwise provided for in this subsection, of any terminating event specified in the applicable continuation coverage provision other than the expiration of a period of any specified number of months.

(c) ACCESS TO STATE HEALTH BENEFITS RISK POOLS.—This section shall supersede any provisions of the law of a State or political subdivision thereof to the extent that such provision has the effect of limiting or precluding access by a qualified beneficiary whose COBRA continuation coverage has been extended under this section to a State health benefits risk pool recognized by the Commissioner for purposes of this section by reason of the extension of such continuation coverage beyond the date on which such coverage otherwise would have expired.

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

(1) COBRA continuation coverage.—The term ‘‘COBRA continuation coverage’’
means continuation coverage provided pursuant to part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (other than under section 608), title XXIII of the Social Security Act, section 1882 of the Internal Revenue Code of 1986, and the Continuation of Health Benefits Act of 1984 (Public Law 98–299). (4) ADMINISTRATION BASED ON CURRENT PROGRAM. —The program under this section is intended to replace the State Best Hope Access Program funded under the Omnibus Appropriations Act, 2009 (Public Law 111–8).

(d) FUNDING LIMITATIONS.—
(1) IN GENERAL.—A grant under this section shall—
(A) only be available for expenditures before the end of the fiscal year to which the grant relates;
(B) only be used to supplement, and not supplant, funds otherwise provided.
(2) MATCHING FUND REQUIREMENT.—
(A) In general.—In paragraph (B), no grant may be awarded to a State unless the State demonstrates the seriousness of its effort by matching at least 20 percent of the amount paid out through non-Federal resources, which may be a combination of State, local, private dollars from insurers, providers, and other private organizations.
(B) Waiver.—The Secretary may waive the requirement of subparagraph (A) if the State demonstrates to the Secretary financial hardship in complying with such requirement.

(e) STUDY.—The Secretary shall review, study, and benchmark the progress and results of the programs funded under this section.

(f) REPORT.—Each State receiving a grant under this section shall submit to the Secretary a report on best practices and lessons learned through implementation and the results of the programs funded under this section.

(g) FUNDING.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 115. ADMINISTRATIVE SIMPLIFICATION.

(a) STANDARDIZING ELECTRONIC ADMINISTRATIVE TRANSACTIONS.—
(1) IN GENERAL.—Part C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.) is amended by inserting after section 11733 the following new sections:

"SEC. 1173A. STANDARDIZE ELECTRONIC ADMINISTRATIVE TRANSACTIONS.

"(a) STANDARDS FOR FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.—

"(1) IN GENERAL.—The Secretary shall adopt and regularly update standards consistent with the goals described in paragraph (2).

"(2) GOALS FOR FINANCIAL AND ADMINISTRATIVE TRANSACTIONS.—The goals for standards under paragraph (1) are that such standards shall—

(A) be unique with no conflicting or redundant standards;

(B) be authoritative, permitting no additions or exceptions to covered transactions, including companion guides;

(C) be comprehensive, efficient and robust, requiring minimal augmentation by interpretative guidance or clarification by further communications;

(D) enable the real-time (or near real-time) determination of an individual's financial responsibility at the point of service and, to the extent possible, prior to service, including whether the individual is eligible for a specific service with a specific physician or provider and coinsurance under a specific plan or range of dates, include utilization of a machine-readable health plan beneficiary identification card or similar mechanism;

(E) enable, where feasible, near real-time adjudication of claims;

(F) provide for timely acknowledgment, response, and status reporting applicable to any electronic transaction deemed appropriate by the Secretary;

(G) describe all data elements (such as reason and remark codes) in unambiguous terms and additional fields, require that data elements be either required or conditioned upon set values in other fields, and prohibit additional conditions except where required by (a) the (requirement) State or Federal law or to protect against fraud and abuse; and

(H) harmonize all common data elements across administrative and clinical transactions.

(3) TIME FOR ADOPTION.—Not later than 2 years after the date of enactment of this section, the Secretary shall adopt standards under this section by interim, final rule.

(4) REQUIREMENTS FOR SPECIFIC STANDARDS.—Not later than 5 years after the date of enactment of this section, the Secretary shall develop, adopt, and enforce so as to—

(A) clarify, refine, complete, and expand, as needed, the standards required under section 1173;

(B) require paper versions of standardized transactions to comply with the same standards as their electronic equivalents so that a fully compliant, equivalent electronic transaction can be populated from the data from a paper version;

(C) enable electronic funds transfers, in order to allow automated reconciliation with the related health care payment and remittance advice;

(D) require timely and transparent claim and denial management processes, including uniform claim edits, uniform reason and remark codes, tracking, adjudication, and appeal processing;

(E) require the use of a standard electronic transaction with health care providers may quickly and efficiently enroll with a health plan to conduct the other electronic transactions provided for in this part; and

(F) provide for other requirements relating to administrative simplification as identified by the Secretary, in consultation with stakeholders.

(5) BUILDING ON EXISTING STANDARDS.—In adopting the standards under this section, the Secretary shall consider existing and planned standards.

(6) IMPLEMENTATION AND ENFORCEMENT.—Not later than 6 months after the date of enactment of this section, the Secretary shall submit to the appropriate committees of Congress a plan for the implementation and enforcement, by not later than 5 years after such date of enactment, of the standards under this section. Such plan shall include—

(A) a process and timeframe with milestones for developing the complete set of standards;

(B) a proposal for accommodating necessary changes between early adopters and late adopters, and a process for upgrading standards as often as annually by interim, final rulemaking;

(C) programs to provide incentives for, and reduce the burden of, health care providers who volunteer to participate in the process of setting standards for electronic transactions;

(D) an estimate of total funds needed to ensure timely completion of the implementation plan; and

(E) an enforcement process that includes the investigation of complaints, random audits to ensure compliance, civil monetary and programmatic penalties for noncompliance consistent with existing laws and regulations, and a fair and reasonable appeals process building off of enforcement provisions under this part, and concurrent State enforcement jurisdiction.

(7) NOTIFICATION.—The Secretary shall submit a notification at least annually to the House Ways and Means Committee and the Senate Finance Committee describing his efforts to advance the implementation and enforcement of the standards adopted under this section.
both syntactically and functionally compli-
ant with all the standard transactions man-
dated pursuant to the administrative sim-
plification provisions of this part and the Health
Insurance Portability and Account-
ability Act of 1996.

(b) LIMITATIONS ON USE OF DATA.—Noth-
ing in the preceding paragraph shall con-
stitute a waiver of HIPAA’s privacy and
security standard adopted under section 30014
of such Act.

SEC. 1173B. INTERIM COMPANION GUIDES, IN-
CLUDING OPERATING RULES.

(1) IN GENERAL.—The Secretary shall
adopt a single, binding, comprehensive
compagny guide, that includes operating rules
for open X12 Version 5010 transaction de-
scribed in section 1173(a)(2), to be effective
by no later than October 1, 2012.

(2) COMPANION GUIDE AND OPERATING RULES
DEVELOPMENT.—In adopting such in-
terim companion guide and rules, the Sec-
retary shall comply with section 1172, except
that a nonprofit entity that meets the fol-
lowing criteria shall also be consulted:

(a) The entity focuses its mission on ad-
ministrative simplification.

(b) The entity uses a multistakeholder
process to create consensus-based com-
panion guides, including operating rules
using a voting process that ensures balanced
representation by the critical stakeholders
(including employers and health plan
participants) so that no one group dominates the
entity and shall include others such as stan-
dards development organizations, and
relevant Federal or State agencies.

(3) The entity has in place a public set of
guiding principles that ensure the com-
pagny guide and operating rules and process are
open, fair, and nondiscriminatory.

(4) The entity coordinates its activities
with the HIT Policy Committee, and the HIT
Standards Committee (established under title
c of the Health Insurance Portabil-
ity and Accountability Act of 1996, and
complements the efforts of the Office of the
National Coordinator for Health Information
Exchange goals).

(5) The entity incorporates the stan-
dards issued under Health Insurance Portabil-
ity and Accountability Act of 1996 and this
part, and in developing the companion guide and
operating rules does not change the definition,
data condition or use of a data element or
segment in a standard, add any elements or
segments to the maximum defined data
set, use any codes or data elements that are
either marked ‘‘not used’’ in the standard’s
implementation specifications or are not in the
standard’s implementation specifications,
or change the meaning or intent of the stan-
dard’s implementation specifications.

(6) The entity uses existing market re-
search and proven best practices.

(7) The entity has a set of measures that
allow for the evaluation of their market
impact and public reporting of aggregate stake-
holder feedback.

(8) The entity supports nondiscrimination
and conflict of interest policies that dem-
strate commitment to open, fair, and
nondiscriminatory practices.

(9) The entity allows for public reviews
and comment on updates of the companion
guide and operating rules.

(c) IMPLEMENTATION.—The Secretary shall
adopt a single, binding companion guide, in-
cluding operating rules under this section,
for each transaction, to become effective
by no later than October 1, 2011.

(d) EXPANSION OR PENALTIES.—Section 1176
of such Act (42 U.S.C. 1320d-5) is amended
with the following new paragraph:

(10) OPERATING RULES.—The term ‘‘oper-
ating rules’’ means business rules for using
and processing transactions, such as service
level requirements, which do not impact the
implementation specifications or other data
content requirements.

(3) CONFORMING AMENDMENT.—Section
1179(a) of such Act (42 U.S.C. 1320d-8(a)) is
amended, in the matter before paragraph (1)—

(A) by inserting ‘‘on behalf of an indi-
vidual’’ after ‘‘1978’’; and

(B) by inserting ‘‘on behalf of an indi-
vidual’’ after ‘‘for a financial institu-
tion’’ and

(a) STANDARDS FOR CLAIMS ATTACH-
MENTS AND COORDINATION OF BENEFITS.

(1) STANDARD FOR HEALTH CLAIMS AT-
ACHMENTS.—Not later than January 1, 2013, the
Secretary of Health and Human Services shall promul-
gate an interim final rule to estab-
lish a standard for health claims attach-
ment transaction described in section 1173(a)(2)(B)
of the Social Security Act (42 U.S.C. 1320d-
2(a)(2)(B)) and coordination of benefits.

(2) REVISION IN PROCESSING PAYMENT TRAN-
SACTIONS BY FINANCIAL INSTITUTIONS.

(A) IN GENERAL.—The Secretary of Health
and Human Services shall promul-
gate an interim final rule to estab-
lish a standard for electronic funds transfer under
section 1173A, by inserting ‘‘on behalf of a
financial institution’’ after ‘‘1978’’; and

(B) by inserting ‘‘on behalf of an indi-
vidual’’ after ‘‘for a financial institu-
tion’’ and

(c) STANDARDS FOR FIRST REPORT OF IN-
SURED.—Not later than October 1, 2013, the
Secretary of Health and Human Services shall promul-
gate an interim final rule to estab-
lish a standard for the first report of in-
jury transaction described in section
1173(a)(2)(G) of the Social Security Act (42

(d) UNIQUE HEALTH PLAN IDENTIFIER.—Not
later than October 1, 2012, the Secretary of Health
and Human Services shall promulgate an inter-
minal final rule to establish a unique health
plan identifier described in section
1173(a)(2)(B) of the Social Security Act (42
U.S.C. 1320d-2(a)(2)(B)) in a manner such that such
transaction described in section
1173(a)(2)(B) of the Social Security Act (42
U.S.C. 1320d-2(a)(2)(B)) shall be adopted not later than
October 1, 2012, in a manner such that such set
of rules is effective beginning not later than
January 1, 2014.

(2) REQUIREMENTS FOR QUALIFIED HEALTH
BENEFITS PLANS.—On or after the first day of
2014, a health benefits plan shall not be a
qualified health benefits plan under this di-
vision unless the plan meets the applicable
requirements of the following subtitles for
the type of plan and plan year involved:

(1) Subtitle B (relating to affordable cov-
erage).

(2) Subtitle C (relating to essential bene-
fits).

(3) Subtitle D (relating to consumer pro-
tection and enforcement).

(o) TERMINOLOGY.—In this division:

(1) Enrollment in Employment-Based Health
Plans.—An individual shall be treat-
ed as being ‘‘enrolled’’ in an employment-
based health plan if the individual is a par-
ticipant or beneficiary (as such terms are de-
defined in section 3(7) and 3(8), respectively, of the

(2) Individual and Group Health Insurance
Coverage.—The terms ‘‘individual health insurance coverage’’ and ‘‘group health insurance coverage’’ mean health insurance coverage offered in the individual market or small group market, respec-
tively, as defined in section 2791 of the
Public Health Service Act.

(d) Treatment of Qualified Direct Primary
Care Medical Home Plans.—The Com-
missioner may permit a qualified health ben-
fits plan to provide through a qualified
primary care medical home plan, as long as the qualified health benefits plan
meets all requirements that are other-
wise applicable and the services covered
by the medical home plan are coordinated
with the QHP offering entity.
SEC. 202. PROTECTING THE CHOICE TO KEEP CURRENT COVERAGE.

(a) GRANDFATHERED HEALTH INSURANCE COVERAGE.—Subject to the preceding provisions of this section, for purposes of establishing acceptable coverage under this division, the term "grandfathered health insurance coverage" means health insurance coverage that is offered and in force and effect before the first day of Y1 if the following conditions are met:

(1) LIMITATION ON NEW ENROLLMENT.—(A) IN GENERAL.—Except as provided in this paragraph, the individual health insurance issuer shall not enroll any individual in such coverage if the first effective date of coverage is on or after the first day of Y1.

(B) GRANDFATHERED COVERAGE PERMITTED.—Subparagraph (A) shall not affect the subsequent enrollment of a dependent of an individual who is covered as of such first day.

(2) LIMITATION ON CHANGES IN TERMS OR CONDITIONS.—Subject to paragraph (3) and except as required by law, the issuer does not change any of its terms or conditions, including benefits and cost-sharing, from those in effect as of the day before the first day of Y1.

(3) RESTRICTIONS ON PREMIUM INCREASES.—The issuer cannot vary the percentage increase in the premium for a risk group of enrollees in specific grandfathered health insurance coverage without changing the premium for all enrollees in the same risk group at the same rate, as specified by the Commissioner.

(b) GRACE PERIOD FOR CURRENT EMPLOYMENT-BASED HEALTH PLANS.—

(1) GRACE PERIOD.—(A) IN GENERAL.—The Commissioner shall establish a grace period whereby, for plan years beginning after the end of the 5-year period beginning with Y1, an employment-based health plan in which the coverage consists only of such limited benefits as the Commissioner deems appropriate to enroll an individual or family in such employment-based health plan during the grace period during which the enrollee has been unable to pay obligations or otherwise being able to pay premiums.

(B) DEPENDENT COVERAGE PERMITTED.—Subparagraph (A) shall not prevent the issuer offering such coverage to a dependent of an individual who is a covered enrollee of such employment-based health plan.

(c) EXCEPTION FOR LIMTED BENEFITS PLANS.—Subparagraph (A) shall not apply to an employment-based health plan in which the coverage consists only of one or more of the following:

(1) any coverage described in section 300L(a)(1)(B)(ii)(IV) of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111-5);

(2) excepted benefits (as defined in section 733(c) of the Employee Retirement Income Security Act of 1974), including coverage under a specified disease or illness policy described in paragraph (3)(A) of such section.

(3) other limited benefits as the Commissioner may specify.

In no case shall an employment-based health plan in which the coverage consists only of one or more of the coverage or benefits described in clauses (i) through (iii) be treated as acceptable coverage under this division.

(d) TRANSITIONAL TREATMENT AS ACCEPTABLE COVERAGE.—During the grace period specified in paragraph (1), an employment-based health plan (which may be a high deductible health plan, as defined in section 223(c)(2) of the Internal Revenue Code of 1986) that is otherwise acceptable under this division shall be treated as acceptable coverage under this division.

(e) LIMITATION ON INDIVIDUAL HEALTH INSURANCE COVERAGE.—

(1) IN GENERAL.—Individual health insurance coverage that is not grandfathered health insurance coverage under subsection (a) may not be enrolled on or after the first day of Y1 as an Exchange-participating health benefits plan.

(2) SEPARATE, EXCEPTED COVERAGE PERMITTED.—Nothing in—

(A) paragraph (1) shall prevent the offering of excepted benefits described in section 2701(b)(1)(A) of the Public Health Service Act (other than subsections (b) and (c) of such section) or otherwise permitted under this division, the term "grandfathered health insurance coverage" means health insurance coverage that is offered and in force and effect before the first day of Y1, and

(B) this division shall be construed—

(i) to prevent the offering of a stand-alone plan that offers coverage of excepted benefits as described in section 2701(b)(1)(A) of the Public Health Service Act (relating to limited scope dental or vision benefits for individuals and families from a State-licensed dental and vision carrier), and

(ii) as applying requirements for a qualified health benefits plan to such a stand-alone plan that is offered and priced separately from a qualified health benefits plan.

Subtitle B—Standards Guaranteeing Access to Affordable Coverage

SEC. 211. PROHIBITING PREEXISTING CONDITION EXCLUSION.

(a) QUALIFIED HEALTH BENEFITS PLAN MAY NOT IMPOSE ANY PREEXISTING CONDITION EXCLUSION.

A qualified health benefits plan may not impose any preexisting condition exclusion (as defined in section 2701(b)(1)(B) of the Public Health Service Act) or otherwise impose an adverse condition on the coverage under the plan with respect to an individual or dependent based on any of the following:

(1) health status, medical condition, claims experience, risk classification, medical history, genetic information, evidence of insurability, disability, or source of injury (including conditions arising out of acts of domestic violence) or any similar factors.

SEC. 212. GUARANTEED ISSUE AND RENEWAL FOR INSURED PLANS AND PROHIBITION OF DISCRIMINATION.

The requirements of sections 2711 (other than subsections (e) and (f)) and 2712 (other than paragraphs (3), and (6) of subsection (b) and section 2713 of the Public Health Service Act, relating to guaranteed availability and renewability of health insurance coverage, shall apply to individuals and employers in all individual and group health insurance coverage, whether offered to individuals or employers through the Health Insurance Exchange, through any employment-based health plan, or otherwise, in the same manner as such sections apply to employers and health insurance coverage offered in the small group market, except that such coverage is not required to include coverage for preexisting conditions, and no risk-based premium may be charged for such coverage.

Subsection (c) of section 2713 of the Public Health Service Act, relating to guaranteed availability and renewability of health insurance coverage, shall apply to individuals and employers in all individual and group health insurance coverage, whether offered to individuals or employers through the Health Insurance Exchange, through any employment-based health plan, or otherwise, in the same manner as such sections apply to employers and health insurance coverage offered in the small group market, except that such coverage is not required to include coverage for preexisting conditions, and no risk-based premium may be charged for such coverage.

Rescissions of such coverage shall be prohibited except in cases of fraud as defined in section 2711(f).

SEC. 213. INSURANCE RATING RULES.

(a) IN GENERAL.—The premium rate charged for a qualified health benefits plan that is health insurance coverage may not vary except as follows:

(1) LIMITED AGE VARIATION PERMITTED.—By age (within such age categories as the Commissioner shall specify) so long as the ratio of the highest such premium to the lowest such premium does not exceed the ratio of 2 to 1.

(2) BY AREA.—By premium rating area (as permitted by State insurance regulators or, in the case of Exchange-participating health benefits plans, as specified by the Commissioner (including applicable marketplaces, and in the case of Exchange-participating health benefits plans, the applicable marketplaces, and in the case of Exchange-participating health benefits plans, the applicable issuers).)

(3) BY FAMILY ENROLLMENT.—By family enrollment (such as variations within categories and combinations of families) so long as the ratio of the highest such premium to the lowest such premium (or enrollments) to the premium for individual enrollment is uniform, as specified under law and consistent with rules of the Commissioner.

(b) ACTUARIAL VALUE OF OPTIONAL SERVICE COVERAGE.

(1) IN GENERAL.—The Commissioner shall prescribe the basic per enrollee, per month cost, determined on an average actuarial basis, including coverage under a basic plan of the services described in section 222(c)(4)(A).

(2) CONSIDERATIONS.—In making such estimates, the Commissioner (A) may take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost-sharing estimates resulting from such services, including prenatal care, delivery, or postnatal care;

(B) shall estimate such costs as if such coverage were included for the entire population covered; and

(C) may not estimate such a cost at less than $1 per enrollee, per month.

(c) STUDY.—

(1) STUDY.—The Commissioner, in coordination with the Secretary of Health and Human Services and the Secretary of Labor, shall conduct a study of the large-group-insured and self-insured employer health care markets. Such study shall examine the following:

(A) The types of employers by key characteristics, including size, that purchase insured products versus those that self-insure.

(B) Employer and individual stories that compare between typical insured and self-insured health plans.

(C) The financial solvency and capital reserve levels of employers that self-insure by employer size.

(D) The risk of self-insured employers not being able to pay obligations or otherwise becoming financially insolvent.

(E) The extent to which rating rules are likely to cause adverse selection in the large group market.

(2) REPORTS.—Not later than 18 months after the date of the enactment of this Act, the Commissioner shall submit to Congress and the applicable agencies a report on the study conducted under paragraph (1). Such report shall include any recommendations of the Commissioner designed to ensure that the law does not provide incentives for small and midsize employers to self-insure.

SEC. 214. NONDISCRIMINATION IN BENEFITS; PARITY IN MENTAL HEALTH AND SUBSTANCE ABUSE DISORDER BENEFITS.

(a) NONDISCRIMINATION IN BENEFITS.—A qualified health benefits plan shall comply with standards established by the Commissioner to prohibit discrimination in health benefits or benefit structures for qualifying health benefits plans, building from section 702 of the Employee Retirement Income Security Act of 1974, section 2702 of the Public Health Service Act, and section 9802 of the Internal Revenue Code of 1986.

(b) PARITY IN MENTAL HEALTH AND SUBSTANCE ABUSE DISORDER BENEFITS.—To the extent such provisions are defined by or inconsistent with title X or title I of the Employee Retirement Income Security Act of 1974, section 2702 of the Public Health Service Act, and section 9802 of the Internal Revenue Code of 1986.
SEC. 215. ENSURING ADEQUACY OF PROVIDER NETWORKS.

(a) In general.—A qualified health benefits plan provider network for items and services shall meet such standards respecting provider networks as the Commissioner may establish to assure the adequacy of such provider network's access to such items and services and transparency in the cost-sharing differentials among providers participating in the network and policies for on- and off-network providers.

(b) Internet Access to Information.—A qualified health benefits plan that uses a provider network shall provide a public list on its website of all providers in its network and such data shall be available on the Health Insurance Exchange Website as a part of the basic information on that plan.

The Commissioner shall also establish an online system whereby an individual may select by name any medical provider (as defined by the Commissioner) and be informed of the plan or plans with which that provider is contracting.

(c) Provider Network Defined.—In this division, the term "provider network" means the providers with respect to which covered benefits, treatments, and services are available under a health benefits plan.

SEC. 216. REQUIRING THE OPTION OF EXTENSION OF DEPENDENT COVERAGE FOR UNEMPLOYED ADULTS.

(a) In general.—A qualified health benefits plan shall make available, at the option of the principal enrollee and at the employer's discretion, health benefits for any entitled child (as defined in subsection (b)) of the enrollee.

(b) Qualifying Child Defined.—In this section, the term "entitled child" means, with respect to a principal enrollee in a qualified health benefits plan, an individual who (but for age) would be treated as a dependent child of the enrollee under such plan and who—

(1) is under 27 years of age; and

(2) is not enrolled in a health benefits plan other than under this section.

(c) Premiums.—Nothing in this section shall be construed to prohibit a qualified health benefits plan from imposing premiums with respect to a principal enrollee in a qualified health benefits plan, an individual who (but for age) would be treated as a dependent child of the enrollee under such plan and who—

(1) is under 27 years of age; and

(2) is not enrolled in a health benefits plan other than under this section.

(d) Premiums.—Nothing in this section shall be construed as preventing a qualified health benefits plan from increasing the premiums otherwise required for coverage provided under this section consistent with standards established by the Commissioner based upon family size under section 231(a)(3).

SEC. 217. CONSISTENCY OF COSTS AND COVERAGE OF QUALIFIED HEALTH BENEFITS PLANS DURING PLAN YEAR.

In the case of a qualified health insurance coverage offered under a qualified health benefits plan, if the coverage decreases or the cost-sharing increases, the issuer of the coverage shall notify enrollees of the change at least 90 days before the change takes effect (or such shorter period of time in cases where the change is necessary to ensure the health and safety of enrollees) and determine the appropriate coverage.

Subtitle C—Standards Guaranteeing Access to Essential Benefits

SEC. 221. COVERAGE OF ESSENTIAL BENEFITS PACKAGES.

(a) In general.—A qualified health benefits plan shall provide coverage that at least minimally meets the standards adopted under section 224 for the essential benefits package described in this subparagraph is the essential benefits package for—

(1) preventive items and services recommended with a grade of A or B by the United States Preventive Services Task Force or those vaccines recommended for use by the Director of the Centers for Disease Control and Prevention; and

(2) non-exchange-participating health benefits plans, such plan is required under section 203 to provide specified levels of benefits and, in the case of a plan offering a premium-plus level of benefits, provide additional benefits.

(b) Minimum Services to Be Covered.—Subject to subsection (d), the items and services described in this subparagraph are the following:

(1) Hospitalization.

(2) Outpatient hospital and outpatient clinical services, including emergency department services.

(3) Professional services of physicians and other health professionals.

(4) Such services, equipment, and supplies incident to the services of a physician’s or a health professional's delivery of care in inpatient hospital settings, physician offices, patient’s homes or place of residence, or other settings, as appropriate.

(5) Prescription drugs.

(6) Rehabilitative and habilitative services.

(7) Mental health and substance use disorder services, including behavioral health treatments.

(8) Preventive services, including those services recommended with a grade of A or B by the Task Force on Clinical Preventive Services or those vaccines recommended for use by the Director of the Centers for Disease Control and Prevention.

(9) Maternity care.

(10) Well-baby and well-child care and oral health, vision, and hearing services, equipment, and supplies for children under 21 years of age.

(11) Durable medical equipment, prosthetics, orthotics and related supplies.

(c) Requirements Relating to Cost-Sharing and Minimum Actuarial Value.—

(1) No Cost-Sharing for Preventive Services and Vaccines Required Under the Essential Benefits Package for—

(A) preventive items and services recommended with a grade of A or B by the United States Preventive Services Task Force; and

(B) vaccines recommended for use by the Director of the Centers for Disease Control and Prevention.

(2) Annual Limitation.—The applicable level specified in this subparagraph meets the minimum actuarial value required under paragraph (3).

(d) Use of Copayments.—In establishing cost-sharing levels for basic, enhanced, and premium plans under this section, the Secretary shall, to the maximum extent possible, use only copayments and not coinsurance.

(e) Minimum Actuarial Value.—

(A) In general.—The cost-sharing under the essential benefits package shall be designed to provide a level of coverage that is actuarially equivalent to approximately 70 percent of the full actuarial value of the benefits provided under the reference benefits package described in subparagraph (B).

(B) Reference Benefits Package Described.—The reference benefits package described in this subparagraph is the essential benefits package if there were no cost-sharing imposed.

(d) Assessment and Counseling for Domestic Violence.—The Secretary shall support the need for an assessment and brief counseling for domestic violence as part of a behavioral health assessment or primary care visit and determine the appropriate coverage for such assessment and counseling.

(e) Abortion Coverage Prohibited as Part of Minimum Benefits Package.—

(1) Prohibition of Required Coverage.—The Health Benefits Advisory Committee may not recommend under section 223(b) and the Secretary may not adopt in standards under section 224(b), the services described in paragraph (4)(A) or (4)(B) and the QHP offering entity may determine whether such coverage is provided.
(3) Coverage under Public Health Insurance Option.—The public health insurance option shall provide coverage for services described in paragraph (4)(B). Nothing in this Act shall be construed as preempting the public health insurance option from providing for or prohibiting coverage of services described in paragraph (4)(A).

(4) Abortion services.—
(A) Abortions for which public funding is prohibited.—The services described in this subparagraph are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is not permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(B) Abortions for which public funding is allowed.—The services described in this subparagraph are abortions for which the expenditure of Federal funds appropriated for the Department of Health and Human Services is permitted, based on the law as in effect as of the date that is 6 months before the beginning of the plan year involved.

(5) Participation.—The membership of the Health Benefits Advisory Committee shall serve a 3-year term, and the term of a Committee member shall begin in accordance with applicable provisions under subchapter I of chapter 57 of title 5, United States Code, and shall otherwise serve without compensation for the periodic updating of the benefit standards.

(6) Requirements.—The Health Benefits Advisory Committee shall meet with respect to qualified health benefits plans that the Commissioner determines to be consistent with the requirements for such a package or level under sections 222 (including subsections (e) and 223(b)(2)), and subsection (a) of title 5, United States Code, and shall provide for timely grievance and appeals mechanisms with respect to qualified health benefits plans that the Commissioner shall establish consistent with the payment rates and payment mechanisms with respect to qualified health benefits plans adopted by the Secretary for each of such mechanisms and implement them in a manner that is protective to the interests of patients.

(7) Internal Claims and Appeals Processes.—Under a qualified health benefits plan of the Department of Health and Human Services of all recommendations made by the Health Benefits Advisory Committee under this section.

SEC. 224. Process for Adoption of Recommendations; Adoption of Benefit Standards.

(a) Process for Adoption of Recommendations.—
(1) Review of recommended standards.—Not later than 45 days after the date of receipt of benefit standards recommended under section 223 (including such standards as modified under paragraph (2)(B)), the Secretary shall review such standards and shall determine whether to propose adoption of such standards as a package.

(2) Determination to adopt standards.—If the Secretary determines—
(A) to propose adoption of benefit standards so recommended as a package, the Secretary shall, by regulation under section 553 of title 5, United States Code, propose adoption of such standards;

(B) not to propose adoption of such standards as a package, the Secretary shall notify the Health Benefits Advisory Committee in writing of such determination and the reasons for not proposing such recommendation and provide the Committee with a further opportunity to modify its previous recommendations and submit new recommendations to the Secretary on a timely basis.

(3) Contingency.—If, because of the application of paragraph (2)(B), the Secretary would otherwise be unable to propose initial adoption of such recommended standards by the deadline specified in subsection (b)(1), the Secretary shall, by regulation under section 553 of title 5, United States Code, propose adoption of initial benefit standards by such deadline.

(b) Adoption of Standards.—
(1) Initial standards.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall, through the rulemaking process consistent with subsection (a), adopt an initial set of benefit standards.

(2) Periodic updating standards.—Under subsection (a), the Secretary shall provide for the periodic updating of the benefit standards previously adopted under this section.

(3) Requirement.—The Secretary may not adopt a benefit standard related to qualified health benefits package or for level of cost-sharing that are inconsistent with the requirements for such a package or level under sections 222 (including subsection (e) and 223(b)(2)).

Subtitle D—Additional Consumer Protections

SEC. 231. Requiring Fair Marketing Practices by Health Insurers.

The Commissioner shall establish uniform marketing standards that all QHPB offering entities shall meet with respect to qualified health benefits plans that are health insurance coverage.


(a) In General.—A QHPB offering entity shall provide for timely grievance and appeals mechanisms with respect to qualified health benefits plans that the Commissioner shall establish consistent with this section.

(b) Internal Claims and Appeals Processes.—Under a qualified health benefits plan of the Department of Health and Human Services of all recommendations made by the Health Benefits Advisory Committee under this section.
the QHBP offering entity shall provide an internal claims and appeals process that initially incorporates the claims and appeals procedures (including urgent claims) set forth in §1927.1 of title 18, United States Code, Federal Regulations, as published on November 21, 2000 (65 Fed. Reg. 70246) and shall update the procedures in conformance with any standards that the Commissioner may establish.

(c) External Review Process.—

(1) The Commissioner shall establish an external review process (including procedures for expedited reviews of urgent claims) that provides for an impartial, independent review of determination of denied claims under this division.

(2) Requiring Fair Grievance and Appeals Mechanisms.—A determination made, with respect to a qualified health benefit plan offered by a QHBP offering entity, under the external review process established under this subsection shall be binding on the plan and the entity.

(d) Time Limits.—The Commissioner shall establish time limits for each of these processes and implement them in a manner that is protective to the patient.

(e) Construction.—Nothing in this section shall be construed as affecting the availability of contract laws under State law, as an exception to adverse decisions under subsection (b) or (c), subject to section 251.

SEC. 233. Requiring Information Transparency and Plan Disclosure

(a) Accurate and Timely Disclosure.—

(1) For Exchange-Participating Health Benefit Plans.—A QHBP offering entity offering an Exchange-participating health benefit plan shall comply with standards established by the Commissioner for the accurate and timely disclosure to the Commissioner and the public of plan documents, plan terms and conditions, claims payment policies and practices, periodic financial disclosure, data on errors in disbursements, data on the number of claims denied, data on rating practices, information on cost-sharing and payments with respect to any out-of-network coverage, and other information as determined appropriate by the Commissioner.

(2) Employment-Based Health Plans.—The Secretary of Labor shall update and harmonize with such rules concerning the accurate and timely disclosure to the Commissioner and the public of plan documents, plan terms and conditions, claims payment policies and practices, periodic financial disclosure, data on errors in disbursements, data on the number of claims denied, data on rating practices, information on cost-sharing and payments with respect to any out-of-network coverage, and other information as determined appropriate by the Commissioner.

(b) Definition.—In this paragraph, the term ‘plan language’ means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise and understandable, and follows other best practices of plain language writing.

(c) Guidance.—The Commissioner and the Secretary of Labor shall jointly develop and issue guidance on best practices of plain language writing.

(d) Information on Rights.—The information disclosed under paragraphs (1) and (2) shall be provided in plain language.

(e) Information on Cost-Sharing.—The Commissioner shall establish standards that the Commissioner may establish to ensure transparency to each health care provider relating to reimbursement arrangements between such plan and such provider.

(f) Pharmacy Benefit Managers Transparency Requirements.—

(1) In General.—If a QHBP offering entity contracts with a pharmacy benefit manager or other entity (in this subsection referred to as a ‘PBM’) to manage prescription drug coverage or otherwise control prescription drug costs under a qualified health benefit plan, the PBM shall provide at least annually to the Commissioner and to the QHBP offering entity offering such plan the following in a form and manner to be determined by the Commissioner:

(A) Information on the number and total cost of prescriptions under the contract that are filled via mail order and at retail pharmacies.

(B) An estimate of aggregate average payment amounts under the contract, per prescription drug, for generic drugs that are made to mail order and retail pharmacies, and the average amount, per prescription, that the PBM was paid by the plan for prescriptions filled at mail order and retail pharmacies.

(C) An estimate of the aggregate average payment per prescription (weighted by prescription volume) under the contract re- ported directly or indirectly to the manufacturer, including all rebates, discounts, prices concessions, or administrative, and other payments from pharmaceutical manufacturers, and a description of the types of payments, and the amount of these payments that were shared with the plan, and a description of the percentage of cases for which the PBM received such payments.

(D) Information on the overall percentage of generic drugs dispensed under the contract at retail and mail order pharmacies, and the percentage of cases in which a generic drug is dispensed when available.

(E) Information on the percentage and number of cases in which individuals were switched because of PBM policies or at the direct or indirect control of the PBM from a prescribed drug that had a lower cost (determined to the extent feasible) than a drug that had a higher cost for the QHBP offering entity, the rationale for these switches, and a description of the PBM policies governing such switches.

(2) Confidentiality of Information.—Information disclosed by a PBM to the Commissioner or a QHBP offering entity under this subsection shall not be disclosed by the PBM or the QHBP offering entity in a form which discloses the identity of a specific PBM or the specific plan or plan sponsor, except for information provided to the PBM whose information related to end-of-life planning.

(3) Penalties.—The provisions of subsection (b)(3)(C) of section 1927 shall apply to a PBM that fails to provide information required under subsection (a) or that knowingly provides false information in the same manner as such provision applies to a manufacturer with an agreement under such section that fails to provide information under subsection (b)(3)(A) of such section or knowingly provides false information under such section, respectively.

SEC. 234. Application to Qualified Health Benefits Plans Not Offered through the Health Insurance Exchange.

The requirements of the previous provi- sions of this subtitle shall apply to qualified health benefit plans that are not being offered through the Health Insurance Exchange only to the extent specified by the Administrator.

SEC. 235. Timely Payment of Claims.

A QHBP offering entity shall comply with the requirements of section 1857(f) of the Social Security Act with respect to a qualified health benefit plan offering under the same manner as a Medicare Advantage organization is required to comply with such require- ments with respect to a Medicare Advantage plan it offers under part C of Medicare.

SEC. 236. Standardized Rules for Coordination and Subrogation of Benefits.

The Commissioner shall establish standards for the coordination and subrogation of benefits and reimbursement of payments in cases of qualified health benefit plans involving individuals and multiple plan coverage.


A QHBP offering entity is required to comply with administrative simplification provi- sions under part C of title XI of the Social Security Act with respect to qualified health benefit plans.

SEC. 238. State Prohibitions on Discrimination Against Health Care Providers.

This Act (and the amendments made by this Act) shall not be construed as supersed- ing laws, as they now or hereinafter exist, of any State or jurisdiction designed to pro- hibit a qualified health benefits plan from discriminating with respect to participation, reimbursement, covered services, indemnification, or related requirements under such plan against a health care provider that is acting within the scope of that provider’s license or certification under applicable State law.

SEC. 239. Protection of Physican Pre-Scriber Information.

(a) Study.—The Secretary of Health and Human Services shall conduct a study on the use of physician prescriber information in sales and marketing practices of pharmaceut- ical manufacturers.

(b) Report.—Based on the study conducted under this subsection, the Secretary shall sub- mit to Congress a report on actions needed to be taken by the Congress or the Secretary to protect providers from biased marketing and sales practices.

SEC. 240. Dissemination of Advance Care Planning Information.

(a) In General.—The QHBP offering entity—

(1) shall provide for the dissemination of information related to end-of-life planning

...
to individuals seeking enrollment in Exchange-participating health benefits plans offered through the Exchange;

(2) shall present such individuals with—

(A) an option to establish advanced directives and physician’s orders for life sustaining treatment according to the laws of the State in which the individual resides; and

(B) information related to other planning tools; and

(3) shall not promote suicide, assisted suicide, euthanasia, or mercy killing.

The information presented under paragraph (3) shall not promote suicide, assisted suicide, euthanasia, or mercy killing.

The information provided to meet the requirements of subsection (a)(2) shall include end-of-life planning information that includes options to maintain all or most medical interventions.

(a) IN GENERAL.—There is hereby established an Office of the Inspector General for the Health Choices Administration, see section 1657.

SEC. 242. DUTIES AND AUTHORITY OF COMMISSIONER.

(c) INSPECTOR GENERAL.—For provision establishing an Office of the Inspector General for the Health Choices Administration, see section 1657.

SEC. 242. DUTIES AND AUTHORITY OF COMMISSIONER.

(a) DUTIES.—The Commissioner is responsible for carrying out the following functions under this division:

(1) QUALIFIED PLAN STANDARDS.—The establishment of qualified health benefits plan standards and enforcement of such standards in coordination with State insurance regulators and the Secretaries of Labor and the Treasury.

(2) HEALTH CARE EXCHANGE.—The establishment and operation of a Health Insurance Exchange under subtitle A of title III.

(3) INDIVIDUAL AFFORDABILITY CREDITS.—The administration of affordability credits under subtitle C of title III, including determination of eligibility for such credits.

(4) ADDITIONAL FUNCTIONS.—Such additional functions as may be specified in this division.

(b) PROMOTING ACCOUNTABILITY.—

(1) IN GENERAL.—The Commissioner shall undertake activities in accordance with this subtitle to promote accountability of QHBP offering entities in meeting Federal health insurance requirements. Whether such accountability is with respect to qualified health benefits plans offered through the Health Insurance Exchange or outside of such Exchange.

(2) COMPLIANCE EXAMINATION AND AUDITS.—

(A) IN GENERAL.—The Commissioner shall, in coordination with States, conduct audits of qualified health benefit plans offered through Federal requirements. Such audits may include random compliance audits and targeted audits in response to complaints or other suspicious actions.

(B) RECOPMENT OF COSTS IN CONNECTION WITH EXAMINATION AND AUDITS.—The Commissioner shall collect data for purposes of carrying out the Commissioner’s duties, including for purposes of promoting quality and value, protection of consumers, and determination of eligibility for such QHBP offering entities.

(c) DATA COLLECTION.—The Commissioner shall collect data for purposes of carrying out the Commissioner’s duties, including for purposes of promoting quality and value, protection of consumers, and determination of eligibility for such QHBP offering entities.

(d) SANCTIONS AUTHORITY.—

(1) IN GENERAL.—In the case of an Exchange-participating health benefits plan offered by a QHBP offering entity, the Commissioner may, in coordination with State insurance regulators and the Secretary of Labor, provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2).

(REMEDIES.—The remedies described in this paragraph, with respect to a qualified health benefit plan offered by a QHBP offering entity, are—

(A) civil money penalties of not more than the amount that would be applicable under similar circumstances for similar violations under section 1857(g) of the Social Security Act;

(B) suspension of enrollment of individuals under such plan after the date the Commissioner notifies the entity of a determination under paragraph (1) and until the Commissioner is satisfied that the basis for such determination has been corrected and is not likely to recur;

(C) in the case of an Exchange-participating health benefits plan, suspension of payment to the Health Insurance Exchange for individuals enrolled in such plan after the date the Commissioner

(notes the entity of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur; or

(D) working with State insurance regulators to terminate plans for repeated failure by the offering entity to meet the require-

ments of this title.

(e) STANDARD DEFINITIONS OF INSURANCE AND MEDICAL TERMS.—The Commissioner shall provide for the development of standard definitions of terms used in health insurance coverage, including insurance-related terms.

(f) EFFICIENCY IN ADMINISTRATION.—The Commissioner shall issue regulations for the effective and efficient administration of the Health Insurance Exchange and affordability credits under subtitle C, including, with respect to the determination of eligibility for affordability credits, the use of personnel who are employed in accordance with the requirements of title 5, United States Code, to carry out the duties of the Commissioner or, in the case of sections 308 and 341(b)(2), the use of State personnel who are employed in accordance with standards prescribed by the Office of Personnel Management to section 208 of the Intergovernmental Personnel Act of 1970 (42 U.S.C. 7478).

SEC. 243. CONSULTATION AND COORDINATION.

(a) CONSULTATION.—In carrying out the Commissioner’s duties under this division, the Commissioner, as appropriate, shall consult at least with the following:

(1) State attorneys general and State insurance regulators, including concerning the standards for health insurance coverage that is a qualified health benefits plan under this title and enforcement.

(2) The National Association of Insurance Commissioners, including for purposes of using model guidelines established by such organization for purposes of this subtitle, and enforcement.

(3) Appropriate State agencies, specifically concerning the administration of individual affordability credits under subtitle C of title III and the offering of Exchange-participating health benefits plans, to Medicaid eligible individuals under subtitle A of such title.

(b) The Federal Trade Commission, specifically concerning the development and issuance of guidance, rules, or standards regarding fair marketing practices under sections 216 for, or otherwise, disclosure requirements under section 233 or otherwise.

(c) Other appropriate Federal agencies.

(d) Indian tribes and tribal organizations.

(b) COORDINATION.—

(1) IN GENERAL.—In carrying out the functions of the Commissioner, including with respect to the enforcement of the provisions of this division, the Commissioner shall work in coordination with existing Federal and State entities to the maximum extent feasible consistent with this division and in a manner that prevents conflicts of interest in duties and ensures effective enforcement.

(2) UNIFORM STANDARDS.—The Commissioner, in coordination with such entities, shall seek to achieve uniform standards that adequately protect consumers in a manner that does not unequally affect employers and insurers.

SEC. 244. HEALTH INSURANCE OMBUDSMAN.

(a) IN GENERAL.—The Commissioner shall appoint within the Health Choices Administration a Health Insurance Ombudsman who shall have expertise and experience in the fields of health care and education of (and assistance to) individuals.

(b) RESPONSIBILITIES OF OMBUDSMAN.—The Commissioner shall establish such duties and powers, the Office of the Ombudsman shall, in a linguistically appropriate manner—
(1) receive complaints, grievances, and requests for information submitted by individuals through means such as the mail, by telephone, electronically, and in person;

(2) provide individuals with respect to complaints, grievances, and requests referred to in paragraph (1), including—

(A) helping individuals determine the relevant procedures to seek an appeal of a decision or determination;

(B) assistance to such individuals in choosing a qualified health benefits plan in which to enroll;

(C) assistance to such individuals with any problems arising from disenrollment from such a plan; and

(D) assistance to such individuals in presenting information under subtitle C relating to affordability credits; and

(3) submit annual reports to Congress and the Commissioner that describe the activities of the Ombudsman and that include such recommendations for improvement in the administration of this division as the Ombudsman determines appropriate. The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment and coverage policies.

Subtitle F—Relation to Other Requirements; Miscellaneous

SEC. 251. RELATION TO OTHER REQUIREMENTS; MISCELLANEOUS.

(a) COVERAGE NOT OFFERED THROUGH EXCHANGE.

(1) IN GENERAL.—In the case of health insurance coverage not offered through the Health Insurance Exchange (whether or not offered in connection with an employment-based health plan), and in the case of employment-based health plans, the requirements of this title do not supersede any requirements of the Public Health Service Act, as determined by the Commissioner, that describe the activities of the Ombudsman and that include such recommendations for improvement in the administration of this division as the Ombudsman determines appropriate. The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment and coverage policies.

(b) COVERAGE OFFERED THROUGH EXCHANGE.

(1) IN GENERAL.—In the case of health insurance coverage offered through the Health Insurance Exchange—

(A) the requirements of this title do not supersede any requirements relating to genetic information nondiscrimination and mental health parity applicable under title XXVII of the Public Health Service Act or under State law, except insofar as such requirements prevent the application of a requirement of this division, as determined by the Commissioner; and

(B) individual rights and remedies under State laws shall apply.

(2) EXCEPTED COVERAGE.—In the case of coverage described in paragraph (1), nothing in such paragraph shall be construed as preventing the application of rights and remedies under State law in connection with an employment-based health plan under section 882(a)(1) of the Employee Retirement Income Security Act of 1974.

SEC. 252. PROHIBITING DISCRIMINATION IN HEALTH CARE.

(a) IN GENERAL.—Except as otherwise explicitly permitted by this Act and by subsection (a) of section 20109(h) of the Employee Retirement Income Security Act of 1974, or State law, employers shall not discriminate against any employee with respect to his compensation, terms, conditions, or other privileges of employment because the employee—

(1) received complaints, grievances, and requests for information submitted by individuals through means such as the mail, by telephone, electronically, and in person;

(2) provides individuals with respect to complaints, grievances, and requests referred to in paragraph (1), including—

(A) helping individuals determine the relevant procedures to seek an appeal of a decision or determination;

(B) assistance to such individuals in choosing a qualified health benefits plan in which to enroll;

(C) assistance to such individuals with any problems arising from disenrollment from such a plan; and

(D) assistance to such individuals in presenting information under subtitle C relating to affordability credits; and

(3) submit annual reports to Congress and the Commissioner that describe the activities of the Ombudsman and that include such recommendations for improvement in the administration of this division as the Ombudsman determines appropriate. The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment and coverage policies.

(b) IMPLEMENTATION.—To implement the requirement asserted in subsection (a), the Secretary of Health and Human Services shall, not later than 18 months after the date of the enactment of this Act, promulgate such regulations as are necessary or appropriate to insure that all health care and related services (including insurance coverage and public health activities) covered by this Act shall be provided to employees (taking into account the benefits and the cost to employees for such benefits) in a manner substantially equivalent to or greater than the coverage provided for employees pursuant to the essential benefits package.

SEC. 253. WHISTLEBLOWER PROTECTION.

(a) RETALIATION PROHIBITED.—No employer may discharge or otherwise discriminate against any employee with respect to his compensation, terms, conditions, or other privileges of employment because the employee—

(1) provided, caused to be provided, or is reasonably believed to be in violation of any provision of this Act or any order, rule, or regulation promulgated under this Act; or

(2) testified or is about to testify in a proceeding concerning such violation;

(3) assisted or participated or is about to assist or participate in such a proceeding; or

(4) objected to, or refused to participate in, any activity, policy, practice, or assigned task that the employee (or other such person) reasonably believed to be in violation of any provision of this Act or any order, rule, or regulation promulgated under this Act;

(b) ENFORCEMENT ACTION.—An employee covered by this section who alleges discrimination by an employer in violation of subsection (a) of this section may—

(1) receive complaints, grievances, and requests for information submitted by individuals through means such as the mail, by telephone, electronically, and in person;

(2) submit annual reports to Congress and the Commissioner that describe the activities of the Ombudsman and that include such recommendations for improvement in the administration of this division as the Ombudsman determines appropriate. The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment and coverage policies.

SEC. 254. CONSTRUCTION REGARDING COLLECTIVE BARGAINING.

(a) IN GENERAL.—Nothing in this Act shall be construed to alter or supersede any statutory or other obligation to engage in collective bargaining over the terms or conditions of employment, including any obligations under a collective bargaining agreement made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by this division shall not be treated as a termination of such collective bargaining agreement.

(b) GENERAL RULE.

If any provision of this Act, or any application of such provision to any person or circumstance, is held to be unconstitutional, such provision and the application of the provision to any other person or circumstance shall not be affected.

SEC. 255. TREATMENT OF HAWAII PREPAID HEALTH CARE ACT.

(a) IN GENERAL.—Subject to this section—

(1) nothing in this division (or an amendment made by this division) shall be construed to modify or limit the application of the exemption for the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 383-1 et seq.) as provided for under section 514(b)(5) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144(b)(5)), and such exemption shall also apply with respect to the provisions of this division; and

(2) for purposes of this division (and the amendments made by this division), coverage provided pursuant to the Hawaii Prepaid Health Care Act shall be treated as a qualified health benefits plan providing acceptable coverage so long as the Secretary of Labor determines that such coverage for employees (taking into account the benefits and the cost to employees for such benefits) is substantially equivalent to or greater than the coverage provided for employees pursuant to the essential benefits package.

(b) COORDINATION WITH STATE LAW OF HAWAII.—The Commissioner shall, based on ongoing consultation with the appropriate official of the State of Hawaii, make adjustments to rules and regulations of the Commissioner under this division as may be necessary, as determined by the Commissioner, to most effectively coordinate the provisions of this division with the provisions of the Hawaii Prepaid Health Care Act, taking into account any changes made from time to time to the Hawaii Prepaid Health Care Act and related laws of such State.

SEC. 256. ACTIONS BY STATE ATTORNEYS GENERAL.

Any State attorney general may bring a civil action in the name of such State as parens patriae on behalf of natural persons residing in such State, in any district court of the United States having jurisdiction of the defendant to secure monetary or equitable relief for violation of any provisions of this title or regulations issued thereunder. Nothing in this section shall be construed as affecting the application of section 514 of the Employee Retirement Income Security Act of 1974.

SEC. 257. APPLICATION OF STATE AND FEDERAL LAWS REGARDING ABORTION.

(a) NO PREEMPTION OF STATE LAWS REGARDING ABORTION.—Nothing in this Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortion or otherwise act to consent for the performance of an abortion on a minor.

(b) NO EFFECT ON FEDERAL LAWS REGARDING ABORTION.

(1) IN GENERAL.—Nothing in this Act shall be construed to have any effect on Federal laws regarding—

(A) conscience protection;

(B) willingness or refusal to provide abortion; and

(C) discrimination on the basis of the willingness or refusal to provide abortion or to participate in training to provide abortion.
(c) No Effect on Federal Civil Rights Law—Nothing in this section shall alter the rights and obligations of employees and employers under title VII of the Civil Rights Act of 1964.

SEC. 259. 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) shall not—

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

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

(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 or service 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 shall carry out this section.

SEC. 260. AUTHORITY OF FEDERAL TRADE COMMISSION.

Section 6 of the Federal Trade Commission Act (15 U.S.C. 45a) is amended by striking ‘‘and prepare reports’’ and all that follows and inserting the following: ‘‘and prepare reports, and to share information under clauses (f) and (k), relating to insurance, without regard to whether the subject of such studies, reports, or information is for-profit or not-for-profit entity.’’.

SEC. 261. CONSTRUCTION REGARDING STANDARD OF CARE.

(a) In General.—The development, recognition, or implementation of any guideline or other standard under this Act, or a provision described in subsection (b) shall not be construed to establish the standard of care or duty of care owed by health care providers to their patients in any medical malpractice action or claim (as defined in section 431(7) of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11151(7))).

(b) Provisions Described.—The provisions described in this subsection are the following:

(1) Section 324 (relating to modernized payers and health insurance exchanges).

(2) Section 304 (relating to the Task Force on Clinical Preventive Services).

(3) Subtitle A of title XIX of the Social Security Act, and other provisions of that title.

SEC. 262. RESTORING APPLICATION OF ANTI-TRUST LAWS TO HEALTH SECTOR IN-SURERS.

(a) AMENDMENT TO McCARRAN-FERGUSON ACT.—Section 27 of the Act of March 9, 1945 (15 U.S.C. 1013), commonly known as the McCarran-Ferguson Act, is amended by adding at the end the following:

``(c)(1) Except as provided in paragraph (2), nothing contained in this Act shall modify, impair, or supersede the operation of any of the antitrust laws with respect to the business of health insurance or the business of medical malpractice insurance.

(2) Paragraph (1) shall not apply to—

(A) collecting, preparing, or disseminating claims information respecting claims paid, or re- serves held for claims reported, by any person engaged in the business of insurance; and

(B) the term ‘‘loss development factor’’ means an adjustment to be made to the aggregate of losses incurred during a prior period of time that have been paid, or for which claims have been received and reserves are being held to estimate the aggregate of losses incurred during such period that will ultimately be paid.”.

(b) RELATED PROVISION.—For purposes of section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition, subsection (c)(1) shall not apply to—

(1) the term ‘‘loss development factor’’ of the Act, or

(2) the term ‘‘loss development factor’’ defined in section 431(7) of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11151(7)) to the extent such section applies to unfair methods of competition, subsection (c)(1) shall not apply to—

(1) the term ‘‘loss development factor’’ of the Act, or

(2) the term ‘‘loss development factor’’ of the Act.

(c) SAVINGS CLAUSE FOR STATE MEDICAL MAL-PRACTICE LAWS.—Nothing in this Act shall be construed to modify or impair State law governing legal standards or procedures used in medical malpractice cases, including the authority of a State to make or implement such laws.

SEC. 263. STUDY AND REPORT ON METHODS TO INCREASE EHR USE BY SMALL HEALTH CARE PROVIDERS.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of potential methods to increase the use of qualified electronic health records (as defined in section 17401 of the Public Health Services Act) by small health care providers. Such study shall consider at least the following methods:

(1) Providing for higher rates of reimbursement or other incentives for such health care providers to use electronic health records (taking into consideration initiatives by private health insurance companies, Medicare Incentives provided under Medicare under title XVIII of the Social Security Act, Medicaid

under title XIX of such Act, and other programs).

(b) Promoting low-cost electronic health record software packages that are available by such health care providers, including software packages that are available to health care providers through the Veterans Administration and other sources.

(c) Training and education of such health care providers on the use of electronic health records.

(d) Providing assistance to such health care providers on the implementation of electronic health records.

SEC. 264. PREPAREMENT ASSESSMENT AND ACCOUNTABILITY: APPLICATION OF PBE EXCHANGE AND RELATED PROVISIONS

(a) APPLICATION OF GPCA.—Section 306 of title 5, United States Code, and sections 1115, 1116, 1117, and 9703 of title 31 of such Code (originally enacted by the Government Performance and Results Act of 1993, Public Law 103-62) apply to the executive agencies established under this Act, the Health Insurance Exchange, and the Health Choices Administration. Under such section 306, each such executive agency is required to provide for a strategic plan every 3 years.

(b) OUTLINE OF DUTIES OF COMMISSIONER.—In accordance with this subtitle and in coordination with appropriate Federal and State officials as provided under section 238(b), the Commissioner shall—

(1) under section 304 establish standards for, accept bids from, and negotiate and enter into contracts with, QHP offering entities for the offering of health benefits plans through the Health Insurance Exchange, with different levels of benefits required under title XIX of such Act, including with respect to oversight and enforcement;

(2) under section 305 facilitate outreach and enrollment in such plans of Exchange-eligible individuals and employers described in section 302; and

(3) conduct such activities related to the Health Insurance Exchange as required, including establishing and operation of a risk pooling mechanism under section 306 and consumer protections under subtitle D of title II.

SEC. 265. EXCHANGE-ELIGIBLE INDIVIDUALS AND EMPLOYER-SPONSORED GROUPS.

(a) ACCESS TO COVERAGE.—In accordance with this section, all individuals are eligible...
to obtain coverage through enrollment in an Exchange-participating health benefits plan offered through the Health Insurance Exchange unless such individuals are enrolled in such qualified health benefits plan or certain other acceptable coverage.

(b) Definitions.—In this division:

(1) EXCHANGE-ELIGIBLE INDIVIDUAL.—The term ‘exchange-eligible individual’ means an individual who is eligible under this section to be enrolled through the Health Insurance Exchange in an Exchange-participating health benefits plan and, with respect to family coverage, includes dependents of such individual.

(2) EXCHANGE-ELIGIBLE EMPLOYER.—The term ‘Exchange-eligible employer’ means an employer that is eligible under this section to enroll through the Health Insurance Exchange employees of the employer (and their dependents) in Exchange-eligible health benefits plans.

(3) EMPLOYMENT-RELATED DEFINITIONS.—The terms ‘employee’, ‘employees’, ‘full-time employee’, and ‘part-time employee’ have the meanings given such terms by the Commissioner for purposes of this division.

(c) EMPLOYERS.—The Commissioner shall provide for rules to determine which employers shall be eligible to enroll or participate in the Health Insurance Exchange in accordance with the following schedule:?

(1) PHASE-IN.—In Y1 (as defined in section 100(c))—

(A) individuals described in subsection (d)(1), including individuals described in subsection (e)(2), and

(B) smallest employers described in subsection (e)(1).

(2) SECOND YEAR.—In Y2—

(A) individuals and employers described in paragraph (1); and

(B) smaller employers described in subsection (d)(2).

(3) THIRD AND SUBSEQUENT YEARS.—In Y3—

(A) individuals and employers described in paragraph (2);

(B) small employers described in subsection (e)(3); and

(C) larger employers as permitted by the Commissioner under subsection (e)(4).

(d) INDIVIDUALS.

(1) INDIVIDUAL DESCRIBED.—Subject to the succeeding provisions of this subsection, an individual described in this paragraph is an individual who—

(A) is not enrolled in coverage described in subparagraph (C) or (D) of paragraph (2); and

(B) is not enrolled in coverage as a full-time employee (as defined in section 3(37) of the Internal Revenue Code) under a group health plan if the coverage and an employer contribution under the plan meet the requirements of section 412.

For purposes of subparagraph (B), in the case of an individual who is self-employed, who has at least 1 employee, and who meets the requirement described in section 412, such individual shall be deemed a full-time employee described in such subparagraph.

(2) ACCEPTABLE COVERAGE.—For purposes of this paragraph, the term ‘qualified health insurance coverage’ means any of the following:

(A) QUALIFIED HEALTH BENEFITS PLAN COVERAGE.—Coverage under a qualified health benefits plan.

(B) GRANDFATHERED HEALTH INSURANCE COVERAGE; COVERAGE UNDER CURRENT GROUP HEALTH PLAN.—Coverage under a grandfathered health insurance coverage (as defined in subsection (a) of section 202) or under a current group health plan (described in subsection (h) of such section).

(C) MEDICARE.—Coverage under part A of title XVIII of the Social Security Act.

(D) MEDICAID.—Coverage for medical assistance under title XIX of the Social Security Act, excluding such coverage that is only available because of the application of subsection (u), (v), or (a), or (h) of section 1902 of such Act.

(E) MEMBERS OF THE ARMED FORCES AND DEPENDENTS (INCLUDING TRICARE).—Coverage under section 1781 of title 38, United States Code, including similar coverage furnished under section 1781 of title 38 of such Code.

(F) VA.—Coverage for health care under chapter 17 of title 38, United States Code.

(G) OTHER COVERAGE.—Such other health benefits coverage for which the state health benefits risk pool, as the Commissioner, in coordination with the Secretary of the Treasury, recognizes for purposes of this division.

The Commissioner shall make determinations under this paragraph in coordination with the Secretary of the Treasury.

(3) CONTINUING ELIGIBILITY PERMITTED.—

(A) IN GENERAL.—Except as provided in subparagraph (B), once an individual qualifies as an Exchange-eligible individual under this section, such individual—

(i) may continue to be enrolled with the Health Insurance Exchange; and

(ii) may obtain health insurance coverage with respect to such individual provided by the Health Insurance Exchange consistent with the provisions of subtitle B of title IV.

(B) EXCEPTIONS.—

(1) IN GENERAL.—Subparagraph (A) shall not apply to an individual once the individual becomes eligible for coverage—

(I) under part A of the Medicare program;

(II) under the Medicaid program as a Medicaid-eligible individual, except as permitted under subsection (e)(2); or

(III) in such other circumstances as the Commissioner determines.

(2) TRANSITION PERIOD.—In the case described in clause (i)(II), the Commissioner shall permit the individual to continue treatment under the plan (as defined in section 3(37) of such Act) until such time as the Commissioner determines it is administratively feasible, consistent with minimizing disruption in the individual’s access to health care.

(3) TRANSITION FOR CHIP ELIGIBLES.—An individual who is eligible for child health assistance under title XXI of the Social Security Act for a period during which Y1 shall not be an Exchange-eligible individual during such period, may obtain health insurance coverage through the Health Insurance Exchange as an Exchange-eligible individual.

(4) OTHER COUNTING RULES.—The Commissioner shall establish rules to determine how employees are counted for purposes of carrying out this subsection.

(f) SPECIAL SITUATION AUTHORITY.—The Commissioner shall have the authority to establish such rules as may be necessary to deal with special situations with regard to uninsured individuals and employers participating as Exchange-eligible individuals and employers, or with respect to families of individuals who lose, or are about to lose, Exchange-eligible participation status, and to establish grace periods for premium payment.

(g) SURVEYS OF INDIVIDUALS AND EMPLOYERS.—The Commissioner shall conduct for periodic surveys of Exchange-eligible individuals and employers concerning satisfaction of such individuals and employers with the Health Insurance Exchange and Exchange-participating health benefits plans.

(h) EXCHANGE ACCESS STUDY.—

(1) IN GENERAL.—The Commissioner shall conduct a survey of access to the Health Insurance Exchange for individuals and for employers, including individuals and employers who are not Exchange-eligible and enrolled in Exchange-participating health benefits plans. The goal of the study is to determine if there are significant groups and types of individuals and employers who are not Exchange-eligible individuals or employers, but who would have improved benefits and affordability if made eligible for coverage in the Exchange.

(2) ITEMS INCLUDED IN STUDY.—Such study shall examine—

(A) the terms, conditions, and affordability of group health coverage offered by employers and QHP offerings outside of the Health Insurance Exchange.
Exchange compared to Exchange-participating health benefits plans; and

(B) the affordability-test standard for ac-
cess of certain employed individuals to cov-
erage in the Health Insurance Exchange.

(3) REPORT.—Not later than January 1 of Y3, in Y6, and thereafter, the Commissioner shall submit to Congress a report on the study conducted under this subsection and shall include in such report recommenda-
tions regarding changes in standards for Ex-
change eligibility for individuals and em-
ployed individuals.

SEC. 303. BENEFITS PACKAGE LEVELS.

(a) IN GENERAL.—The Commissioner shall spec-
aify, by rule and regulation, standards for Ex-
change-participating health benefits plans; and

(b) LIMITATION ON BENEFITS.—The Commis-
sioner may not enter into a contract with a QHBP offering entity under section 301(b) to offer a basic plan that does not, during each plan year, consistent with subtitle C of title II and this section.

SEC. 304. CONTRACTS FOR THE OFFERING OF EX-
CHANGE-PARTICIPATING HEALTH BENEFITS PLANS.

(a) CONTRACTING DUTIES.—In carrying out section 301(b)(1) and consistent with this sub-
title:

(1) OFFERING ENTITY AND PLAN STAND-
ARDS.—The Commissioner shall

(A) establish standards necessary to imple-
ment the requirements of this title and title II for—

(i) QHBP offering entities for the offering of an Exchange-participating health benefits plan; and

(ii) Exchange-participating health benefits plans; and

(B) certify QHBP offering entities and

(b) CONTRACTS.—The Commissioner shall enter into contracts with such entities for the offering of such plans through the Health Insurance Exchange under terms (consistent with this subtitle).

(c) DELEGATION.—The Commissioner may, to the extent permitted under section 223(b)(5)(A), enter into contracts with entities that are not Exchange-participating health benefits plans; such contracts shall include the following:

(A) REQUIREMENTS FOR CONTRACTS.—The Commissioner shall enter into contracts with such entities for the offering of such plans through the Health Insurance Exchange under terms (consistent with this subtitle).

(B) EFFECT OF CONTRACTS.—The Commissioner may not enter into a contract with such an entity until the Commissioner has determined that such entity is able to meet the requirements of this subtitle.

(c) CONTRACTS.—The Commissioner shall enter into contracts with such entities for the offering of such plans through the Health Insurance Exchange under terms (consistent with this subtitle).

(d) SALE OF PRODUCTS.—The Commissioner shall enter into contracts with such entities for the offering of such plans through the Health Insurance Exchange under terms (consistent with this subtitle).

(e) CONTRACTS.—The Commissioner shall enter into contracts with such entities for the offering of such plans through the Health Insurance Exchange under terms (consistent with this subtitle).

(f) CONTRACTS.—The Commissioner shall enter into contracts with such entities for the offering of such plans through the Health Insurance Exchange under terms (consistent with this subtitle).
specify the extent to which and manner in which the previous sentence shall apply in the case of a basic plan with respect to which the Commissioner determines provides substantially all benefits through a health maintenance organization, as defined in section 2791(b)(3) of the Public Health Service Act. This paragraph shall not be construed to require the plan to contract with a provider if such provider refuses to accept the generally applicable payment rates of such plan.

(9) CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES AND COMMUNICATIONS.—The entity shall provide for culturally and linguistically appropriate communication and health services.

(10) SPECIAL RULES WITH RESPECT TO INDIAN ENROLLERS AND INDIAN HEALTH CARE PROVIDERS.—

(A) CHOICE OF PROVIDERS.—The entity shall—

(i) demonstrate to the satisfaction of the Commissioner that it has contracted with a sufficient number of Indian health care providers to ensure timely access to covered services furnished by such providers to individuals, with the entity maintaining an Exchange-participating health benefits plan; and

(ii) agree to pay Indian health care providers, whether such providers are participating or nonparticipating providers, with respect to the entity, for covered services provided at a rate that is not less than the level and amount of payment which the entity would make for the services of a participating provider which is not an Indian health care provider.

(B) SPECIAL RULE RELATING TO INDIAN HEALTH CARE PROVIDERS.—Provision of services by an Exchange-participating provider to substantially all enrollees and Indian health care providers shall not constitute discrimination under this Act.

(C) PROGRAM INTEGRITY STANDARDS.—The entity shall establish and operate a program to protect and promote the integrity of Exchange-participating health benefits plans it offers, in accordance with standards and functions established by the Commissioner.

(11) ADDITIONAL REQUIREMENTS.—The entity shall comply with other applicable requirements, as specified by the Commissioner, which shall include standards regarding billing and collection practices for premiums and cost-sharing, and standards which may include standards to ensure that the entity does not use coercive practices to force providers not to contract with other entities offering coverage through the Health Insurance Exchange.

(c) CONTRACTS.—

(1) BID APPLICATION.—To be eligible to enter into a contract under this section, a QHPB offering entity shall submit to the Commissioner a bid at such time, in such manner, and containing such information as the Commissioner may require.

(2) TERM.—Each contract with a QHPB offering entity under this section shall be for a term of not less than one year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

(3) ENFORCEMENT OF NETWORK ADEQUACY.—In the case of a health benefits plan of a QHPB offering entity that uses a provider network, the contract under this section with the entity shall provide that if—

(A) the Commissioner determines that such provider network does not meet such standards as the Commissioner shall establish under section 215, and

(B) enrollees enrolled in such plan receive an item or service from a provider that is not within such network;

then any cost-sharing for such item or service shall be equal to the amount of such cost-sharing that would be imposed if such item or service was furnished by a provider within such network.

(4) OVERSIGHT AND ENFORCEMENT RESPONSIBILITIES.—The Commissioner shall establish processes, in coordination with State insurance regulators, to oversee, monitor, and enforce applicable requirements of this title with respect to QHBP offering entities offering Exchange-participating health benefits plans and complying with the requirements of such plans. Such processes shall include the following:

(A) GRIEVANCE AND COMPLAINT MECHANISMS.—The Commissioner shall establish, in coordination with each State insurance regulator, a process under which Exchange-eligible individuals and enrollees may file complaints concerning violations of such standards.

(B) ENFORCEMENT.—In carrying out authorities under this division relating to the Health Insurance Exchange, the Commissioner may impose one or more of the intermediate sanctions described in section 212(a).

(C) TERMINATION.—

(I) IN GENERAL.—The Commissioner may terminate a contract with a QHPB offering entity under the authority in the case of an Exchange-participating health benefits plan if such entity fails to comply with the applicable requirements of this title. Any determination by the Commissioner to terminate a contract shall be made in accordance with formal investigation and compliance procedures established by the Commissioner under which—

(i) the Commissioner provides the entity with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Commissioner’s determination; and

(ii) the Commissioner provides the entity with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before terminating the contract.

(II) EXCEPTION FOR IMMINENT AND SERIOUS RISK TO HEALTH.—Clause (i) shall not apply if the Commissioner determines that a delay in termination, resulting from compliance with exchange of information or formal investigation, would pose an imminent and serious risk to the health of individuals enrolled under the qualified health benefits plan of the contract.

(D) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the application of other sanctions under subtitle C.

(5) SPECIAL RULE RELATED TO COST-SHARING AND INDIAN HEALTH CARE PROVIDERS.—The contract under this section with a QHPB offering entity for a health benefits plan shall provide that if an individual who is an Indian is enrolled in such a plan and such individual receives a service from an Indian health care provider (regardless of whether such provider is in the plan’s provider network), the cost-sharing for such item or service shall be equal to the amount of cost-sharing that would be imposed if such item or service—

(A) had been furnished by another provider in the plan’s provider network; or

(B) in the case that the plan has no such network, was furnished by a non-Indian provider.

(6) National Plan.—Nothing in this section shall be construed as preventing the Commissioner from entering into a contract under this subsection with a QHPB offering entity for a health benefits plan with the same benefits in every State so long as such entity is licensed to offer such plan in each State and the benefits meet the applicable requirements in each such State.

(d) NO DISCRIMINATION ON THE BASIS OF PROVISION OF ABORTION.—No Exchange-participating health benefits plan may discriminate against any individual health care provider or health care facility because of its willingness or unwillingness to provide, pay the costs of, or arrange for the referral of an individual for any service that such provider or facility is legally permitted to provide, or to provide coverage of, or refer for abortions.

SEC. 305. OUTREACH AND ENROLLMENT OF EXCHANGE-ELIGIBLE INDIVIDUALS AND EMPLOYERS IN EXCHANGE-PARTICIPATING HEALTH BENEFITS PLAN.

(a) IN GENERAL.—

(B) SPECIAL ENROLLMENT.—The Commissioner shall establish a process consistent with this title for enrollments in Exchange-participating health benefits plans. Such process shall provide for enrollment through means such as the mail, by telephone, electronically, and in person.

(2) ENROLLMENT PERIODS.—

(A) OPEN ENROLLMENT PERIOD.—The Commissioner shall establish an annual open enrollment period during which an Exchange-eligible individual or employer may elect to enroll in, disenroll from, or change Exchange-participating health benefits plans for the following plan year and an enrollment period for affordability credits under subtitle C. Such periods shall be determined by the Commissioner in the accompanying regulations. Such periods shall be for a duration of at least one full calendar month each year, or such other time that would maximize timeliness of income verification for purposes of such subtitle. The open enrollment period shall not be less than 30 days.

(B) SPECIAL ENROLLMENT.—The Commissioner shall also provide for special enrollment periods to take into account special circumstances of individuals and employers, such as an individual who—

(i) loses acceptable coverage;

(ii) experiences a change in marital or other dependent status;

(iii) moves outside the service area of the Exchange-participating health benefits plan in which the individual is enrolled; or

(iv) experiences a significant change in income.

(C) ENROLLMENT INFORMATION.—The Commissioner shall provide for the broad dissemination of information to prospective enrollees on the enrollment process, including before each open enrollment period. In carrying out the previous sentence, the Commissioner may work with other appropriate entities to facilitate such provision of information.

(3) AUTOMATIC ENROLLMENT FOR NON-MEDICAID ELIGIBLE INDIVIDUALS.—

(A) IN GENERAL.—The Commissioner shall provide for a process under which individuals
who are Exchange-eligible individuals described in subparagraph (B) are automatically enrolled under an appropriate Exchange-participating health benefits plan. Such enrollment may involve a random assignment or some other form of assignment that takes into account the health care providers used by the individual involved or such other relevant factors as the Commissioner may specify.

(B) SUBSIDIZED INDIVIDUALS DESCRIBED.—An individual described in this subparagraph is a Medicaid-eligible individual who is either of the following:

(1) AFFORDABILITY CREDIT ELIGIBLE INDIVIDUALS.—The individual (i) has applied for, and been determined eligible for, affordability credits under subtitle C; (ii) has not opted out from receiving such affordability credit; and (III) does not otherwise enroll in another Exchange-participating health benefits plan.

(ii) INDIVIDUALS ENROLLED IN A TERMINATED PLAN.—The individual who is enrolled in an Exchange-participating health benefits plan that is terminated (during or at the end of a plan year) without the individual otherwise enrolling in another Exchange-participating health benefits plan.

(4) DIRECT PAYMENT OF PREMIUMS TO PROVIDERS.—In the enrollment process, individuals enrolled in an Exchange-participating health benefits plan shall pay such premiums directly, and not through the Commissioner, in accordance with the terms of such plan.

(c) COVERAGE INFORMATION AND ASSISTANCE.

(1) COVERAGE INFORMATION.—The Commissioner shall provide for the broad dissemination of information on Exchange-participating health benefits plans offered under this title, including such information on benefits, premiums, cost-sharing, quality, provider networks, and consumer satisfaction.

(2) CONSUMER ASSISTANCE WITH CHOICE.—To provide assistance to Exchange-eligible individuals and employers, the Commissioner shall:

(A) provide for the operation of a toll-free telephone hotline to respond to requests for assistance and maintain an Internet Web site through which individuals may obtain information on coverage under Exchange-participating health benefits plans and file complaints; (B) develop and disseminate information to Exchange-eligible enrollees on their rights and responsibilities; (C) assist Exchange-eligible individuals in selecting Exchange-participating health benefits plans and obtaining benefits through such plans; and (D) develop a system to allow the Internet Web site described in subparagraph (A) and the information described in subparagraph (B) is developed using plain language (as defined in section 259(a)(2) of title X)

(ii) TO OTHER ENTITIES.—In carrying out this subsection, the Commissioner may work with other appropriate entities to facilitate the dissemination of information under this subsection and to provide assistance as described in paragraph (2).

(d) COVERAGE FOR CERTAIN NEWBORNS UNDER MEDICAID.

(1) IN GENERAL.—In the case of a child born in the United States who at the time of birth is not otherwise covered under acceptable coverage and during the period beginning on the date of birth and ending on the date the child otherwise is covered under acceptable coverage (or, if earlier, the end of the month in which the 60-day period, beginning on the date of birth, ends), the child shall be deemed—

(A) to be a Medicaid eligible individual for purposes of this division and Medicaid; and (B) to be automatically enrolled in Medicaid as a traditional Medicaid eligible individual under section 1943(c) of the Social Security Act.

(2) EXTENDED TREATMENT AS MEDICAID ELIGIBLE INDIVIDUAL.—In the case of a child described in subparagraph (B) of this paragraph, the child shall be deemed (until such period referred to in such paragraph is not otherwise covered under acceptable coverage, the child shall be deemed (until such period referred to in such paragraph is not otherwise covered under acceptable coverage), the State otherwise makes a determination of the child’s eligibility for medical assistance under its Medicaid plan pursuant to section 1902(a)(10) of the Social Security Act (to be a Medicaid eligible individual described in section 1902(a)(1)(B) of such Act).

(e) MEDICAID COVERAGE FOR MEDICAID ELIGIBLE INDIVIDUALS.—

(1) MEDICAID ENROLLMENT OBLIGATION.—An individual may apply, in the manner described in section 341(b)(1), for a determination of whether the individual is a Medicaid-eligible individual. If the individual is determined to be so eligible, the Commissioner, through the memorandum of understanding under paragraph (2), shall provide for the enrollment of the individual under the State Medicaid plan in accordance with such section. If in the case of such an enrollment, the State shall provide for the same periodic redetermination of eligibility under Medicaid as would otherwise have applied had the individual had not directly applied for medical assistance to the State Medicaid agency.

(2) COORDINATED ENROLLMENT WITH STATE THROUGH MEMORANDUM OF UNDERSTANDING.—The Commissioner, in consultation with the Secretary of Health and Human Services, shall enter into a memorandum of understanding with each State that is Exchange-eligible to coordinate the enrollment of individuals in Exchange-participating health benefits plans and under the State’s Medicaid program consistent with this section and to otherwise coordinate the implementation of the provisions of this division with respect to the Medicaid program. Such memorandum shall permit the exchange of information consistent with the limitations described in section 1902(a)(7) of the Social Security Act. Nothing in this section shall be construed as permitting such memorandum to modify or to authorize, either directly or by contract, any requirement of a State Medicaid plan.

(i) EFFECTIVE CULTURALLY AND LINGUISTICALLY APPROPRIATE COMMUNICATION.—In carrying out this section, the Commissioner shall establish effective methods for communicating in plain language and a culturally and linguistically appropriate manner.

(ii) ROLE FOR ENROLLMENT AGENTS AND BROKERS.—Nothing in this division shall be construed to affect the role of enrollment agents and brokers under State law, including with regard to the enrollment of individuals and employers in qualified health benefits plans including the public health insurance option.

(b) ASISTANCE FOR SMALL EMPLOYERS.—

(1) IN GENERAL.—In carrying out this section, the Commissioner shall establish a mechanism whereby there is an adjustment made of the premium amounts payable among QHP offering entities offering Exchange-participating health benefits plans.

(ii) TO OTHER ENTITIES.—In carrying out this section, the Commissioner shall establish a mechanism whereby there is an adjustment made of the premium amounts payable among QHP offering entities offering Exchange-participating health benefits plans.

(iii) TO OTHER ENTITIES.—In carrying out this section, the Commissioner shall establish a mechanism whereby there is an adjustment made of the premium amounts payable among QHP offering entities offering Exchange-participating health benefits plans.

(b) COORDINATION OF RISK POOLING.—The Commissioner shall establish a mechanism whereby there is an adjustment made of the premium amounts payable among QHP offering entities offering Exchange-participating health benefits plans.

(2) IN GENERAL.—The Commissioner in consultation with the Small Business Administration, shall establish and carry out a program to provide to small employers, employers that are members of such an arrangement under Exchange participating health benefits plans.

(3) ASISTANCE FOR SMALL EMPLOYERS.—

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(1) IN GENERAL.—In carrying out this section, the Commissioner shall establish a mechanism whereby there is an adjustment made of the premium amounts payable among QHP offering entities offering Exchange-participating health benefits plans.

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(iii) TO OTHER ENTITIES.—In carrying out this section, the Commissioner shall establish a mechanism whereby there is an adjustment made of the premium amounts payable among QHP offering entities offering Exchange-participating health benefits plans.
SEC. 307. HEALTH INSURANCE EXCHANGE TRUST FUND.

(a) ESTABLISHMENT OF HEALTH INSURANCE EXCHANGE TRUST FUND.—There is created within the Treasury of the United States a trust fund to be known as the “Health Insurance Exchange Trust Fund” (in this section referred to as “Trust Fund”). The amounts received in the Treasury under section 58B of the Internal Revenue Code of 1986 (relating to regulation of health insurance coverage for individuals) are hereby appropriated to the Trust Fund.

(b) EMPLOYMENT TAXES ON EMPLOYERS NOT PROVIDING ACCCEPTABLE COVERAGE.—The amounts received in the Treasury under sections 3111(c) and 3221(c) of the Internal Revenue Code of 1986 relating to employers electing to provide health benefits are hereby appropriated to the Trust Fund.

(c) REQUIREMENTS FOR APPROVAL.—

(1) ESTABLISHMENT OF HEALTH INSURANCE EXCHANGE.—The amounts received in the Treasury under section 4980H(b) (relating to excise tax on individuals not obtaining acceptable coverage) are hereby appropriated to the Trust Fund.

(2) PROVIDING ASSURANCES TO THE COMMISSIONER.—There are hereby appropriated, out of any moneys in the Treasury not otherwise appropriated, to the Trust Fund an amount equivalent to the amount deposited with the Internal Revenue Service and by such a State-based Health Insurance Exchange to operate the State-based Health Insurance Exchange under this section.

(d) T AXES ON INDIVIDUALS NOT OBTAINING ACCEPTABLE COVERAGE.—The amounts received in the Treasury under section 4980H(b) (relating to excise tax with respect to failure to meet health coverage participation requirements) are hereby appropriated to the Trust Fund.

(e) APPROPRIATIONS TO COVER GOVERNMENT REQUIREMENTS.—The amounts received in the Treasury under section 4980H(b) (relating to provide for the sale of health insurance) are hereby appropriated to the Trust Fund.

(f) REQUIREMENTS FOR APPROVAL.—(1) A State-based Health Insurance Exchange may, at the option of each Exchange-eligible individual, either (A) elect the Exchange to administer such functions in accordance with the requirements of subsection (b); or (B) (i) negotiate and contracting with QHBP issuers to offer coverage and (ii) operate, instead of the Health Insurance Exchange, including payments under subtitle C (relating to affordability credits).

(2) A TRANSFER TO TRUST FUND.—(A) There is hereby appropriated to the Trust Fund amounts necessary reduced by the amounts deposited in the Treasury under section 59B of the Internal Revenue Code of 1986 (relating to requirements of health insurance coverage for individuals).

(3) RETAINING ADDITIONAL AUTHORITY.—(a) The Commissioner may specify functions of the Health Insurance Exchange that—

(i) may not be performed by a State-based Health Insurance Exchange under this section; or

(ii) may be performed by the Commissioner and by such a State-based Health Insurance Exchange.

(b) REFERENCES.—In the case of a State-based Health Insurance Exchange except as the Commissioner may otherwise specify under subsection (d), any references in this subtitle to the Health Insurance Exchange or to such a State-based Health Insurance Exchange shall be deemed a reference to the State-based Health Insurance Exchange and the functions of such Exchange respectively.

(f) FUNDING.—In the case of a State-based Health Insurance Exchange, there shall be provided for the operation of such Exchange in the form of a matching grant with a State share of expenditures required.

SEC. 309. INTERSTATE HEALTH INSURANCE COMPACTS.

SEC. 310. OPTIONAL OPERATION OF STATE-BASED HEALTH INSURANCE EXCHANGES.

(a) IN GENERAL.—If—

(1) a State (or group of States, subject to the approval of the Commissioner) applies to the Commissioner for approval of a State-based Health Insurance Exchange to operate in the State (or group of States); and

(2) the Commissioner approves such State-based Health Insurance Exchange, then, subject to subsections (c) and (d), the State-based Health Insurance Exchange shall operate, instead of the Health Insurance Exchange, with respect to such State (or group of States).

(b) REQUIREMENTS FOR APPROVAL.—(1) IN GENERAL.—The Commissioner may not approve a State-based Health Insurance Exchange under this section unless the following requirements are met:

(A) The State-based Health Insurance Exchange must demonstrate the capacity to and provide assurances satisfactory to the Commissioner that the State-based Health Insurance Exchange will carry out the functions specified for the Health Insurance Exchange in the State (or States) involved, including—

(i) negotiating and contracting with QHBP offering entities for the offering of Exchange-participating health benefits plans,

(ii) enrolling Exchange-eligible individuals and employers in such State in such plans; (iii) the establishment of sufficient local offices to meet the needs of Exchange-eligible individuals and employers;

(iv) administering affordability credits under this subtitle in a manner more effective in such time and manner as the Commissioner shall specify.

(2) RETENTION OF AUTHORITY.—(A) The Commissioner shall retain authority with respect to—

(i) requirements of such Exchange no longer meeting the requirements of subsection (d); and

(ii) enforcement activities consistent with Federal requirements.

(3) EXCEPTIONS.—(A) The requirement of this section did not apply; and

(B) the cost to the Federal Government which does exceed the Federal Government which did not exceed the cost to the Federal Government if this section did not apply; and

(c) NO REQUIREMENT TO COMPACT.—Nothing in this section shall be construed to require a State to join a compact.

(d) STATE AUTHORITY.—A State may not enter into a compact under this subsection until the State enters into a compact with the Commissioner.

(e) CONSUMER PROTECTIONS.—If a State enters into a compact with the Commissioner, the compact shall be subject to the laws and regulations of the State in which the purchaser resides.

(f) NO REQUIREMENT TO COMPACT.—Nothing in this section shall be construed to require a State to join a compact.

(g) STATE AUTHORITY.—A State may not enter into a compact under this subsection until the State enters into a compact with the Commissioner on the date of enactment of this Act that specifically authorizes the State to enter into such compact.

(h) STATE AUTHORITY.—A State may not enter into a compact under this subsection until the State enters into a compact with the Commissioner on the date of enactment of this Act that specifically authorizes the State to enter into such compact.

(i) STATE AUTHORITY.—A State may not enter into a compact under this subsection until the State enters into a compact with the Commissioner on the date of enactment of this Act that specifically authorizes the State to enter into such compact.

(j) STATE AUTHORITY.—A State may not enter into a compact under this subsection until the State enters into a compact with the Commissioner on the date of enactment of this Act that specifically authorizes the State to enter into such compact.

(k) STATE AUTHORITY.—A State may not enter into a compact under this subsection until the State enters into a compact with the Commissioner on the date of enactment of this Act that specifically authorizes the State to enter into such compact.

(l) STATE AUTHORITY.—A State may not enter into a compact under this subsection until the State enters into a compact with the Commissioner on the date of enactment of this Act that specifically authorizes the State to enter into such compact.

(m) STATE AUTHORITY.—A State may not enter into a compact under this subsection until the State enters into a compact with the Commissioner on the date of enactment of this Act that specifically authorizes the State to enter into such compact.
(f) ASSISTANCE TO COMPACTING STATES.—
(1) IN GENERAL.—Beginning January 1, 2015, the Secretary shall make awards, from amounts appropriated under paragraph (5), to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

(2) AMOUNT SPECIFIED.—
(A) IN GENERAL.—For each fiscal year, the Secretary shall determine the total amount that the Secretary shall make available for grants under this subsection.

(B) GRANTS.—For each State that is awarded a grant under paragraph (1), the amount of such grants shall be based on a formula determined by the Secretary that shall not exceed $1 million per State, under which States shall receive an award in the amount that is based on the following two components:

(i) A minimum amount for each State.

(ii) An additional amount based on population of the State.

(C) USE OF FUNDS.—A State shall use amounts awarded under this subsection for activities (including planning activities) related to regulating health insurance coverage sold in that State.

(3) RENEWABILITY OF GRANT.—The Secretary may make grants to cooperatives to assist such cooperatives in meeting State solvency requirements in the States in which such cooperative offers or issues insurance coverage.

(4) RULES OF CONSTRUCTION.—Nothing in this section shall be construed as requiring the Secretary to do anything in any State in which such cooperative offers, intends to offer, or issues insurance coverage in the States in which such cooperative operates to comply with a State law of such State in requiring the Secretary to do anything in any State in which such cooperative offers, intends to offer, or issues insurance coverage.

(d) ESTABLISHMENT.—For years beginning with 2011, the Secretary of Health and Human Services shall provide for the offering of an Exchange-participating health benefits plan (in this division referred to as the “public health insurance option”) that ensures choice, competition, and stability of affordable, high-quality coverage throughout the United States in accordance with this section.

(b) OFFERING AS AN EXCHANGE-PARTICIPATING HEALTH BENEFITS PLAN.—
(1) EXCLUSIVE TO THE EXCHANGE.—The public health insurance option shall only be made available through the Health Insurance Exchange.

(2) FILING SYSTEM.—Conforming this subsection to the public health insurance option shall comply with requirements that are applicable under this title to an Exchange-participating health benefits plan, including requirements related to benefits, benefit levels, provider networks, notices, consumer protections, and cost-sharing.

(3) PROVISION OF BENEFIT LEVELS.—The public health insurance option—
(A) shall offer basic, enhanced, and premium plans; and

(B) may offer premium-plus plans.

(c) ADMINISTRATIVE CONTRACTING.—The Secretary may enter into contracts for the purpose of performing administrative functions, including functions described in subsection (a)(4) of section 1874A of the Social Security Act with respect to the public health insurance option in the same manner as the Secretary may enter into contracts under subsection (a)(1) of such section. The Secretary has the same authority with respect to the public health insurance option as the Secretary has under subsections (a)(1) and (b) of section 1874A of the Social Security Act with respect to title XVII of such Act. Contracts under this subsection shall not involve the transfer of insurance risk to such entity.

(d) OMBUDSMAN.—The Secretary shall establish an office of the ombudsman for the public health insurance option which shall have duties with respect to the public health insurance option similar to the duties of the Medicare Beneficiary Ombudsman under section 1879C of the Social Security Act with respect to the public health insurance option for other purposes under this subtitle, including to improve quality and to reduce racial, ethnic, and other disparities in health and health care.

(e) DATA COLLECTION.—The Secretary shall collect such data as may be required to establish and maintain the public health insurance option for the public health insurance option and for other purposes under this subtitle, including to improve quality and to reduce racial, ethnic, and other disparities in health and health care.

(f) TREATMENT OF PUBLIC HEALTH INSURANCE OPTION.—With respect to the public health insurance option, the Secretary shall be treated as a QHP offering entity offering an Exchange-participating health benefits plan.

(g) ACCESS TO FEDERAL COURTS.—The provisions of Medicare (as provided in the provisions of title II of the Social Security Act) relating to access of Medicare beneficiaries to Federal courts for the enforcement of rights under Medicare, including with respect to amounts in controversy, shall apply to the public health insurance option and individuals enrolled under such option under the same manner and such provisions apply to Medicare and Medicare beneficiaries.

SEC. 322. PREMIUMS AND FINANCING.

(a) ESTABLISHMENT OF PREMIUMS.—
(1) IN GENERAL.—The Secretary shall establish geographically adjusted premium rates for the public health insurance option—

(2) AMOUNT SPECIFIED.—
(A) IN GENERAL.—For each fiscal year, the Secretary shall determine the total amount that the Secretary shall make available for grants under this subsection.

(B) GRANTS.—For each State that is awarded a grant under paragraph (1), the amount of such grants shall be based on a formula determined by the Secretary that shall not exceed $1 million per State, under which States shall receive an award in the amount that is based on the following two components:

(i) A minimum amount for each State.

(ii) An additional amount based on population of the State.

(C) USE OF FUNDS.—A State shall use amounts awarded under this subsection for activities (including planning activities) related to regulating health insurance coverage sold in that State.

(D) RENEWABILITY OF GRANT.—The Secretary may make grants and loans to cooperatives to assist such cooperatives in meeting State solvency requirements in the States in which such cooperative offers, intends to offer, or issues insurance coverage.

(E) RULES OF CONSTRUCTION.—Nothing in this section shall be construed as requiring the Secretary to do anything in any State in which such cooperative offers, intends to offer, or issues insurance coverage in the States in which such cooperative operates to comply with a State law of such State in requiring the Secretary to do anything in any State in which such cooperative offers, intends to offer, or issues insurance coverage.

(f) ESTABLISHMENT OF PREMIUMS.—
(1) IN GENERAL.—Beginning January 1, 2015, the Secretary shall make awards, from amounts appropriated under paragraph (5), to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

(2) AMOUNT SPECIFIED.—
(A) IN GENERAL.—For each fiscal year, the Secretary shall determine the total amount that the Secretary shall make available for grants under this subsection.

(B) GRANTS.—For each State that is awarded a grant under paragraph (1), the amount of such grants shall be based on a formula determined by the Secretary that shall not exceed $1 million per State, under which States shall receive an award in the amount that is based on the following two components:

(i) A minimum amount for each State.

(ii) An additional amount based on population of the State.

(C) USE OF FUNDS.—A State shall use amounts awarded under this subsection for activities (including planning activities) related to regulating health insurance coverage sold in that State.

(3) RENEWABILITY OF GRANT.—The Secretary may make grants and loans to cooperatives to assist such cooperatives in meeting State solvency requirements in the States in which such cooperative offers, intends to offer, or issues insurance coverage.

(4) RULES OF CONSTRUCTION.—Nothing in this section shall be construed as requiring the Secretary to do anything in any State in which such cooperative offers, intends to offer, or issues insurance coverage in the States in which such cooperative operates to comply with a State law of such State in requiring the Secretary to do anything in any State in which such cooperative offers, intends to offer, or issues insurance coverage.

(F) THE COOPERATIVE IS NOT SponsORED BY A STATE GOVERNMENT.—

(1) IN GENERAL.—Beginning January 1, 2015, the Secretary shall make awards, from amounts appropriated under paragraph (5), to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

(2) AMOUNT SPECIFIED.—
(A) IN GENERAL.—For each fiscal year, the Secretary shall determine the total amount that the Secretary shall make available for grants under this subsection.

(B) GRANTS.—For each State that is awarded a grant under paragraph (1), the amount of such grants shall be based on a formula determined by the Secretary that shall not exceed $1 million per State, under which States shall receive an award in the amount that is based on the following two components:

(i) A minimum amount for each State.

(ii) An additional amount based on population of the State.

(C) USE OF FUNDS.—A State shall use amounts awarded under this subsection for activities (including planning activities) related to regulating health insurance coverage sold in that State.

(D) RENEWABILITY OF GRANT.—The Secretary may make grants and loans to cooperatives to assist such cooperatives in meeting State solvency requirements in the States in which such cooperative offers, intends to offer, or issues insurance coverage.

(E) RULES OF CONSTRUCTION.—Nothing in this section shall be construed as requiring the Secretary to do anything in any State in which such cooperative offers, intends to offer, or issues insurance coverage in the States in which such cooperative operates to comply with a State law of such State in requiring the Secretary to do anything in any State in which such cooperative offers, intends to offer, or issues insurance coverage.

(G) THE GOVERNANCE OF THE COOPERATIVE MUST BE SUBJECT TO A MAJORITY VOTE OF ITS MEMBERS.—

(H) AS PROVIDED IN GUIDANCE ISSUED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES, THE COOPERATIVE OPERATES WITH A STRONG CONSUMER FOCUS, INCLUDING TIMELINESS, RESPONSIVENESS, AND ACCOUNTABILITY TO MEMBERS.—

(I) ANY PROFITS MADE BY THE COOPERATIVE ARE USED TO LOWER PREMIUMS, IMPROVE BENEFITS, OR TO OTHERWISE IMPROVE THE QUALITY OF HEALTH CARE DELIVERED TO MEMBERS.—

(3) USE OF FUNDS.—A State shall use amounts awarded under this subsection for any of the following:

(ii) An additional amount based on population of the State.

(C) USE OF FUNDS.—A State shall use amounts awarded under this subsection for any of the following:

(ii) An additional amount based on population of the State.

(C) USE OF FUNDS.—A State shall use amounts awarded under this subsection for any of the following:

(ii) An additional amount based on population of the State.

(C) USE OF FUNDS.—A State shall use amounts awarded under this subsection for any of the following:

(ii) An additional amount based on population of the State.

(C) USE OF FUNDS.—A State shall use amounts awarded under this subsection for any of the following:

(ii) An additional amount based on population of the State.

(C) USE OF FUNDS.—A State shall use amounts awarded under this subsection for any of the following:

(ii) An additional amount based on population of the State.

(C) USE OF FUNDS.—A State shall use amounts awarded under this subsection for any of the following:

(ii) An additional amount based on population of the State.

(C) USE OF FUNDS.—A State shall use amounts awarded under this subsection for any of the following:

(ii) An additional amount based on population of the State.

(C) USE OF FUNDS.—A State shall use amounts awarded under this subsection for any of the following:

(ii) An additional amount based on population of the State.
(A) in a manner that complies with the premium rules established by the Commissioner under section 213 for Exchange-participating health benefits plans; and

(B) at an level sufficient to fully finance the costs of—

(i) health benefits provided by the public health insurance option; and

(ii) administrative costs related to operating the public health insurance option.

(2) CONTINGENCY MARGIN.—In establishing premium rates under paragraph (1), the Secretary shall appropriately account for a contingency margin (which shall be not less than 90 days of estimated claims). Before setting the appropriate amount for years starting with Y3, the Secretary shall solicit a recommendation on such amount from the American Academy of Actuaries.

(b) MANNER OF NEGOTIATION.—(1) ESTABLISHMENT.—There is established in the Treasury of the United States an Account for the receipt of disbursements attributable to the operation of the public health insurance option, including the startup funding provided under paragraph (2). Section 1854(g) of the Social Security Act shall apply to receipt and disbursement of funds in the previous sentence in the same manner as such section applies to payments or premiums described in such section.

(2) START-UP FUNDING.—(A) IN GENERAL.—In order to provide for the establishment of the public health insurance option, there is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $2,000,000,000. In order to provide for initial claims reserves before the collection of premiums, there are hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, such sums as necessary to cover 90 days worth of claims reserves based on projected enrollment.

(B) AMORTIZATION OF START-UP FUNDING.—The Secretary shall provide for the repayment of the startup funding provided under subparagraph (A) to the Treasury in an amortized manner over the 10-year period beginning with Y1.

(c) LIMITATION ON FUNDING.—Nothing in this section shall be construed as authorizing any additional appropriations to the Account, other than such amounts as are otherwise provided with respect to other Exchange-participating health benefits plans.

(d) NO BAILOUTS.—No case shall the public health insurance option receive any Federal share of involuntary losses in a manner similar to the manner in which entities receive Federal funding under the Troubled Assets Relief Program of the Secretary of the Treasury.

SEC. 323. PAYMENT RATES FOR ITEMS AND SERVICES.

(a) NEGOTIATION OF PAYMENT RATES.—

(1) IN GENERAL.—The Secretary shall negotiate payment for the public health insurance option for health care providers and items and services, including prescription drugs, consistent with this section and section 324.

(2) MANNER OF NEGOTIATION.—The Secretary shall negotiate such rates in a manner that results in payment rates that are not lower, in the aggregate, than rates under title XVIII of the Social Security Act, and not higher, in the aggregate, than the average rates paid by other QHP offering entities for services and health care providers.

(b) INNOVATIVE PAYMENT METHODS.—Nothing in this section shall be construed as preventing the use of innovative payment methods such as those described in section 324 in connection with the negotiation of payment rates under this subsection.

(c) TREATMENT OF CERTAIN STATE WAIVERS.—In the case of any State operating a cost-containment waiver for health care providers in accordance with section 1814(b)(3) of the Social Security Act, the Secretary shall provide for payment to such providers under the public health insurance option consistent with the provisions and requirements of that waiver.

(d) ESTABLISHMENT OF A PROVIDER NETWORK.—(1) IN GENERAL.—Health care providers (including physicians and hospitals) participating in the public health insurance option unless they opt out in a process established by the Secretary consistent with this subsection.

(2) REQUIREMENTS FOR OPT-OUT PROCESS.—Under the process established under paragraph (1)—

(A) providers described in such paragraph shall be provided at least a 1-year period prior to the first day of Y1 to opt out of participating in the public health insurance option;

(B) no provider shall be subject to a penalty for not participating in the public health insurance option;

(C) the Secretary shall provide information on how providers participating in Medicare who chose to opt out of participating in the public health insurance option may opt back in;

(D) there shall be an annual enrollment period in which providers may decide whether to participate in the public health insurance option.

(e) RULEMAKING.—Not later than 18 months before the first day of Y1, the Secretary shall promulgate rules (pursuant to notice and comment for the process described in paragraph (1).

(f) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review of a payment rate made under this section in a manner that—

(A) improve health outcomes;

(B) reduce health disparities (including racial, ethnic, and other disparities);

(C) provide efficient and affordable care;

(D) address geographic variation in the provision of care; or

(E) promote or manage chronic illness;

and (2) promote care that is integrated, patient-centered, quality, and efficient.

(g) ENCOURAGING THE USE OF HIGH VALUE SERVICES.—To the extent allowed by the benefit standard applied to all Exchange-participating health benefits plans, the public health insurance option may modify cost-sharing and payment rates to encourage the use of services that promote health and value.

(h) PROMOTION OF DELIVERY SYSTEM REFORM.—The Secretary shall monitor and evaluate the progress of payment and delivery system reforms under this Act and shall seek to implement such reforms subject to the following:

(1) To the extent that the Secretary finds a payment and delivery system reform successful in improving quality and reducing costs, the Secretary shall implement such reform on a nationwide geographic scale as practical and economical.

(2) The Secretary may delay the implementation of such a reform in geographic areas in which such implementation would place the public health insurance option at a competitive disadvantage.

(3) The Secretary may prioritize implementation of such a reform in high cost geographic areas or otherwise in order to reduce total program costs or to promote high value care.

(i) NON-UNIFORMITY PERMITTED.—Nothing in this subtitle shall prevent the Secretary from varying payments based on different payment structure models (such as accountable care organizations and medical homes) under the public health insurance option for different geographic areas.

SEC. 325. PROVIDER PARTICIPATION.

(a) IN GENERAL.—The Secretary shall establish conditions of participation for health care providers under the public health insurance option.

(b) LICENSURE OR CERTIFICATION.—(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the Secretary shall allow a health care provider to participate in the public health insurance option unless such provider is appropriately licensed, certified, or otherwise permitted to practice under State law.

(2) SPECIAL RULE FOR IHS FACILITIES AND PROVIDERS.—The requirements under paragraph (1) shall not apply to—

(A) a facility that is operated by the Indian Health Service;

(B) a facility operated by an Indian Tribe or Tribal organization under the Indian Self-Determination Act (Public Law 92–638);

(C) a health care professional employed by the Indian Health Service; or

(D) a health care professional—

(i) who is employed to provide health care services in a facility operated by an Indian Tribe or tribal organization under the Indian Self-Determination Act; and

(ii) who is licensed or certified in any State.

(c) PAYMENT TERMS FOR PROVIDERS.—(1) PHYSICIANS.—The Secretary shall provide for the annual payment of physicians under the public health insurance option, for which payment may be made for services furnished during the year, in one of 2 classes:

(A) PREFERRED PHYSICIANS.—Those physicians who agree to accept the payment under section 323 (without regard to cost-sharing) as the payment in full.

(B) PARTICIPATING, NON-PREFERRED PHYSICIANS.—Those physicians who agree not to impose charges (in relation to the payment described in section 323) that exceed the sum of the in-network cost-sharing plus 15 percent of the total payment for each item and service. The Secretary shall reduce the payment described in section 323 for such physicians.

(2) OTHER PROVIDERS.—The Secretary shall provide for the participation (on an annual basis specified by the Secretary) of health care providers (other than physicians) under the public health insurance option under which payment is available. If the provider agrees to accept the payment under section 323 (without regard to cost-sharing) as the payment in full.

(d) EXCLUSION OF CERTAIN PROVIDERS.—The Secretary shall exclude from the public health insurance option a health care provider that is excluded from
SEC. 326. APPLICATION OF FRAUD AND ABUSE CONTROL PROVISIONS.

Provisions of civil law identified by the Secretary by regulation, in consultation with the Inspector General of the Department of Health and Human Services, that impose sanctions with respect to waste, fraud, and abuse under Medicare, such as sections 1128 and 1129 of title 11, United States Code (commonly known as the False Claims Act), shall also apply to the public health insurance option.

SEC. 327. APPLICATION OF HIPAA INSURANCE REQUIREMENTS.

The requirements of sections 2701 through 2792 of the Public Health Service Act shall apply to the public health insurance option in the same manner as they apply to health insurance coverage offered by a health insurance issuer in the individual market.

SEC. 329. ENROLLMENT IN PUBLIC HEALTH INSURANCE OPTION IS VOLUNTARY.

Nothing in this division shall be construed as requiring anyone to enroll in the public health insurance option. Enrollment in such option shall be entirely voluntary.

SEC. 330. ENROLLMENT IN PUBLIC HEALTH INSURANCE OPTION BY MEMBERS OF THE ARMED FORCES.

Notwithstanding any other provision of this Act, Members of Congress may enroll in the public health insurance option.

SEC. 331. REMUNERATION OF SECRETARY OF VETERANS AFFAIRS.

The Secretary of Health and Human Services shall seek to enter into a memorandum of understanding with the Secretary of Veterans Affairs regarding the recovery of costs related to non-service-connected care or services provided by the Secretary of Veterans Affairs to a veteran covered under the public health insurance option in a manner consistent with recovery of costs related to non-service-connected care from private health insurance plans.

Subtitle C—Individual Affordability Credits

SEC. 341. AVAILABILITY THROUGH HEALTH INSURANCE EXCHANGE.

(a) In General.—In addition to the succeeding provisions of this subtitle, in the case of an individual who is an eligible individual enrolled in an Exchange-participating health benefits plan—

(1) the individual shall be eligible for, in accordance with this subtitle, affordability credits consisting of—

(A) an affordability premium credit under section 343 to be applied against the premium for the Exchange-participating health benefits plan in which the individual is enrolled; and

(B) an affordability cost-sharing credit under section 344 to be applied as a reduction of the cost-sharing otherwise applicable to such plan; and

(2) the Commissioner shall pay the QHP offering entity that offers such plan from the Health Insurance Exchange Trust Fund the aggregate affordability credits derived from all affordable credit eligible individuals enrolled in such plan.

(b) Application.—

(1) In General.—An Exchange eligible individual may apply to the Commissioner through the Health Insurance Exchange or through another public entity under an arrangement made with the Commissioner, in a form and manner specified by the Commissioner. The Commissioner through the Health Insurance Exchange or through another public entity under an arrangement made with the Commissioner shall make a determination as to the eligibility of the individual for affordability credits under this subtitle. The Commissioner shall establish a process whereby, on the basis of information otherwise available, individuals may be deemed to be affordable credit eligible. In making this determination, the Commissioner shall establish effective methods to ensure that individuals with limited English proficiency are able to apply for affordability credits.

(2) Use of State Medicaid Agencies.—If the Commissioner determines that a State Medicaid agency has the capacity to make a determination of eligibility for affordability credits under this subtitle and under the same standards as used by the Commissioner, under the Medicaid memorandum of understanding, that State Medicaid agency shall be authorized to conduct such determinations.

(c) Verification Process for Citizens.—

(1) In General.—An Exchange eligible individual may apply to the Commissioner through the Health Insurance Exchange or through another public entity under an arrangement made with the Commissioner, in a form and manner specified by the Commissioner. The Commissioner through the Health Insurance Exchange or through another public entity under an arrangement made with the Commissioner shall make a determination as to the eligibility of the individual for affordability credits under this subtitle. The Commissioner shall establish a process whereby, on the basis of information otherwise available, individuals may be deemed to be affordable credit eligible. In making this determination, the Commissioner shall establish effective methods to ensure that individuals with limited English proficiency are able to apply for affordability credits.

(2) Use of State Medicaid Agencies.—If the Commissioner determines that a State Medicaid agency has the capacity to make a determination of eligibility for affordability credits under this subtitle and under the same standards as used by the Commissioner, under the Medicaid memorandum of understanding, that State Medicaid agency shall be authorized to conduct such determinations.
 Ways and Means, the Committee on Energy and Commerce, the Committee on Education and Labor, and the Committee on the Judiciary of the House of Representatives and the Committee on Finance, the Committee on the Budget, the Committee on Education and Labor, and the Committee on the Judiciary of the Senate have examined the effectiveness of the verification procedures and systems applied under this paragraph. Such report shall include an analysis of the following:

(i) The causes of erroneous determinations under such systems.
(ii) The effectiveness of the processes used in preventing erroneous determinations.
(iii) The impact of such systems on individuals, health care providers, and Federal and State agencies, including the effect of erroneous determinations under such systems.

(iv) The effectiveness of such systems in preventing ineligible individuals from receiving for affordability credits.
(v) The characteristics of applicants described in subparagraph (E)(i).

(P) PROHIBITION OF DATABASE.—Nothing in this paragraph or in section 341(b)(4)(C) shall be construed as authorizing the Health Choices Commissioner or the Commissioner of Social Security to establish a database of information on citizen-ship or immigration status.

(H) INITIAL FUNDING.—

(1) For any of the funds in the Treasury not otherwise appropriated, there is appropriated to the Commissioner of Social Security $30,000,000, to be available without fiscal year limit to carry out this paragraph and section 205(v) of the Social Security Act.

(2) FUNDING LIMITATION.—In no case shall funds appropriated under this paragraph or in section 205 Limitation on Administrative Expenses be used to carry out activities related to this paragraph or section 205(v) of the Social Security Act.

(5) AGREEMENT WITH SOCIAL SECURITY COMMISSIONER.—

(A) IN GENERAL.—The Health Choices Commissioner shall enter into and maintain an agreement described in section 205(v)(2) of the Social Security Act with the Commissioner of Social Security.

(B) FUNDING.—Any agreement entered into under subparagraph (A) shall, for each fiscal year (beginning with fiscal year 2013—

(i) require the Commissioner of Social Security for the full costs of the responsibilities of the Commissioner of Social Security under paragraph (4), including—

(A) providing, financing, and maintaining technological equipment and systems necessary for the fulfillment of the responsibilities of the Commissioner of Social Security under paragraph (4), but only that portion of such costs that are attributable to such responsibilities; and

(B) responding to individuals who contest with the Commissioner of Social Security or the Department of Homeland Security relating to citizenship or immigration status, name, or social security account number under paragraph (4); and

(ii) based on an estimating methodology agreed to by the Commissioner of Social Security and the Health Choices Commissioner, provide such funds, within 10 calendar days of the beginning of the fiscal year for the first quarter, for each quarter in subsequent quarters in that fiscal year; and

(iii) provide for an annual accounting and reconciliation of the actual costs incurred and the funds provided under the agreement for any fiscal year that has not reached as of the first day of such fiscal year, the latest agreement reached. In any case in which an interim agreement is reached under this subparagraph, the Commissioner of Social Security shall, not later than the first day of such fiscal year, notify the appropriate Committees of the Congress of the failure to reach an agreement with respect to such provisions for such fiscal year. Until such time as the agreement with respect to such provisions has been reached for such fiscal year, the Commissioner of Social Security shall, not later than the end of each 90-day period after October 1 of such fiscal year, notify such Committees of the status of negotiations between such Commissioner and the Health Choices Commissioner in order to reach such an agreement.

(C) REVIEW OF ACCOUNTING.—The annual accounting and reconciliation conducted pursuant to subparagraph (B)(i) shall be reviewed by the Inspectors General of the Social Security Administration and the Health Choices Administration, including an analysis of consistency with the requirements of paragraph (4).

(D) CONTINGENCY.—In any case in which agreement with respect to the provisions required by subparagraph (A) for any fiscal year has not been reached as of the first day of such fiscal year, the latest agreement reached. In any case in which an interim agreement is reached under this subparagraph, the Commissioner of Social Security shall, not later than the first day of such fiscal year, notify the appropriate Committees of the Congress of the failure to reach an agreement with respect to such provisions for such fiscal year. Until such time as the agreement with respect to such provisions has been reached for such fiscal year, the Commissioner of Social Security shall, not later than the end of each 90-day period after October 1 of such fiscal year, notify such Committees of the status of negotiations between such Commissioner and the Health Choices Commissioner in order to reach such an agreement.

(E) APPLICATION TO PUBLIC ENTITIES ADMINISTERING AFFORDABILITY CREDITS.—If the Health Choices Commissioner provides for the conduct of verifications under paragraph (4) through a public entity, the Health Choices Commissioner shall require the public entity to enter into an agreement with the Commissioner of Social Security which provides for the agreement described in this paragraph (and section 205(v) of the Social Security Act) between the Health Choices Commissioner and the Commissioner of Social Security, except that the Health Choices Commissioner shall be responsible for providing funds for the Commissioner of Social Security to the Health Choices Commissioner under such subparagraph and for carrying out such an agreement.

(F) COORDINATING INFORMATION WITH HEALTH CARE FOR AMERICA ACT.—

(1) The Health Choices Commissioner may collect and use the names and social security account numbers of individuals as required to provide for verification of citizenship under subsection (b)(4)(C) of section 341 under the Affordable Care Act for America Act in connection with determinations of eligibility for affordability credits under such section.

(2) The Commissioner of Social Security shall enter into and maintain an agreement with the Health Choices Commissioner for the purpose of establishing, in compliance with the requirements of section 1902(e) as applied pursuant to section 341(b)(4)(C) of the Affordable Care Act for America Act, a program for verifying information required to be collected by the Health Choices Commissioner under such section 341(b)(4)(C).

(3) The agreement entered into pursuant to subparagraph (A) shall provide that in the event of a disagreement between the Health Choices Commissioner and the Commissioner of Social Security as to any determination made under such agreement, the Commissioner of Social Security determines appropriate.

(G) The agreement entered into pursuant to subparagraph (A) shall provide that in the event of a disagreement between the Health Choices Commissioner and the Commissioner of Social Security as to any determination made under such agreement, the Commissioner of Social Security determines appropriate.

(H) CONFORMING AMENDMENT.—Section 205(c)(2)(C) of such Act (42 U.S.C. 405(c)(2)(C)) is amended by adding at the end the following new clause:

(II) IMPROVING THE INTEGRITY OF DATA AND EFFECTIVENESS OF SAVE PROGRAM.—Section 1137(d) of the Social Security Act (42 U.S.C. 1396b(d)) is amended by adding at the end the following new paragraphs:

"(6)(A) With respect to the use by any agency of the system described in subsection (b) by programs specified in subsection (b) or any other use of such system, the U.S. Citizenship and Immigration Services and any other agency charged with enforcement of the system shall establish appropriate safeguards necessary to protect and improve the integrity and accuracy of data relating to such aliens by—

(i) establishing a process through which such individuals are provided access to, and the ability to amend, correct, and update, their own personally identifiable information contained within the system;

(ii) providing a written response, without undue delay, to any individual who has made such a request to amend, correct, or update such individual’s own personally identifiable information contained within the system;

and

(iii) developing a written notice for user agencies to provide to individuals who are denied a benefit due to a determination of ineligibility based on a final verification determined by the Commissioner of Social Security.

(B) The notice described in subparagraph (A)(i) shall include—

"(1) The agreement entered into pursuant to subparagraph (A) shall provide that information required to be collected by the Commissioner of Social Security to the Health Choices Commissioner pursuant to an agreement entered into pursuant to subparagraph (A) shall be considered as strictly confidential and shall be used only for the purposes described in this paragraph and for carrying out such agreement. Any officer or employee or former officer or employee of the Health Choices Commissioner, or any officer or employee of a contractor of the Health Choices Commissioner, who, without the written authority of the Commissioner of Social Security, publishes or communicates any information in such individual’s possession by reason of such employment or position as such an officer or employee, shall be fined not more than $10,000 or imprisoned, or both, as described in section 208.

(C) The agreement entered into pursuant to subparagraph (A) shall provide that in the event of a disagreement between the Health Choices Commissioner and the Commissioner of Social Security, the Commissioner of Social Security shall require the public entity that conducts verifications under section 341(b)(4) of the Affordable Health Care for America Act and the obligations of this subsection shall apply to such an entity in the same manner as such obligations apply to the Health Choices Commissioner and the Health Choices Commissioner is conducting such verifications.”

"(IV)(C) The agreement entered into pursuant to subparagraph (A) shall provide that in the event of a disagreement between the Health Choices Commissioner and the Commissioner of Social Security, the Commissioner of Social Security shall require the public entity that conducts verifications under section 341(b)(4) of the Affordable Health Care for America Act and the obligations of this subsection shall apply to such an entity in the same manner as such obligations apply to the Health Choices Commissioner and the Health Choices Commissioner is conducting such verifications.”

"(V)(1) The Health Choices Commissioner may collect and use the names and social security account numbers of individuals as required to provide for verification of citizen-ship under subsection (b)(4)(C) of section 341 under the Affordable Health Care for America Act in connection with determinations of eligibility for affordability credits under such section.

"(VI)(A) The Commissioner of Social Security shall enter into and maintain an agreement with the Health Choices Commissioner for the purpose of establishing, in compliance with the requirements of section 1902(e) as applied pursuant to section 341(b)(4)(C) of the Affordable Care Act for America Act, a program for verifying information required to be collected by the Health Choices Commissioner under such section 341(b)(4)(C).

(II) REVIEW OF ACCOUNTING.—The annual accounting and reconciliation conducted pursuant to subparagraph (B)(i) shall be reviewed by the Inspectors General of the Social Security Administration and the Health Choices Administration, including an analysis of consistency with the requirements of paragraph (4).
(1) information about the reason for such notice;
(2) a description of the right of the recipient of the notice under subparagraph (A)(i) to contest the correctness of the information contained in the notice, including notice of the right to rectify any information contained in the notice that is clearly erroneous or not consistent with information contained in records of the system described in paragraph (3); and
(4) instructions on how to contest such notice and attempt to correct records of such system relating to the recipient, including contact information for relevant agencies.

(2) STREAMLINING ADMINISTRATION OF VERIFICATION PROCESSES FOR UNITED STATES CITIZENS.—Section 1902(e)(2) of the Social Security Act (42 U.S.C. 1396a(e)(2)) is amended by adding at the end the following:

(4) In carrying out the verification procedures under this subsection with respect to a State, if the Commissioner of Social Security determines that the records maintained by such Commissioner are not consistent with an individual’s application for United States citizenship, pursuant to procedures which shall be established by the State in coordination with the Commissioner of Social Security, the Secretary of Homeland Security, and the Secretary of Health and Human Services:

(i) the Commissioner of Social Security shall inform the State of the inconsistency;
(ii) upon being so informed of the inconsistency, the State shall submit the information on the individual to the Secretary of Homeland Security for a determination of whether the records of the Department of Homeland Security indicate that the individual is a citizen;
(iii) upon making such determination, the Department of Homeland Security shall inform the State of such determination; and
(iv) if the determination provided by the Commissioner of Social Security shall be considered as strictly confidential and shall only be used by the State and the Secretary of Homeland Security for the purposes of such verification procedures.

(E) Verification of status eligibility pursuant to the procedures established under this subsection shall include a verification of status eligibility for purposes of this title, title XXI, and affordability credits under section 341(b)(4) of the Affordable Care Act for America, regardless of the program in which the individual is applying for benefits.

(c) Use of Affordability Credits.—

(1) General.—For purposes of Y1 and Y2, an affordable credit eligible individual may use an affordability credit only with respect to a basic plan.

(2) Flexibility in plan enrollment authorized.—Beginning with Y3, the Commissioner shall establish a process to allow an affordability premium credit under section 341(b)(4), but not the affordability cost-sharing credit under section 341, to be used for enrollees in enhanced or premium plans. In the case of an affordable credit eligible individual who enrolls in an enhanced or premium plan, the individual shall be responsible for any difference between the premium for such plan and the affordability credit amount otherwise applicable if the individual had enrolled in a basic plan.

(3) Prohibition of use of public funds for abortion coverage.—An affordability credit may not be used for payment of services described in section 222(e)(4)(A).

(4) Exchange-participating health benefits plan.—For purposes of this title, the term “Exchange-participating health benefits plan” means the Federal Health Benefits Program (other than as a nonimmigrant described in subparagraphs (K), (T), (U), and (V)) of section 101(a)(15) of the Immigration and Nationality Act—

(A) which is established and maintained in accordance with section 222(e)(4)(A) of the Internal Revenue Code of 1986 and is designed to provide health insurance to employees and retirees of the Federal government;

(B) the affordability premium credit under this section for an affordability premium credit under this section is in effect and

(C) is a plan the Commission determines appropriate.

For purposes of this title, the term “affordability credit eligible individual” means a full-time employee who is eligible under section 341(b)(4) of title XIX.

(b) Limitation on employer and dependendent disqualification.—

(1) In general.—For purposes of this section, a plan is an affordability premium credit eligible plan if

(A) the plan is an Exchange-participating health benefits plan;

(B) the affordability credit amount specified in section 341(b)(4) of the Internal Revenue Code of 1986 is available for purposes of this section;

(C) the plan meets the requirements of section 222(e)(4)(A) of title XIX; and

(D) the plan meets the requirements of section 222(e)(4)(A) of title XIX.

(c) Reference Premium Amount.—The reference premium amount specified in this section for a plan year for an individual in a premium rating area is equal to the average premium for the 3 basic plans in the area for the plan year with the lowest premium. In computing such amount the Commissioner may exclude plans with extremely limited enrollments.

(d) Table of Reference Premium Amount Limits, Actuarial Value Percentages, and Out-of-Pocket Limits for Y1 Based on Income Tier.—

(1) In general.—For purposes of this subsection, subject to paragraph (2) and section 303, the table specified in this subsection is as follows:

<table>
<thead>
<tr>
<th>Income Tier</th>
<th>Actuarial Value Percentage</th>
<th>Out-of-Pocket Limit for Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>133% through 150%</td>
<td>1.5%</td>
<td>$5,000</td>
</tr>
<tr>
<td>150% through 200%</td>
<td>3.0%</td>
<td>$1,000</td>
</tr>
<tr>
<td>200% through 250%</td>
<td>5.5%</td>
<td>$2,000</td>
</tr>
<tr>
<td>250% through 300%</td>
<td>8.0%</td>
<td>$4,000</td>
</tr>
<tr>
<td>300% through 350%</td>
<td>10.0%</td>
<td>$7,000</td>
</tr>
<tr>
<td>350% through 400%</td>
<td>12.0%</td>
<td>$14,000</td>
</tr>
</tbody>
</table>

In the case of modified adjusted gross income (expressed as a percent of FPL) within the following income tier:

<table>
<thead>
<tr>
<th>Income Tier</th>
<th>Actuarial Value Percentage</th>
<th>Out-of-Pocket Limit for Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>133% through 150%</td>
<td>1.5%</td>
<td>$5,000</td>
</tr>
<tr>
<td>150% through 200%</td>
<td>3.0%</td>
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</tr>
<tr>
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<td>5.5%</td>
<td>$2,000</td>
</tr>
<tr>
<td>250% through 300%</td>
<td>8.0%</td>
<td>$4,000</td>
</tr>
<tr>
<td>300% through 350%</td>
<td>10.0%</td>
<td>$7,000</td>
</tr>
<tr>
<td>350% through 400%</td>
<td>12.0%</td>
<td>$14,000</td>
</tr>
</tbody>
</table>

The out-of-pocket limit for coverage is $14,000.
not exceed 133 percent of FPL, the individual
reduction in cost-sharing described in sub-
section (c) in the table under
section 343(d) for the income tier involved; or
(ii) TERRITORIES DEFINED.—In this subpara-
graph, the term “territories of the United States
includes the Commonwealth of Puer-
t Rico, the United States Virgin Islands,
Guam, the Northern Marianas Islands,
and any other territory or possession of the
United States.

(2) PENALTIES FOR MISREPRESENTATION.—In
the case of an individual who intentionally
misrepresents modified adjusted gross in-
come in order to be an affordable credit eligible individual when the
individual is not or in the amount of the af-
fordable credit exceeding the correct
amount
(1) the individual is liable for repayment of
the improper affordability credit;

(2) in the case of such an intentional mis-
representation or other egregious cir-
cumstances specified by the Commissioner,
the Commissioner may impose an additional
penalty.

SEC. 346. SPECIAL RULES FOR APPLICATION TO
TERRITORIES.

(a) ONE-TIME ELECTION FOR TREATMENT AND
APPLICATION OF FUNDING.—

(A) IN GENERAL.—The Secretary of Health
and Human Services shall conduct a study to
examine the feasibility and implication of
adjusting the application of the Federal pov-
erty level in different geographical areas so as to
reflect the variations in cost-of-living among different areas within
in the United States. If the Secretary deter-
mines that such a study should include a methodology to make
such an adjustment. Not later than the first
day of Y1, the Secretary shall submit to Con-
grress a report on such study includ-

ing such recommendations as the Sec-


in the case of an individual's income
(expressed as a percentage of the Federal
poverty level for a family of the size in-


(1) the Commissioner shall establish rules requiring
an individual to report, consistent with the
mechanism established under paragraph (2),
significant changes in such income (includ-
ing a significant change in family composi-
tion) to the Commissioner and requiring the
substitution of such income for the income
otherwise applicable.

(2) REPORTING OF SIGNIFICANT CHANGES IN
INCOME.—The Commissioner shall establish
rules under which an individual determined
to be an affordable credit eligible individual
would be required to inform the Commis-


the individual is liable for repayment of
the amount of the improper affordability credit;

(2) CONDITIONS FOR ACCEPTANCE.—The Com-
m issioner has the nonreviewable authority to
accept or reject an election described in
paragraph (1)(A). Any such acceptance is—

(A) contingent upon entering into an agreement described in
paragraph (2) between the Commissioner and the territory
and subsection (c); and

(B) subject to the approval of the Sec-


(1) the Commissioner shall establish rules under which
an individual determined to be an affordable credit eligible individ-
ual is deemed to be no greater than the
family income of the child as most recently
determined before Y1 by the State under
title XXII of the


(1) the individual is liable for repayment of
the amount of the improper affordability credit;

(2) CONDITIONS FOR ACCEPTANCE.—The Com-
m issioner has the nonreviewable authority to
accept or reject an election described in
paragraph (1)(A). Any such acceptance is—

(A) contingent upon entering into an agreement described in
paragraph (2) between the Commissioner and the territory
and subsection (c); and

(B) subject to the approval of the Sec-


(1) the individual is liable for repayment of
the amount of the improper affordability credit;

(2) CONDITIONS FOR ACCEPTANCE.—The Com-
m issioner has the nonreviewable authority to
accept or reject an election described in
paragraph (1)(A). Any such acceptance is—

(A) contingent upon entering into an agreement described in
paragraph (2) between the Commissioner and the territory
and subsection (c); and

(B) subject to the approval of the Sec-


(1) the individual is liable for repayment of
the amount of the improper affordability credit;

(2) CONDITIONS FOR ACCEPTANCE.—The Com-
m issioner has the nonreviewable authority to
accept or reject an election described in
paragraph (1)(A). Any such acceptance is—

(A) contingent upon entering into an agreement described in
paragraph (2) between the Commissioner and the territory
and subsection (c); and

(B) subject to the approval of the Sec-


under paragraph (1A) not accepted under paragraph (2) shall be treated as having made the election described in paragraph (1B).
(b) Agreement for Substitution of Percentages and Dollar Amounts.—
(1) Negotiation.—In the case of a territory making an offer of coverage under paragraphs (a)(1A) (in this section referred to as an ‘‘electing territory’’), the Commissioner, in consultation with the Secretaries of Health and Human Services and the Treasury, shall enter into negotiations with the government of such territory so that, before Y1, there is an agreement reached between the parties on the percentages and dollar amounts to be applied under paragraphs (2) for that territory. The Commissioner shall not enter into such an agreement unless—
(A) payments made under this subtitle with respect to residents of the territory are consistent with the cap established under subsection (c) for such territory and with subsection (d); and
(B) the requirements of paragraphs (3) and (4) are met.
(2) Application of Substitute Percentages and Dollar Amounts.—In the case of an electing territory, there shall be substituted in section 342(a)(1B) and in the table in subsection (a)(2) for 100 percent, and other percentages and dollar amounts specified in such table, such respective percentages and dollar amounts as are established under the agreement under paragraph (1) consistent with the following:
(A) No Income Gap Between Medicaid and Affordability Credits.—The substituted percentages shall be specified in a manner so as to prevent any gap in coverage for individuals between income level at which medical assistance is available through Medicaid and the income level at which affordability credits are available.
(B) Adjustment for Out-Of-Pocket Responsibility for Premiums and Cost-Sharing in Relation to Income.—The substituted percentages of FPL for income tiers under such table shall be specified in a manner so as to prevent any gap in coverage for individuals between income level at which affordability credits are available.
(C) Special Rules with Respect to Affordability Credits.—The electing territory shall enact one or more laws under which provisions similar to the laws under which provisions are available in the United States or the District of Columbia in relation to average income for such residents.
(3) Special Rules with Respect to Affordability Credits.—The electing territory shall enact one or more laws under which provisions similar to the following provisions apply with respect to such laws:
(A) Section 59B of the Internal Revenue Code of 1986, except that any resident of the territory who is not an affordable credit eligible individual shall be treated as if such resident were a resident of one of the 50 States (and any qualifying child residing with such individual) may be treated as covered by acceptable coverage.
(C) Section 321(e) of the Internal Revenue Code of 1986.
(D) IMPLEMENTATION OF INSURANCE REFORM AND CONSUMER PROTECTION REQUIREMENTS.—The electing territory shall enact and implement such laws and regulations as may be required to meet the requirements of this section with respect to health insurance coverage offered in the territory.
(c) Cap on Additional Expenditures.—
(1) In General.—In entering into an agreement with an electing territory under subsection (b), the Commissioner shall ensure that the cap on additional expenditures with respect to residents of such territory during the period beginning with Y1 and ending with Y2 will not exceed the cap amount calculated under subparagraph (C) for such electing territory. The Commissioner shall adjust from time to time the percentages applicable under such agreement as needed in order to carry out the purposes of this sentence.
(2) Cap Amount.—
(A) In General.—The cap amount specified in this paragraph—
(i) for Puerto Rico is $3,700,000,000 increased by the amount (if any) elected under subparagraph (C); or
(ii) for another territory is the portion of $300,000,000 negotiated for such territory under subparagraph (B).
(B) Negotiation for Certain Territories.—The Commissioner in consultation with the Secretary of Health and Human Services shall negotiate with the government of the territories (other than Puerto Rico) to allocate the amount specified in subparagraph (A) among such territories.
(C) Optional Supplementation for Puerto Rico.—
(i) In General.—Puerto Rico may, elect, in a form specified by the Secretary of Health and Human Services in consultation with the Commissioner to increase the dollar amount specified in subparagraph (A) by up to $1,000,000,000.
(ii) Offset in Medicaid Cap.—If Puerto Rico makes the election described in clause (i), the Secretary shall decrease the dollar limitation otherwise applicable Puerto Rico under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308) for a fiscal year by the additional aggregate amounts specified in this paragraph.

SEC. 412. EMPLOYER RESPONSIBILITY TO CONTRIBUTE TOWARD EMPLOYEE AND DEPENDENT COVERAGE.
(a) In General.—An employer meets the requirements of this section with respect to an employee if the following requirements are met:
(1) Offering of Coverage.—The employer offers the coverage described in section 411(1). In the case of an Exchange-eligible employer, the employer may offer such coverage either through an Exchange-participating health benefits plan or other than through such a plan.
(2) Employer Required Contribution.—The employer through the issuer of such coverage an amount not less than the employer required contribution specified in subsection (b) for such coverage.
(3) Provision of Information.—The employer provides the Health Choices Commissioner, the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury, as applicable, with such information as the Commissioner may require to ascertain compliance with the requirements of this section, including the following:
(A) The name, date, and employer identification number of the employer.
(B) A certification as to whether the employer provided its full-time employees (and their dependents) the opportunity to enroll in a qualified health benefits plan or a current employment-based health plan (within the meaning of section 201(b)).
(C) If the employer certifies that the employer did offer to its full-time employees (and their dependents) the opportunity to so enroll:
(i) the months during the calendar year for which such coverage was available; and
(ii) the monthly premium for the lowest cost coverage offered to such employee (and their dependents) under each such plan.
(D) The name, address, and EIN of each full-time employee during the calendar year and the months (if any) during which such employee (and any dependents) were covered under any such plans.
(4) AUTORENROLLMENT OF EMPLOYERS.—The employer provides for autoreenrollment of the employee in accordance with subsection (c).

SEC. 411. HEALTH COVERAGE PARTICIPATION REQUIREMENTS.
(a) Provisions of this section apply to an employer if the following requirements are met:
(1) Offer of Coverage.—The employer offers to its full-time employees (and their dependents) the opportunity to so enroll:
(i) in a plan (or under a current employment-based health plan) that would prevent automatic pay-roll deduction of employee contributions to an employment-based health plan.
(ii)
(b) Reduction of Employee Premiums Through Minimum Employer Contribution.—
(1) Full-Time Employees.—The minimum employer contribution described in this subsection for coverage of a full-time employee (and, if any, the employee’s spouse and qualifying children (as defined in section 152(c) of the Internal Revenue Code of 1986)) under a qualified health benefits plan (current employment-based health plan) is equal to—
(A) in case of individual coverage, not less than 72.5 percent of the applicable premium (as defined in section 201(b) of such Code); and
(B) in case of group coverage, not less than 73 percent of the applicable premium (as defined in section 201(b) of such Code), subject to paragraph (2) of the lowest cost plan offered by the employer that is a

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qualified health benefits plan (or is such current employment-based health plan);

B) in the case of family coverage which includes coverage of such spouse and children, not less than 34 percent of such applicable premium of such lowest cost plan.

2) APPLICABLE PREMIUM FOR EXCHANGE COVERAGE.—In this subtitle, the amount of the applicable premium under this subsection with respect to coverage under an Exchange-participating health benefits plan is the reference premium amount under section 415(a) applied to the applicable premium of such individual coverage (or, if elected, family coverage) for the premium rating area in which the individual or family resides.

3) MINIMUM EMPLOYER CONTRIBUTION FOR EMPLOYERS OTHER THAN FULL-TIME EMPLOYEES.—In the case of coverage for an employee who is not a full-time employee, the amount of the minimum employer contribution under this subsection shall be a proportion (as determined in accordance with rules of the Health Choices Commissioner, the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury, as applicable) of the minimum employer contributions made in this subsection with respect to a full-time employee that reflects the proportion of:

A) the average weekly hours of employment determined by the employer, to

B) the minimum weekly hours specified by the Commissioner for an employee to be a full-time employee.

4) SELF-INSURANCE NOT TREATED AS EMPLOYER CONTRIBUTIONS.—For purposes of this section, any contribution on behalf of an employee with respect to which there is a corresponding reduction in the compensation of the employee shall not be treated as an amount paid by the employer.

C) AUTOMATIC ENROLLMENT FOR EMPLOYER SPONSORED HEALTH BENEFITS.—(1) IN GENERAL.—The requirement of this subsection with respect to an employer and an employee is that the employer automatically enroll such employee into the employer-sponsored health benefits plan for individual coverage under the lowest applicable employee premium.

(2) OPT-OUT.—In no case may an employer automatically enroll an employee in a plan under paragraph (1) if such employee makes an affirmative election to opt out of such plan or if such employee's election to such plan or employer responsibility requirements described in section 413(a) and make a recommendation to Congress about whether an employer hardship exemption would be appropriate.

(2) SPECIAL RULES FOR SMALL EMPLOYERS.—(1) IN GENERAL.—In the case of any employer who is a small employer for any calendar year, subsection (a) shall be applied by substituting the applicable percentage determined in accordance with the following table for "65 percent":

<table>
<thead>
<tr>
<th>Percentage of Annual Payroll</th>
<th>Minimum Employer Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not exceed $500,000</td>
<td>0 percent</td>
</tr>
<tr>
<td>Exceeds $500,000, but does not exceed $585,000</td>
<td>2 percent</td>
</tr>
<tr>
<td>Exceeds $585,000, but does not exceed $670,000</td>
<td>4 percent</td>
</tr>
<tr>
<td>Exceeds $670,000, but does not exceed $750,000</td>
<td>6 percent</td>
</tr>
</tbody>
</table>

(2) SMALL EMPLOYERS.—For purposes of this subsection, the term "small employer" means any employer for any calendar year if the annual payroll of such employer for the preceding calendar year does not exceed $750,000.

3) ANNUAL PAYROLL.—For purposes of this paragraph, "annual payroll" means the aggregate wages paid by the employer during such calendar year.

(4) RULES.—Related employers and predecessors shall be treated as a single employer for purposes of this subsection.

SEC. 414. AUTHORITY RELATED TO IMPROPER STEERING.

The Health Choices Commissioner (in coordination with the Secretary of Labor, the Secretary of Health and Human Services, and the Secretary of the Treasury) shall have authority to set standards for determining whether employers or insurers are underwriting risk pools to affect the risk pool within the Health Insurance Exchange by inducing individuals to decline coverage under a qualified health benefits plan (or current employment-based health plans, and employees in each industry. A report on findings on how employer responsibility requirements have impacted and are likely to impact employers, plans, and employees during the previous year and projected trends.

(a) LEGISLATIVE RECOMMENDATIONS.—No later than January 1, 2012 and on an annual basis thereafter, the Secretary of Labor shall submit legislative recommendations to Congress to modify the employer responsibility requirements if the average employer responsibility requirements described in section 413(a) are not designed to work.

(b) STUDY ON EMPLOYER HARDSHIP EXEMPTION.—(a) IN GENERAL.—The Secretary of Labor, together with the Secretary of Treasury, the Secretary of Health and Human Services, and the Commissioner, shall conduct a study to examine the effect of the employer responsibility requirements described in section 413(a) and make a recommendation to Congress about whether an employer hardship exemption would be appropriate.
*PART 8—NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS*

**SEC. 801. ELECTION OF EMPLOYER TO BE SUBJECT TO NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS.**

(a) In General.—An employer may make an election with the Secretary to be subject to the health coverage participation requirements.

(b) Time and Manner.—An election under subsection (a) may be made at such time and in such form and manner as the Secretary may prescribe.

**SEC. 802. TREATMENT OF COVERAGES RESULTING FROM ELECTION.**

(a) In General.—An employer makes an election to the Secretary under section 801—

(1) such election shall be treated as the establishment and maintenance of a group health plan (as defined in section 732(a)) for purposes of this title, subject to section 251 of the Affordable Health Care for America Act; and

(2) the health coverage participation requirements shall be deemed to be included as terms and conditions of such plan.

(b) Periodic Investigations to Discover Noncompliance.—From the date of such election the Secretary shall regularly audit a representative sampling of employers and group health plans and conduct investigations and other activities under section 504 with respect to any employer who is in substantial noncompliance with the health coverage participation requirements in connection with such plans. The Secretary shall communicate findings of noncompliance made by the Secretary under this subsection to the Secretary of the Treasury and the Health Choices Commissioner. The Secretary shall coordinate such timely enforcement action as appropriate to achieve compliance.

(c) Recordkeeping.—To facilitate the audits described in subsection (b), the Secretary shall promulgate recordkeeping requirements for employers to account for all employees of the employer and all individuals who the employer has not treated as employees of the employer but with whom the employer, in the course of its trade or business, has engaged for the performance of labor or services. The Secretary may prescribe such forms and contents of such recordkeeping requirements shall be determined by the Secretary and shall be designed to enable employers who are not properly treated as such may be identified and properly treated.

**SEC. 803. HEALTH COVERAGE PARTICIPATION REQUIREMENTS.**

For purposes of this part, the term ‘health coverage participation requirements’ means the requirements of part 1 of subtitle B of title IV of division A of (as in effect on the date of the enactment of such Act).

**SEC. 804. RULES FOR APPLYING REQUIREMENTS.**

(a) Affiliated Groups.—In the case of any employer which is a part of a group of employers who are treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986, the election of such employer shall be made by such employer as the Secretary may provide. Any such election, once made, shall apply to all members of such group.

(b) Separate Elections.—Under regulations prescribed by the Secretary, separate elections may be made under section 801 with respect to—

(1) different lines of business, and

(2) full-time employees and employees who are not full-time employees.

**SEC. 805. TERMINATION OF ELECTION IN CASES OF SUBSTANTIAL NONCOMPLIANCE.**

The Secretary may terminate the election of any employer under section 801 if the Secretary (in coordination with the Health Choices Commissioner) determines that such employer is in substantial noncompliance with the health coverage participation requirements. The Secretary may apply any such determination with respect to the Secretary of the Treasury as appropriate.

**SEC. 806. REGULATIONS.**

The Secretary may promulgate such regulations as may be necessary to carry out the provisions of this part, in accordance with section 422(b) of the Internal Revenue Code of 1986 so as to avoid duplication of penalties with respect to such failure.

(P) Deposit of Penalty Collected.—Any amount of penalty collected under this paragraph shall be deposited as miscellaneous revenue in the Treasury of the United States.

**PART 8—NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS.**

**SEC. 801. ELECTION OF EMPLOYER TO BE SUBJECT TO NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS.**

(a) In General.—An employer may make an election with the Secretary to be subject to the health coverage participation requirements.

(b) Time and Manner.—An election under subsection (a) may be made at such time and in such form and manner as the Secretary may prescribe.

**SEC. 802. TREATMENT OF COVERAGES RESULTING FROM ELECTION.**

(a) In General.—An employer makes an election to the Secretary under section 801—

(1) such election shall be treated as the establishment and maintenance of a group health plan (as defined in section 732(a)) for purposes of this title, subject to section 251 of the Affordable Health Care for America Act; and

(2) the health coverage participation requirements shall be deemed to be included as terms and conditions of such plan.

(b) Periodic Investigations to Discover Noncompliance.—From the date of such election the Secretary shall regularly audit a representative sampling of employers and group health plans and conduct investigations and other activities under section 504 with respect to any employer who is in substantial noncompliance with the health coverage participation requirements in connection with such plans. The Secretary shall communicate findings of noncompliance made by the Secretary under this subsection to the Secretary of the Treasury and the Health Choices Commissioner. The Secretary shall coordinate such timely enforcement action as appropriate to achieve compliance.

(c) Recordkeeping.—To facilitate the audits described in subsection (b), the Secretary shall promulgate recordkeeping requirements for employers to account for all employees of the employer and all individuals who the employer has not treated as employees of the employer but with whom the employer, in the course of its trade or business, has engaged for the performance of labor or services. The Secretary may prescribe such forms and contents of such recordkeeping requirements shall be determined by the Secretary and shall be designed to enable employers who are not properly treated as such may be identified and properly treated.

(d) Effective Date.—The amendments made by this section shall apply to periods beginning after December 31, 2012.

**SEC. 803. HEALTH COVERAGE PARTICIPATION REQUIREMENTS.**

(a) Civil Penalties.—In the case of any employer who fails (during any period with respect to which an election under section 801(a) has been made) to satisfy the health coverage participation requirements with respect to any employee, the Secretary may assess a civil penalty against the employer of $100 for each day in the period beginning on the date such failure first occurs and ending on the date such failure is corrected.

(b) Health Coverage Participation Requirements.—For purposes of this paragraph, the term ‘health coverage participation requirements’ has the meaning provided in section 803.

(c) Limitations on Amount of Penalty.—

(i) Penalty Not to Apply Where Failure Not Discovered Exercising Reasonable Diligence.—No penalty shall be assessed under subparagraph (A) with respect to any failure during any period for which it is established to the satisfaction of the Secretary that the employer did not know, or exercising reasonable diligence did not have known, that such failure existed.

(ii) Penalty Not to Apply to Failures Corrected Within 30 Days.—No penalty shall be assessed under subparagraph (A) with respect to any failure if—

(I) such failure was due to reasonable cause and not to willful neglect, and

(II) such failure is corrected during the 30-day period beginning on the 1st date that the employer knew, or exercising reasonable diligence would have known, that such failure existed.

(d) Effective Date.—The amendments made by this section shall apply to periods beginning after December 31, 2012.

**SEC. 804. RULES FOR APPLYING REQUIREMENTS.**

(a) Failure To Elect, or Substantially Comply With, Health Coverage Participation Requirements.—For employment tax purposes, employers who fail to substantially comply with the health coverage participation requirements described in part 1, see section 331(c) of the Internal Revenue Code of 1986 (as added by section 512 of this Act).

(b) Other Failures.—For excise tax on other failures of employing employers to comply with such requirements, see section 4980H of the Internal Revenue Code of 1986 (as added by section 511 of this Act).

**SEC. 806. REGULATIONS.**

(a) In General.—Part C of title XXVII of the Public Health Service Act is amended by adding at the end the following new section:

SEC. 2793. NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS.

(1) ELECTION OF EMPLOYER TO BE SUBJECT TO NATIONAL HEALTH COVERAGE PARTICIPATION REQUIREMENTS.**

(a) Failure To Elect, or Substantially Comply With, Health Coverage Participation Requirements.—For employment tax purposes, employers who fail to substantially comply with the health coverage participation requirements described in part 1, see section 331(c) of the Internal Revenue Code of 1986 (as added by section 512 of this Act).

(b) Other Failures.—For excise tax on other failures of employing employers to comply with such requirements, see section 4980H of the Internal Revenue Code of 1986 (as added by section 511 of this Act).

**SEC. 805. TERMINATION OF ELECTION IN CASES OF SUBSTANTIAL NONCOMPLIANCE.**

The Secretary may terminate the election of any employer under section 801 if the Secretary determines that such employer is in substantial noncompliance with the health coverage participation requirements. The Secretary may apply any such determination with respect to the Secretary of the Treasury as appropriate.

**SEC. 806. REGULATIONS.**

The Secretary may promulgate such regulations as may be necessary to carry out the provisions of this part, in accordance with section 422(b) of the Internal Revenue Code of 1986 so as to avoid duplication of penalties with respect to such failure.

(P) Deposit of Penalty Collected.—Any amount of penalty collected under this paragraph shall be deposited as miscellaneous revenue in the Treasury of the United States.
“(2) Periodic investigations to determine compliance with health coverage participation requirements.—The Secretary shall regularly audit a representative sampling of employers to detect noncompliance and other activities with respect to such sampling of employers so as to discover noncompliance with the health coverage participation requirements of this section. The Secretary shall take appropriate enforcement action as appropriate to achieve compliance.

“(3) Recordkeeping.—To facilitate the audits described in subsection (b), the Secretary shall promulgate recordkeeping requirements for employers to account for both employees of the employer and individuals whom the employer has not treated as employees of the employer but with whom the employer, in the course of its trade or business, has engaged for the performance of labor or services. The scope and content of such requirements shall be determined by the Secretary and shall be designed to ensure that employees who are not properly treated as such may be identified properly treated as such may be identified.

“(c) Health coverage participation requirements.—For purposes of this section, the term ‘health coverage participation requirements’ means the requirements of part 1 of subtitle B of title IV of division A of the (as in effect on the date of the enactment of this section).

“(d) Separate elections.—Under regulations prescribed by the Secretary, separate elections may be made under subsection (a) with respect to full-time employees and employees whose employment is full-time at the time an election is made.

“(e) Termination of election in cases of substantial noncompliance.—The Secretary may terminate the election of any employee under subsection (a) if the Secretary (in coordination with the Health Insurance Exchanges) determines that such employer is in substantial noncompliance with the health coverage participation requirements and shall refer any such determination to the Secretary of the Treasury as appropriate.

“(f) Enforcement of health coverage participation requirements.—

“(1) Civil penalties.—In the case of any employer who fails (during any period with respect to any employee) to account for all employees of the employer but with whom the employer knew, or exercising reasonable diligence would have known, that such failure existed.

“(2) Penalty not to apply where failure not discovered exercising reasonable diligence.—No penalty shall be assessed under paragraph (1) with respect to any failure during any period for which it is established to the satisfaction of the Secretary that the employer did not know, or exercising reasonable diligence would not have known, that such failure existed.

“(3) Civil penalties.—In the case of any employer who fails (during any period with respect to any employee) to account for all employees of the employer but with whom the employer knew, or exercising reasonable diligence would have known, that such failure existed.

“(4) Penalties for certain failures related to health care participation requirements.—

“(a) Assuring coordination.—The Secretary shall provide for TWO OR MORE INDIVIDUALS DURING THE TAXABLE YEAR, the average premium paid by the employer (or the predecessor employer) during the preceding taxable year with respect to group health plans of.

“(B) the entire taxable year.

“(g) Regulations.—The Secretary shall promulgate regulations which are appropriate to carry out the provisions of this section.

“(h) Failure to provide coverage for more than one individual.—In the case of any taxpayer who fails to meet the health coverage participation requirements of subsection (c) with respect to more than one individual during the taxable year, the average premium (as determined by the Secretary in coordination with the Health Insurance Exchanges) for self-only coverage under a basic plan which is offered in a Health Insurance Exchange for the calendar year in which such taxable year begins.

“(1) such failure was due to reasonable cause and to not willful neglect, and

“(2) the employer, in conformity with the advice of counsel, has taken all appropriate corrective action with respect to such failure.

“(3) the employer, in conformity with the advice of counsel, has taken all appropriate corrective action with respect to such failure.

“(4) exceptions.—
"(1) Dependents.—Subsection (a) shall not apply to any individual for any taxable year if a deduction is allowable under section 151 with respect to such individual to another taxpayer for the taxable year beginning in the same calendar year as such taxable year.

"(2) Nonresident aliens.—Subsection (a) shall not apply to any individual who is a nonresident alien for purposes of this chapter.

"(3) Individuals residing outside United States.—Any qualified individual (as defined in section 911(d)(1)) and any qualifying child residing with such individual) shall be treated for purposes of this section as covered by acceptable coverage during the period described in subparagraph (A) or (B) of section 911(d)(1) for purposes of this section.

"(4) Individuals residing in possession of the United States.—Any individual who is a bona fide resident of any possession of the United States (as determined under section 937(a)) for any taxable year (and any qualifying child residing with such individual) shall be treated for purposes of this section as covered by acceptable coverage during such taxable year.

"(5) Religious conscience exemption.—

"(a) In general.—Subsection (a) shall not apply to any individual (and any qualifying child residing with such individual) for any period if such individual has in effect an exemption which certifies that such individual is a member of a recognized religious denomination or division thereof described in section 1402(g)(1) and an adherent of established tenets or teachings of such sect or division as described in section 1402(g)(1).

"(b) Exemption.—An application for the exemption described in subparagraph (A) shall be filed with the Secretary at such time and in such manner as the Secretary may prescribe. The Secretary may treat an application for exemption under section 1402(g)(1) as an application for exemption from such term or, may otherwise coordinate applications under such sections, as the Secretary determines appropriate. Any such exemption granted by the Secretary shall be effective for such period as the Secretary determines appropriate.

"(d) Acceptable Coverage Requirement.

"(1) In general.—The requirements of this subsection are met with respect to any individual for any period if such individual (and each qualifying child of such individual) is covered by acceptable coverage at all times during such period.

"(2) Acceptable Coverage.—For purposes of this section, the term 'acceptable coverage' means the following:

"(A) Qualified Health Benefits Plan Coverage.—Coverage under a qualified health benefits plan (as defined in section 100(c) of the ).

"(B) Grandfathered Health Insurance Coverage; Coverage Under Grandfathered Employment-Based Health Plan.—Coverage under a health insurance coverage (as defined in subsection (a) of section 202 of the Affordable Health Care for America Act) or under a current employment-based health plan (within the meaning of subsection (b) of such section).

"(C) Medicare.—Coverage under part A of title XVIII of the Social Security Act.

"(D) Medicaid.—Coverage for medical assistance under title XIX of the Social Security Act.

"(E) Members of the Armed Forces and Dependents THEREOF.—Coverage under chapter 55 of title 10, United States Code, including similar coverage furnished under section 1781 of title 38 of such Code.

"(F) Indian health care program.—Coverage under the veteran’s health care program under chapter 17 of title 38, United States Code.

"(G) Members of Indian tribes.—Health care services made available through the Indian Health Service, a tribal organization (as defined in section 1402(g)(1)) or an Indian tribe, or an Indian organization (as defined in section 1402(g)(1)) for purposes of this section to members of an Indian tribe (as defined in such section).

"(H) Other Coverage.—Such other health benefits coverage as the Secretary, in coordination with the Health Choices Commissioner, recognizes for purposes of this subsection.

"(6) Other Definitions and Special Rules.—

"(1) Qualifying Child.—For purposes of this section, the term ‘qualifying child’ has the meaning given such term by section 152(c). With respect to any period during which health coverage for a child must be provided by an individual pursuant to a child support order, such child shall be treated as a qualifying child of such individual (and not as a qualifying child of any other individual).

"(2) Basic Plan.—For purposes of this section, the term ‘basic plan’ has the meaning given such term under section 100(c) of the Affordable Health Care for America Act.

"(3) Health Insurance Exchange.—For purposes of this section, the term ‘Health Insurance Exchange’ has the meaning given such term by section 911(d) of the Affordable Health Care for America Act, including any State-based health insurance exchange approved for operation under section 308 of such Act.

"(4) Family Coverage.—For purposes of this section, the term ‘family coverage’ means any coverage other than self-only coverage.

"(5) Modified Adjusted Gross Income.—For purposes of this section, the term modified adjusted gross income means adjusted gross income increased by—

"(A) any amount excluded from gross income under section 911, and

"(B) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

"(6) Not Treated as Tax Imposed by this Chapter for Certain Purposes.—The tax imposed under this section shall not be treated as tax imposed by this chapter for purposes of determining the amount of any credit under this chapter or for purposes of section 59B(j).

"(7) Regulations.—The Secretary shall prescribe such regulations or other guidance as may be necessary or appropriate to carry out the purposes, including regulations or other guidance (developed in coordination with the Health Choices Commissioner) which provide—

"(i) exemption from the tax imposed under subsection (a) in cases of de minimis lapses of acceptable coverage, and

"(ii) a waiver of the application of subsection (a) in cases of hardship, including a process for applying for such a waiver.

"(8) Information Reporting.—

"(1) In general.—Subpart B of part III of subtitle B of chapter 61 of such Code is amended by inserting after subsection (e) the following new section:

"SEC. 6050X. RETURNS RELATING TO HEALTH INSURANCE COVERAGE.

"(a) Requirement of Reporting.—Every person who provides acceptable coverage (as defined in section 59B(d)) to any individual during any calendar year shall, at such time as the Secretary may prescribe, make the return described in subsection (b) with respect to such individual.

"(b) Form and Manner of Returns.—A return is described in this subsection if such return—

"(1) is in such form as the Secretary may prescribe, and

"(2) contains—

"(A) the name, address, and TIN of the primary insurer and the name of each other individual obtaining coverage under the policy,

"(B) the period for which each such individual was provided with the coverage referred to in subsection (a), and

"(c) other information as the Secretary may require.

"(7) Statements to be Furnished to Individuals With Respect to Whom Information Required.—Every person required to make a return under subsection (a) shall furnish to each primary insured whose name is required to be set forth in such return a written statement showing—

"(1) the name and address of the person required to make such return and the phone number of the information contact for such person; and

"(2) the information required to be shown on the return with respect to such individual.

"The written statement required under the preceding sentences shall be furnished on or before January 31 of the year following the taxable year for which the return under subsection (a) is required to be made.

"(d) Coverage Provided by Governmental Units.—In the case of coverage provided by any governmental agency or instrumentality thereof, the officer or employee who enters into the agreement to provide such coverage (or the person appropriately designated for purposes of this section) shall make the returns and statements required by this section.

"(2) Penalty for Failure to File.—

"(A) Return.—Subparagraph (B) of section 6724(d)(1) of such Code is amended by striking "or" at the end of clause (xxii), by striking "and" at the end of clause (xxiii) and inserting "or", and by adding at the end the following new clause:

"(xxiv) section 6050X (relating to returns relating to health insurance coverage),

"(B) Statement.—Paragraph (2) of section 6724(d) of such Code is amended by striking "or" at the end of subparagraph (EE), by striking the period at the end of subparagraph (EE) and inserting "or", by adding at the end the following new paragraph:

"(GG) section 6050X (relating to returns relating to health insurance coverage),

"(c) Return Requirement.—Subsection (a) of section 6012 of such Code is amended by inserting after paragraph (9) the following new paragraph:

"(10) Every individual to whom section 59B(a) applies and who fails to meet the requirements of section 59B(d) with respect to such individual or any qualifying child (as defined in section 152(c)) of such individual.

"(d) Clerical Amendments.—

"(1) The table of parts for subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding the end the following new item:

"PART VIII. HEALTH CARE RELATED TAXES.

"(2) The table of sections for subpart B of part III of subchapter A of chapter 61 is amended by adding at the end the following new item:

"Sec. 6050X. Returns relating to health insurance coverage.

"(e) Section 15 Not to Apply.—The amendment made by subsection (a) shall not be applied to a tax year for purposes of section 15 of the Internal Revenue Code of 1986.

"(f) Effective Date.—

"(1) In general.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.
tion.''

'"(4) SPECIAL RULE FOR SEPARATE ELEC-
tions.—In the case of an employer who makes a separate election described in sec-
tion 4980H(a)(4) for any period, paragraph (1) shall be applied for such period by taking
into account only the wages paid to employ-
ees who are not subject to such election.''

'"(5) AGR egation: Predecessors.—For purposes of this section—
(A) all persons treated as a single em-
ployer under subsection (b), (c), (m), or (o) of
section 414 shall be treated as 1 employer, and
(B) any reference to any person shall be treated as including a reference to any pre-
decessor of such person.''

'"(c) CONFORMING AMENDMENT.—Subsection
(d) of section 3111 of such Code, as redesig-
nated by this section, is amended by striking
"subsections (a) and (b)'' and inserting "subsec-
tions (a), (b), (c), and (f)'' therefor.''

'"(d) APPLICATION TO RAILROADS.—
(1) In general.—Section 3221 of such Code
is amended in section 3231(c) as subsection (c) as
subsection (d) and by inserting after sub-
section (b) the following new subsection:

'"(1) R ETURNS.—The amendments made by
this section shall be applied to returns for
years beginning after December 31, 2012.''

'"(2) TIME AND MANNER.—An employer may
make an election under this subsection at
such time and in such form and manner as the
Secretary may prescribe.''

'"(3) APPOINTED GROUPS.—In the case of
any employer which is part of a group of
employers who are treated as a single employer under subsection (b), (c), (m), or (o) of
section 414, the election under paragraph (2) shall be made by such person as the Sec-
retary may prescribe. Any such election, once
made, shall apply to all members of such

'"(4) SEPARATE ELECTIONS.—Under regula-
tions prescribed by the Secretary, separate
elections may be made under paragraph (2) with respect to—
(A) separate lines of business, and
(B) full-time employees and employees who are not full-time employees.''

'"(5) TERMINATION OF ELECTION IN CASES
OF SUBSTANTIAL NONCOMPLIANCE.—The Sec-
retary (in coordination with the Health
Choices Commissioner) determines that such
employer is in substantial noncompliance
with the health coverage participation re-
quirements.''

If the annual payroll of such employer for the preceding calendar year:

<table>
<thead>
<tr>
<th>Annual Payroll</th>
<th>The Applicable Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does not exceed $500,000</td>
<td>6 percent</td>
</tr>
<tr>
<td>Exceeds $500,000, but does not exceed $670,000</td>
<td>7 percent</td>
</tr>
<tr>
<td>Exceeds $670,000, but does not exceed $750,000</td>
<td>8 percent</td>
</tr>
</tbody>
</table>

'"(B) SMALL EMPLOYER.—For purposes of this
section 'small employer' means any employer for any calendar year if the annual payroll of such employer for the preceding calendar year does not exceed $750,000.''

'"(C) ANNUAL PAYROLL.—For purposes of
this paragraph, the term 'annual payroll' means, with respect to any employer for any calendar year, the aggregate wages (as de-

'"(D) COORDINATION WITH OTHER ENFORCE-
MENT PROVISIONS.—The tax imposed under paragraph (1) with respect to any failure
shall be reduced (but not below zero) by the amount of any civil penalty collected under
section 502(c)(11) of the Employee Retire-
ment Income Security Act of 1974 or section
4980B(b)(6) of title 26.''

'"(E) EXCISE TAX WITH RESPECT TO FAILURE TO
SatisFY HEALTH COVERAGE PARTICIPATION RE-
quirements.—
(1) IN GENERAL.—In the case of any em-
ployer who fails (during any period for
which it is established to the satisfaction of
the Secretary that the employer neither
knew, nor exercising reasonable diligence
would have known, that such failure existed.
(2) LIMITATIONS ON AMOUNT OF TAX .—
(A) TAX NOT TO APPLY WHERE FAILURE NOT
DISCOVERED EXERCISING REASONABLE DILI-
GENCE.—No tax shall be imposed by para-
graph (1) on any failure during any period for
which it is established to the satisfaction of
the Secretary that the employer neither
knew, nor exercising reasonable diligence
would have known, that such failure existed.

(3) OVERALL LIMITATION FOR UNINTEN-
TIONAL FAILURES .—In the case of failures
which are due to reasonable cause and not to
willful neglect, the tax imposed by sub-
section (a) for failures during the taxable
year of the employer shall not exceed the amount equal to the lesser of—
(i) 10 percent of the aggregate amount
paid or incurred by the employer (or prede-
cessor employer) during the preceding tax-
able year for employment-based health plans,
or
(ii) $500,000.''

'"(F) SEPARATE ELECTIONS.—Under regula-
tions prescribed by the Secretary, separate

'"(G) SPECIAL RULE FOR SEPARATE ELEC-
tions.—In the case of an employer who makes a separate election described in sec-
tion 4980H(a)(4) for any period, paragraph (1) shall be applied for such period by taking
into account only the wages paid to employ-

'"(H) AGR egation: Predecessors.—For purposes of this section—
(A) all persons treated as a single em-
ployer under subsection (b), (c), (m), or (o) of
section 414 shall be treated as 1 employer, and
(B) any reference to any person shall be treated as including a reference to any pre-
decessor of such person.''

SEC. 512. HEALTH CARE CONTRIBUTIONS OF
NONELECTING EMPLOYERS.

(a) IN GENERAL.—Section 3111 of the Inter-
nal Revenue Code of 1986 is amended by re-
designating subsection (c) as subsection (d) and
by inserting after subsection (d) the fol-

'"(2) LIMITATIONS ON AMOUNT OF TAX .—
(A) TAX NOT TO APPLY WHERE FAILURE NOT
DISCOVERED EXERCISING REASONABLE DILI-
GENCE.—No tax shall be imposed by para-
graph (1) on any failure during any period for
which it is established to the satisfaction of
the Secretary that the employer neither
knew, nor exercising reasonable diligence
would have known, that such failure existed.

(3) OVERALL LIMITATION FOR UNINTEN-
TIONAL FAILURES .—In the case of failures
which are due to reasonable cause and not to
willful neglect, the tax imposed by sub-
section (a) for failures during the taxable
year of the employer shall not exceed the amount equal to the lesser of—
(i) 10 percent of the aggregate amount
paid or incurred by the employer (or prede-
cessor employer) during the preceding tax-
able year for employment-based health plans,
or
(ii) $500,000.''

'"(4) SEPARATE ELECTIONS.—Under regula-
tions prescribed by the Secretary, separate

'"(2) LIMITATIONS ON AMOUNT OF TAX .—
(A) TAX NOT TO APPLY WHERE FAILURE NOT
DISCOVERED EXERCISING REASONABLE DILI-
GENCE.—No tax shall be imposed by para-
graph (1) on any failure during any period for
which it is established to the satisfaction of
the Secretary that the employer neither
knew, nor exercising reasonable diligence
would have known, that such failure existed.

(2) LIMITATIONS ON AMOUNT OF TAX .—
(A) TAX NOT TO APPLY WHERE FAILURE NOT
DISCOVERED EXERCISING REASONABLE DILI-
GENCE.—No tax shall be imposed by para-
graph (1) on any failure during any period for
which it is established to the satisfaction of
the Secretary that the employer neither
knew, nor exercising reasonable diligence
would have known, that such failure existed.

(3) OVERALL LIMITATION FOR UNINTEN-
TIONAL FAILURES .—In the case of failures
which are due to reasonable cause and not to
willful neglect, the tax imposed by sub-
section (a) for failures during the taxable
year of the employer shall not exceed the amount equal to the lesser of—
(i) 10 percent of the aggregate amount
paid or incurred by the employer (or prede-
cessor employer) during the preceding tax-
able year for employment-based health plans,
or
(ii) $500,000.''

"(a) SPECIAL RULES FOR TAX ON EMPLOY-
ERS ELECTING NOT TO PROVIDE HEALTH BEN-
EFITS.—For purposes of this section—
(1) Paragraphs (1), (5), and (19) of sub-
section (b) shall not apply.
(2) Paragraph (7) of subsection (b) shall apply by treating activities as not covered
by the retirement systems referred to in sub-
paragraphs (C) and (F) thereof.
(3) Subsection (e) shall not apply and the term 'State' shall include the District of Co-
lumbia.''

"(b) C LERICAL AMENDMENT.—The table of
sections for chapter 43 of such Code is
sections prescribed by the Secretary, separate

"(c) Employers electing not to Provid e Health Benefits.—
"(1) IN GENERAL.—In addition to other

"(2) SPECIAL RULES FOR SMALL EM-
PLOYERS.—

"(A) IN GENERAL.—In the case of any em-
ployer who is small employer for any cal-
endar year, paragraph (1) shall be applied by
substituting the applicable percentage deter-
mined in accordance with the following table for '8 percent':

"(4) SPECIAL RULE FOR SEPARATE ELEC-
tions.—In the case of an employer who makes a separate election described in sec-
tion 4980H(a)(4) for any period, paragraph (1) shall be applied for such period by taking
into account only the wages paid to employ-

"(c) Employers electing not to Provid e Health Benefits.—
"(1) IN GENERAL.—In addition to other

"(2) EXCEPTION FOR SMALL EM-
PLOYERS.—Rules similar to the rules of section 3111(c)(2) shall apply for purposes of
this subsection.

"(3) NONELECTING EMPLOYER.—For purposes
of paragraph (1), the term 'nonelecting em-
ployer' means any employer for any period
with respect to which such employer does not have an election under section 4980H(a) in
effect.

"(4) SPECIAL RULE FOR SEPARATE ELEC-
tions.—In the case of an employer who makes a separate election described in sec-
tion 4980H(a)(4) for any period, subsection (a) shall be applied for such period by taking
into account only the compensation paid to employees who are not subject to such elec-
tions.

"(2) DEFINITIONS.—Subsection (e) of section
3231 of such Code is amended by adding at
the end the following new paragraph:
(a) In General.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business-related credits) is amended by adding at the end the following new section:

SEC. 521. CREDIT FOR SMALL BUSINESS EMPLOYEE HEALTH COVERAGE EXPENSES.

(a) In General.—Subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to business-related credits) is amended by adding at the end the following new section:

SEC. 45R. SMALL BUSINESS EMPLOYEE HEALTH COVERAGE CREDIT.

(a) In General.—For purposes of section 45R, in the case of a small employer, the small business employee health coverage credit determined under this section for the taxable year is an amount equal to the applicable percentage of the qualified employee health coverage expenses of such employer for such taxable year.

(b) Applicable Percentage.—

(1) PHASEOUT BASED ON EMPLOYER SIZE.—

In the case of an employer who employs more than 10 qualified employees during the taxable year, the credit determined under subsection (a) shall be reduced by an amount which bears the same ratio to the amount of such credit determined under subsection (a) for such employer for the preceding taxable year as the number of qualified employees employed by such employer during the preceding taxable year bears to 10.

(2) PHASEOUT BASED ON AVERAGE COMPENSATION.—In the case of an employer whose average annual employee compensation for the taxable year exceeds $20,000, the percentage specified in paragraph (1) shall be reduced by a number of percentage points which bears the same ratio to 50 as such excess bears to $20,000.

(c) Limitations.—

(1) PHASEOUT BASED ON EMPLOYER SIZE.—In the case of an employer who employs more than 10 qualified employees during the taxable year, the credit determined under subsection (a) shall be reduced by an amount which bears the same ratio to the amount of such credit (determined without regard to this paragraph and after the application of the other provisions of this section) as the average annual employee compensation of such employer for such taxable year exceeds $20,000, the percentage specified in paragraph (1) shall be reduced by a number of percentage points which bears the same ratio to 50 as such excess bears to $20,000.

(2) CREDIT NOT ALLOWED WITH RESPECT TO CERTAIN EMPLOYEES.—No credit shall be determined under subsection (a) with respect to qualified employee health coverage expenses paid or incurred by such employer for any taxable year if the aggregate compensation paid by the employer to such employee during such taxable year exceeds $5,000.

(3) CREDIT ALLOWED FOR ONLY 2 TAXABLE YEARS.—No credit shall be determined under subsection (a) with respect to qualified employee health coverage expenses paid or incurred by such employer for any taxable year if the aggregate compensation paid by the employer to such employee during such taxable year exceeds $10,000.

(4) DENIAL OF DOUBLE BENEFIT.—Any deduction otherwise allowable with respect to amounts paid or incurred for health insurance to which this section applies shall be reduced by the amount of the credit determined under this section.

(5) INFLATION ADJUSTMENT.—In the case of any taxable year beginning after 2013, each dollar amount in subsections (b)(2), (c)(2), and (e)(2) shall be increased by an amount equal to—

(A) the factor applying for calendar year 2012 to calendar year 2012 in subsection (b)(1) of section 1(f)(3) for ‘calendar year 2012’ in paragraph (b) thereof,

(B) the cost of living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins determined under section 1(f)(3) for calendar year 1992 in subparagraph (B) thereof.

(6) INQUIRY.—If any increase determined under this paragraph is the result of a decrease in the number of qualified employees employed by such employer during the preceding taxable year, the aggregate amount paid or incurred by such employer during such taxable year for coverage of any qualified employee of the employer (including any family coverage which covers such employee) under qualified health coverage determined under this paragraph shall be reduced to the next lowest multiple of $50.

(7) GENERAL RULE.—For purposes of this section—

(A) Special Rules.—For purposes of this section—

(i) the number of qualified employees employed by such employer during the taxable year does not exceed 25, and

(ii) the average annual employee compensation of such employer for such taxable year does not exceed the sum of the dollar amounts in effect under subsection (b)(2).

(B) The term ‘qualified employee’ means any employee of an employer for any taxable year of the employer if such employee received at least $5,000 of compensation paid or incurred by such employer for services performed in the trade or business of such employer during such taxable year.

(8) AVERAGE ANNUAL EMPLOYEE COMPENSATION.—The term ‘average annual employee compensation’ means, with respect to any employer for any taxable year, the average of the dollar amounts in effect under subsection (b)(2).

(9) COMPENSATION.—The term ‘compensation’ has the meaning given such term in section 308(b)(6)(A).

(10) FAMILY COVERAGE.—The term ‘family coverage’ means any coverage other than self-only coverage.

(f) SPECIAL RULES.—For purposes of this section—

(1) SPECIAL RULE FOR PARTNERSHIPS AND SELF-EMPLOYED.—In the case of a partnership (or a trade or business carried on by an individual) which has one or more qualified employees (determined by applying to this paragraph with respect to whom the election under section 4980H(a) applies, each partner (or, in the case of a trade or business carried on by such individual) shall be treated as an employee.

(2) AGGREGATION RULE.—All persons treated as a single employer under subsection (b), (c), (m), or (n) of section 411 shall be treated as 1 employer.

(3) PREDECCESSORS.—Any reference in this section to an employer shall include a reference to a predecessor of such employer.

(4) DENIAL OF DOUBLE BENEFIT.—Any deduction otherwise allowable with respect to amounts paid or incurred for health insurance to which this section applies shall be reduced by the amount of the credit determined under this section.

(5) INFLATION ADJUSTMENT.—In the case of any taxable year beginning after 2013, each dollar amount in subsections (b)(2), (c)(2), and (e)(2) shall be increased by an amount equal to—

(A) the factor applying for calendar year 2012 to calendar year 2012 in subsection (b)(1) of section 1(f)(3) for ‘calendar year 2012’ in paragraph (b) thereof,

(B) the cost of living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins determined under section 1(f)(3) for calendar year 1992 in subparagraph (B) thereof.

If any increase determined under this paragraph is the result of a decrease in the number of qualified employees employed by such employer during the preceding taxable year, the aggregate amount paid or incurred by such employer during such taxable year for coverage of any qualified employee of the employer (including any family coverage which covers such employee) under qualified health coverage determined under this paragraph shall be reduced to the next lowest multiple of $50.

(6) GENERAL RULE.—For purposes of this section—

(1) CREDIT TO BE PART OF GENERAL BUSINESS CREDIT.—Subsection (b) of section 38 of such Code (relating to general business credit) is amended by striking ‘plus’ at the end of paragraph (34), by inserting at the end of paragraph (35) and inserting ‘plus’ and by adding at the end the following new paragraph:

(36) in the case of a qualified small employer (as defined in section 45R(e)), the small business employee health coverage credit determined under section 45R(a).

(7) AMENDMENTS.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

PART 3—LIMITATIONS ON HEALTH CARE RELATED EXPENDITURES

SEC. 531. DISTRIBUTIONS FOR MEDICINE QUALIFIED ONLY IF FOR PRESCRIBED DRUG OR INSULIN.

(a) HSAs.—Subparagraph (A) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following: “Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug or is insulin.”

(b) Archer MSAs.—Subparagraph (A) of section 223(d)(2) of such Code is amended by adding at the end the following: “Such term shall include an amount paid for medicine or a drug only if such medicine or drug is a prescribed drug or is insulin.”

(c) HEALTH FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.—Section 106 of such Code is amended by adding at the end the following new subsection:

(1) REIMBURSEMENTS FOR MEDICINE RESTRICTED TO PRESCRIBED DRUGS AND INSULIN.—For purposes of this section and section 105, reimbursement for expenses incurred for a medicine or a drug shall be treated as a reimbursement for medical expenses only if such medicine or drug is a prescribed drug or is insulin.”

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 532. LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS UNDER CAFETERIA PLANS.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 is amended—

(1) by redesignating subsections (j) and (k) as subsections (j) and (k), respectively, and

(2) by inserting after subsection (h) the following new subsection:

LIMITATION ON HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—

(1) IN GENERAL.—For purposes of this section, if a benefit is provided under a cafeteria plan (or through employer contributions to a health flexible spending arrangement, such benefit shall not be treated as a qualified benefit unless the cafeteria plan provides that an eligible individual shall not receive such benefit unless the cafeteria plan provides that an eligible individual shall be treated as an employer.

(2) INFLATION ADJUSTMENT.—In the case of any taxable year beginning after 2013, the dollar amount in paragraph (1) shall be increased by an amount equal to—

(A) the factor applying for calendar year 2012 to calendar year 2012 in paragraph (b) thereof.

(B) the cost of living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins determined under section 1(f)(3) for calendar year 1992 in subparagraph (B) thereof.

If any increase determined under this paragraph is the result of a decrease in the number of qualified employees employed by such employer during the preceding taxable year to have salary reduction contributions in excess of $2,500 made to such arrangement.

(C) INFLATION ADJUSTMENT.—In the case of any taxable year beginning after 2013, the dollar amount in paragraph (1) shall be increased by an amount equal to—

(A) the factor applying for calendar year 2012 to calendar year 2012 in paragraph (b) thereof.

(B) the cost of living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins determined under section 1(f)(3) for calendar year 1992 in subparagraph (B) thereof.
If any increase determined under this paragraph is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 353. INCREASE IN PENALTY FOR NON-PARTICIPATION IN HEALTH SAVINGS ACCOUNTS.

(a) In General.—Subparagraph (A) of section 223(f)(4) of the Internal Revenue Code of 1986 is amended by striking “10 percent” and inserting “20 percent”.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to taxable years beginning after December 31, 2010.

PART 4—OTHER PROVISIONS TO CARRY OUT INSURANCE REFORM

SEC. 451. DISCLOSURES TO CARRY OUT HEALTH INSURANCE EXCHANGE SUBSIDIES.

(a) In General.—Section 139A of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

“(21) Disclosure of return information to carry out health insurance exchange subsidies.—

“(A) In General.—The Secretary, upon written request from the Health Choices Commissioner or the head of a State-based health insurance exchange approved for operation under section 308 of the Affordable Health Care for America Act, shall disclose to officers and employees of the Health Choices Administration or such State-based health insurance exchange, as the case may be, return information of any taxpayer whose income is relevant in determining any affordability credit described in subtitle C of title III of the Affordable Health Care for America Act. Such return information shall be limited to—

“(i) taxpayer identity information with respect to such taxpayer,

“(ii) the filing status of such taxpayer,

“(iii) the adjusted gross income of such taxpayer (as defined in section 59(b)(5)),

“(iv) the number of dependents of the taxpayer,

“(v) such other information as is prescribed by the Secretary by regulation as might indicate whether the taxpayer is eligible for such affordability credits (and the amount thereof), and

“(vi) the taxable year with respect to which the preceding information relates or, if applicable, the fact that such information is not available.

“(B) Restriction on use of disclosed information.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Health Choices Administration or such State-based health insurance exchange, as the case may be, only for the purposes of, and to the extent necessary in, establishing and verifying the appropriate amount of any affordability credit described in subtitle C of title III of the Affordable Health Care for America Act and providing for the repayment of any such credit which was in excess of such appropriate amount.”.

(b) PROVISIONS AND REGULATIONS RELATED TO DISCLOSURES.—Paragraph (4) of section 6103(p) of such Code is amended—

(1) by inserting “, or any entity described in subsection (l)(21),” after “(or 20)” in the matter preceding subparagraph (A),

(2) by inserting “or any entity described in subsection (l)(21),” after “(or (i)1(A),” in subparagraph (F)(ii), and

(3) by inserting “or any entity described in subsection (l)(21),” after “(or 20),” both places it appears in the matter after subparagraph (F).

(c) UNAUTHORIZED DISCLOSURE OR INSPECTION.—Paragraph (2) of section 7213(a) of such Code is amended by striking “(or 20)” and inserting “(or 20),”.

SEC. 542. OFFERING OF EXCHANGE-PARTICIPATING HEALTH BENEFITS PLANS THROUGH CAFETERIA PLANS.

(a) In General.—Subsection (f) of section 125 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

“(8) Certain exchange-participating health benefits plans not qualified.—

“(A) In General.—The term ‘qualified benefit’ shall not include any exchange-participating health benefits plan (as defined in section 101(c) of the Affordable Health Care for America Act).

“(B) Exception for exchange-eligible employers.—Subparagraph (A) shall not apply with respect to any employee if such employer’s employee-eligible employer (as defined in section 302 of the Affordable Health Care for America Act).”.

(b) CONFORMING AMENDMENTS.—Subsection (f) of section 125 is amended—

(1) by striking “For purposes of this section, the term” and inserting “For purposes of this section,”

“(I) In General.—The term”, and

(2) by striking “Such term shall not include” and inserting the following:

“(2) Long-term care insurance not qualified.—The term ‘qualified benefit’ shall not include”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 543. EXCLUSION FROM GROSS INCOME OF PAYMENTS MADE UNDER REINSURANCE PROGRAM FOR RETIREES.

(a) In General.—Section 139A of the Internal Revenue Code of 1986 is amended—

(1) by striking “Gross Income” and inserting the following:

“(a) Federal Subsidies for Prescription Drug Plans—Gross Income,” and

(2) by adding at the end the following new subsection:

“(b) Federal Reinsurance Program for Retirees.—A rule similar to the rule of subsection (a) shall apply with respect to payments made under section 111 of the Affordable Health Care for America Act.”.

(b) CONFORMING AMENDMENT.—The heading of section 139A of such Code (and the item relating to such section in the table of sections for part III of subchapter B of chapter 1 of such Code) is amended by inserting “AND RETIREE MEDICAL PLANS” after “PRESCRIPTION DRUG PLANS”.

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

SEC. 544. CLASS PROGRAM TREATED IN SAME MANNER AS LONG-TERM CARE INSURANCE.

(a) In General.—Subsection (f) of section 7702B of the Internal Revenue Code of 1986 is amended—

(1) by striking “State long-term care plan” in paragraph (1)(A) and inserting “government long-term care plan”,

(2) by redesignating paragraphs (2) as paragraph (3), and

(3) by inserting after paragraph (2) the following new paragraph:

“(2) Government long-term care plan.—For purposes of this subsection, the term ‘government long-term care plan’ means—

“(A) the CLASS program established under title XXXII of the Public Health Service Act, and

“(B) any State long-term care plan.”.

(b) CONFORMING AMENDMENTS.—

(1) Paragraph (3) of section 7702B(b) of such Code, as redesignated by subsection (a), is amended by striking “paragraph (1)” and inserting “this subsection”.

(2) Subsection (f) of section 7702B(b) of such Code is amended by striking “STATES-MAINTAINED” in the heading thereof and inserting “GOVERNMENT”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2010.

SEC. 545. EXCLUSION FROM GROSS INCOME FOR MEDICAL CARE PROVIDED FOR INDIANS.

(a) In General.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to items specifically excluded from gross income) is amended by inserting after section 139C the following new section:

“SEC. 139D. MEDICAL CARE PROVIDED FOR INDIANS.

“(a) In General.—Gross income does not include—

“(1) health services or benefits provided or purchased by the Indian Health Service, either directly or indirectly, through a grant to or a contract or compact with an Indian tribe or tribal organization or through programs of third parties funded by the Indian Health Service,

“(2) medical care provided by an Indian tribe or tribal organization to a member of an Indian tribe (including for the purpose of covering the expenses of a dependent (as defined in section 152) of the member) under any of the following: provided or purchased medical care services; accident or health insurance; or (an arrangement having the effect of accident or health insurance); or amounts paid, directly or indirectly, to reimburse the member for expenses incurred for medical care,

“(3) the value of accident or health plan coverage provided by an Indian tribe or tribal organization for medical care to a member of an Indian tribe (including for this purpose, coverage that extends to such member’s spouse or dependents) under an accident or health plan (or through an arrangement having the effect of accident or health insurance), and

“(4) any other medical care provided by an Indian tribe that supplements, replaces, or contributes to the programs and services provided by the Federal Government to Indian tribes or Indians.

“(b) Definitions.—For purposes of this section—

“(1) In General.—The terms ‘accident or health insurance’ and ‘accident or health plan’ have the same meaning as when used in sections 139A and 139B.

“(2) Medical care.—The term ‘medical care’ has the meaning given such term in section 213.

“(3) Dependent.—The term ‘dependent’ has the meaning given such term in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B).

“(4) Indian tribe.—The term ‘Indian tribe’ means any Indian tribe, band, nation, pueblo, or other organized group or community, including any Alaska Native village, or region of village corporation, as defined in, or established pursuant to, the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), which is recognized as eligible for the purpose of programs and services provided by the United States to Indians because of their status as Indians.”.
"(5) THIRAL ORGANIZATION.—The term 'tribal organization' has the meaning given such term in section 418.1 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450c).

(b) CLERICAL AMENDMENT.—The table of sections for such part III is amended by inserting after the item relating to section 13928 the following new item:

"Sec. 139D. Medical care provided for Indian ans."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

 SEC. 552. SURCHARGE ON HIGH INCOME INDIVIDUALS.

"(a) IN GENERAL.—Chapter 31 of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

"Subchapter D—Medical Devices

"Sec. 4061. Medical devices.

"SEC. 4061. MEDICAL DEVICES.

"(a) IN GENERAL.—There is hereby imposed a tax equal to 5 percent of the price for which such medical device is sold.

"(b) FIRST TAXABLE SALE.—For purposes of this section—

"(1) IN GENERAL.—The term 'first taxable sale' means the sale of a medical device for use in the general public, and

"(2) EXCEPTION FOR SALES AT RETAIL ESTABLISHMENTS.—Such term shall not include the sale of such device if—

"(B) the amounts of any deductions or exclusions disallowed under section 911(d)(6) are taken into account under this section.

"(c) SECTION 15 NOT TO APPLY.—The amendment made by this section shall be reduced by the amount of the tax paid by such seller under this section with respect to such sale.

"(D) SPECIAL RULES.—

"(1) IN GENERAL.—Rules similar to the rules of paragraphs (3), (4), and (5) of section 4217 shall apply for purposes of this section.

"(2) EXCEPTION FOR SALES AT RETAIL ESTABLISHMENTS.—Such term shall not include the sale of such device if—

"(B) the seller is not the manufacturer, or importer of such device, and

"(D) NO INFERENCE.—Nothing in the amendment made by this section shall be construed to create an inference with respect to the exclusion from gross income of—

"(B) the amounts of any deductions or exclusions disallowed under section 911(d)(6) are taken into account under this section.

"(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

 SECTION 552. EXCISE TAX ON MEDICAL DEVICES.

"(a) IN GENERAL.—Chapter 31 of the Internal Revenue Code of 1986 is amended by adding at the end the following new section:

"Subchapter D—Medical Devices

"Sec. 4061. Medical devices.

"SEC. 4061. MEDICAL DEVICES.

"(a) IN GENERAL.—There is hereby imposed a tax equal to 5 percent of so much of the modified adjusted gross income of the taxpayer as exceeds $500,000.

"(b) FIRST TAXABLE SALE.—For purposes of this section—

"(1) IN GENERAL.—The term 'first taxable sale' means the sale of a medical device for use in the general public, and

"(2) EXCEPTION FOR SALES AT RETAIL ESTABLISHMENTS.—Such term shall not include the sale of such device if—

"(B) the amounts of any deductions or exclusions disallowed under section 911(d)(6) are taken into account under this section.

"(c) SECTION 15 NOT TO APPLY.—The amendment made by this section shall be reduced by the amount of the tax paid by such seller under this section with respect to such sale.

"(D) SPECIAL RULES.—

"(1) IN GENERAL.—Rules similar to the rules of paragraphs (3), (4), and (5) of section 4217 shall apply for purposes of this section.

"(2) EXCEPTION FOR SALES AT RETAIL ESTABLISHMENTS.—Such term shall not include the sale of such device if—

"(B) the seller is not the manufacturer, or importer of such device, and

"(D) NO INFERENCE.—Nothing in the amendment made by this section shall be construed to create an inference with respect to the exclusion from gross income of—

"(B) the amounts of any deductions or exclusions disallowed under section 911(d)(6) are taken into account under this section.

"(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

 SECTION 553. EXPANSION OF INFORMATION REPORTING REQUIREMENTS.

"(a) IN GENERAL.—Section 6041 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

"(1) MEDICAL DEVICE.—The term 'medical device' means any device as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act intended for human use.

"(2) LEASE TREATED AS SALE.—Rules similar to the rules of section 4217 shall apply.

"(b) PAYMENTS FOR PROPERTY AND OTHER GROSS PROCEEDS.—Subsection (a) of section 6041(b) of such Code is amended by—

"(1) Paragraph (4) of such section is amended by striking "and merely providing financing for the purchase or lease of property under a lease to which section 671 applies." and inserting "or merely providing financing for the purchase or lease of property under a lease to which section 671 applies."

"(2) Paragraph (5) of such section is amended by inserting the following new paragraph:

"(A) IN GENERAL.—(i) If a medical device is sold (otherwise than through an arm's length transaction) at less than the fair market price, or

"(ii) a person is liable for a tax for a use described in subparagraph (A) of section 4217 of the Internal Revenue Code of 1986, the tax under this section shall be computed on the price for which such similar devices are sold in the ordinary course of trade and determined by the Secretary of the Treasury.

"(3) NOT TREATED AS TAX IMPOSED BY THIS SUBTITLE.—The tax imposed under section 4217 shall not apply to a trust all the unexpired years beginning after December 31, 2010.

"(4) IN GENERAL.—(i) If a medical device is sold (otherwise than through an arm’s length transaction) at less than the fair market price, or

"(ii) a person is liable for a tax for a use described in subparagraph (A) of section 4217 of the Internal Revenue Code of 1986, the tax under this section shall be computed on the price for which such similar devices are sold in the ordinary course of trade and determined by the Secretary of the Treasury.

"(5) RESALES PERTAINING TO CERTAIN CONTRACT ARRANGEMENTS.—

"(a) IN GENERAL.—In the case of a specified contract sale, a medical device referred to in subparagraph (B)(i) shall be entitled to recover from the producer, manufacturer, or importer referred to in subparagraph (B)(i) the amount of the tax paid by such seller under this section with respect to such sale.

"(b) SPECIFIED CONTRACT SALE.—For purposes of this paragraph, the term 'specified contract sale' means, with respect to any medical device, the first taxable sale of such device if—

"(i) the seller is not the producer, manufacturer, or importer of such device, and

"(ii) the price at which such device is sold is determined in accordance with a contract entered into between the producer, manufacturer, or importer of such device and the person to whom such device is sold.

"(c) SPECIAL RULES RELATED TO CREDITS AND REFUNDS.—In the case of any credit or refund under section 6416 of the tax imposed under this section on a specified contract sale of a medical device, the amount of such credit or refund shall be allowed or made only if the seller has filed with the Secretary the written consent of the producer, manufacturer, or importer referred to in subparagraph (B)(i) to the allowance of such credit or the making of such refund, and

"(i) the amount of tax taken into account under subparagraph (A) shall be reduced by the amount of such credit or refund.

"(D) USE TREATED AS SALE.—

"(1) IN GENERAL.—If any person uses a medical device before the first taxable sale of such device, then such person shall be liable for tax under such subsection in the same manner as if such use were the first taxable sale of such device.

"(2) EXCEPTIONS.—The preceding sentence shall not apply if—

"(A) the use of a medical device as material in the manufacture or production of, or as a component part of, another medical device to be manufactured or produced by such person,

"(B) the use of a medical device after a sale described in subsection (b)(2)(B), and

"(D) DETERMINATION OF PRICE.—

"(A) IN GENERAL.—Rules similar to the rules of subsections (a), (c), and (d) of section 4216 shall apply for purposes of this section.

"(B) CONSTRUCTIVE SALE PRICE.—If—

"(1) the seller is not the producer, manufacturer, or importer of such device, and

"(ii) the price at which such device is sold is determined in accordance with a contract entered into between the producer, manufacturer, or importer of such device and the person to whom such device is sold.

"(D) USE TREATED AS SALE.—

"(1) IN GENERAL.—If any person uses a medical device before the first taxable sale of such device, then such person shall be liable for tax under such subsection in the same manner as if such use were the first taxable sale of such device.

"(2) EXCEPTIONS.—The preceding sentence shall not apply if—

"(A) the use of a medical device as material in the manufacture or production of, or as a component part of, another medical device to be manufactured or produced by such person,

"(B) the use of a medical device after a sale described in subsection (b)(2)(B), and

"(D) DETERMINATION OF PRICE.—

"(A) IN GENERAL.—Rules similar to the rules of subsections (a), (c), and (d) of section 4216 shall apply for purposes of this section.

"(B) CONSTRUCTIVE SALE PRICE.—If—

"(1) the seller is not the producer, manufacturer, or importer of such device, and

"(ii) the price at which such device is sold is determined in accordance with a contract entered into between the producer, manufacturer, or importer of such device and the person to whom such device is sold.
SEC. 554. REPEAL OF WORLDWIDE ALLOCATION OF INTEREST.

(a) In General.—Section 861 of the Internal Revenue Code of 1986 is amended by adding at the end the following new clause:

"(i) the determination shall be made with respect to a transaction if the origin of such financial accounting benefit is a reduction of Federal income tax.

(b) DEFINITIONS AND SPECIAL RULES.—For purposes of this subsection—

"(A) the term 'economic substance doctrine' means a rule of law that requires that the manner as if this subsection had never been enacted.

"(B) the term 'economic substance doctrine; penalties' means a rule of law that requires that the manner as if this subsection had never been enacted.

"(E) the taxpayer has a substantial purpose (apart from Federal income tax effects) for entering such a transaction.

"(1) IN GENERAL.—The potential for profit of a transaction shall be taken into account in determining whether the requirements of subparagraph (A) and paragraph (1) are met with respect to the transaction only if the present value of the reasonably expected pre-tax profit from the transaction is at least 40 percent of the present value of the expected net tax benefits that would be allowed if the transaction were respected.

"(2) TREATMENT OF PES AND FOREIGN TAXES.—For purposes of this section, taxes imposed under chapter 3 (and any other similar rule of law).

"(f) CLARIFICATION OF ECONOMIC SUBSTANCE DOCTRINE.—

"(1) APPLICATION OF DOCTRINE.—In the case of any transaction to which the economic substance doctrine is relevant, such transaction shall be treated as having economic substance only if—

"(A) the transaction changes in a meaningful way (apart from Federal income tax effects) the taxpayer's economic position, and

"(B) the taxpayer has a substantial purpose (apart from Federal income tax effects) for entering into such transaction.

"(2) SPECIAL RULE WHERE TAXPAYER RELIES ON PROFIT POTENTIAL.—In the case of a transaction to which the economic substance doctrine is relevant, any amount treated as profit potential for purposes of section 1563(a)(1), except that—

"(i) 'more than 50 percent' shall be substituted for 'at least 80 percent' each place it appears therein, and

"(ii) the determination shall be made with respect to subsections (a)(4) and (b)(2) of section 1563.

A partnership or any other entity (other than a corporation) shall be treated as a member of a foreign controlled group of entities if such entity is controlled (within the meaning of section 956(a)(2)(A)) by members of such group (including any entity treated as a member of such group by reason of this sentence).

"(3) CONFORMING AMENDMENT.—Subparagraph (B) of section 662(a)(2) of such Code is amended—

"(B) the taxpayer is first contacted by the Secretary.''

"(C) CLARIFICATION OF ECONOMIC SUBSTANCE DOCTRINE; PENALTIES.—

"(A) IN GENERAL.—Subsection (b) of section 662 of such Code is amended by inserting after paragraph (5) the following new paragraph:

"(6) Any disallowance of claimed tax benefits by reason of a transaction lacking economic substance (within the meaning of section 7801(o)) or failing to meet the requirements of any similar rule of law.

"(2) INCREASED PENALTY FOR NONDISCLOSED TRANSACTIONS.—Section 6662 of such Code is amended by adding at the end the following new subsection:

"(1) IN GENERAL.—In the case of any portion of an underpayment which is attributable to one or more nondisclosed non-economic substance transactions, subsection (a) shall be applied with respect to such portion by substituting '40 percent' for '20 percent'.

"(2) NONDISCLOSED NONECONOMIC SUBSTANCE TRANSACTIONS.—For purposes of this subsection, the term 'nondisclosed noneconomic substance transaction' means any portion of a transaction described in subsection (b)(6) with respect to which the absence of facts affecting the tax treatment are not adequately disclosed in the return nor in a statement attached to the return.

"(3) SPECIAL RULE FOR AMENDED RETURNS.—Except as provided in regulations, in no event shall any amendment or supplement to a return of tax be taken into account for purposes of this subsection if the amendment or supplement is filed after the earlier of the date the taxpayer is first contacted by the Secretary regarding the examination of the return or such other date as is specified by the Secretary.

"(C) CLARIFICATION OF ECONOMIC SUBSTANCE DOCTRINE; PENALTIES.—

"(1) IN GENERAL.—Subparagraph (B) of section 662(a)(2) of such Code is amended—

"(B) by striking "section 6662(b)" and inserting "sections (h) or (i) of section 6662", after "a return", and

"(C) by striking "gross valuation misstatement penalty" in the heading and inserting "certain increased underpayment penalties".
(A) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively.

(B) by striking “paragraph (2)” in paragraph (4)(A), as so redesignated, and inserting “paragraph (3)(C)”; and

(C) by inserting after paragraph (1) the following new paragraph:

“(2) EXCEPTION.—Paragraph (1) shall not apply to any part of an underpayment attributable to one or more tax shelters (as defined in section 6662(d)(2)(C)) or transactions described in section 6662(b)(6).

(2) REASONABLE CAUSE EXCEPTION FOR REPORTABLE TRANSACTION UNDERSTATEMENTS.—

Subsection (d) of section 6664 of such Code is amended—

(A) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively,

(B) by striking “paragraph (2)(C)” in paragraph (4), as so redesignated, and inserting “paragraph (3)(C)”, and

(C) by inserting after paragraph (1) the following new paragraph:

“(2) EXCEPTION.—Paragraph (1) shall not apply to any portion of a reportable transaction underpayment which is attributable to one or more tax shelters (as defined in section 6662(d)(2)(C)) or transactions described in section 6662(b)(6).

(2) PENALTY FOR ERRONEOUS CLAIM FOR REFUND OR CREDIT TO NON-ECONOMIC SUBSTANCE TRANSACTIONS.—

Section 6664 of such Code is amended by redesignating subsection (d) as subsection (e) and inserting after subsection (b) the following new subsection:

“(e) ERRONEOUS SUBSTANCE TRANSACTIONS TREATED AS LACKING REASONABLE BASIS.—For purposes of this section, any excessive amount which is attributable to any transaction described in section 6662(d)(2)(C) or transactions described in section 6662(b)(6) shall not be treated as having a reasonable basis.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to underpayments attributable to transactions entered into after the date of the enactment of this Act.

(2) NONAPPLICABILITY OF UNDERSTATEMENT REDUCTION.—The amendment made by subsection (d) shall not apply to transactions entered into after the date of the enactment of this Act.

(3) PAYROLL TAXES.—

The first sentence of section 105(a) of the Internal Revenue Code of 1986 shall not be treated as attributable to transactions entered into after the date of the enactment of this Act.

SEC. 571. CERTAIN EXCLUDED BENEFITS APPLICABLE TO SPOUSES AND DEPENDENTS EXTENDED TO ELIGIBLE BENEFICIARIES

(a) APPLICATION OF ACCIDENT AND HEALTH PLANS TO ELIGIBLE BENEFICIARIES.—

(1) EXCLUSION OF CONTRIBUTIONS.—Section 108 of the Internal Revenue Code of 1986 (relating to contributions by employer to accident and health plans), as amended by section 1433, is amended to read as follows:

“(1) ALLOWANCE OF DEDUCTION.—In the case of an employer which is an eligible beneficiary plan, there shall be allowed as a deduction for the taxable year for insurance which constitutes a part of the accident and health plan maintained by such employer for an eligible beneficiary if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under section 106(b) or under section 106 by reference in section 106(b) to section 106(g).

(2) EXCEPTION.—Subparagraph (A) of section 2231(e) of such Code is amended by striking “or” at the end of paragraph (2), by striking the period at the end of paragraph (3) and inserting “; or”, by inserting after paragraph (2) the following new paragraph:

“(2) FOR REDUCING UNDERSTATEMENTS.—Paragraph (1) of section 152(c) is amended—

(i) by striking “or any of his dependents” and inserting “any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee”,

(ii) by striking “and their dependents” and inserting “and such employee’s dependents and eligible beneficiaries (within the meaning of section 106(g))”,

(iii) by inserting “or any of his dependents” in the matter preceding subparagraph (A) and inserting “any of his dependents, or any eligible beneficiary (within the meaning of section 106(g)) with respect to the employee”,

(iv) by striking “and their dependents” both places it appears and inserting “and such employee’s dependents and eligible beneficiaries (within the meaning of section 106(g))”,

(b) EXPANSION OF DEPENDENCY FOR PURPOSES OF DEDUCTION FOR HEALTH INSURANCE COSTS OF SELF-EMPLOYED INDIVIDUALS.—

(1) IN GENERAL.—

Paragraph (1) of section 162 of the Internal Revenue Code of 1986 (relating to special rules for health insurance costs of self-employed individuals) is amended to read as follows:

“(1) ALLOWANCE OF DEDUCTION.—In the case of a taxpayer who is an employee within the meaning of section 401(c)(1), there shall be allowed as a deduction under this section an amount paid by the employer on behalf of the employee during the taxable year for insurance which constitutes medical care for—

“A. the taxpayer,

B. the taxpayer’s spouse,

C. the taxpayer’s dependents,

D. any individual who—

(i) satisfies the age requirements of section 152(c)(3)(A),

(ii) bears a relationship to the taxpayer described in section 152(d)(2)(H), and

(iii) meets the requirements of section 152(d)(2)(H), and

E. one individual who—

(i) does not satisfy the age requirements of section 152(c)(3)(A),

(ii) bears a relationship to the taxpayer described in section 152(d)(2)(H), and

(iii) meets the requirements of section 152(d)(2)(H), and

(iv) is not the spouse of the taxpayer and does not bear any relationship to the taxpayer described in subparagraphs (A) through (G) of section 152(d)(2),

(2) CONFORMING AMENDMENT.—Subparagraph (B) of section 162(b)(2) of such Code is amended by inserting “any, any dependant, or individual described in subparagraph (D) or (E) of paragraph (1) with respect to “spouse”.

(3) EXTENSION TO ELIGIBLE BENEFICIARIES OF SICK AND ACCIDENT BENEFITS PROVIDED TO—
MEMBERS OF A VOLUNTARY EMPLOYEES’ BENEFICIARY ASSOCIATION AND THEIR DEPENDENTS.—Section 501(c)(9) of the Internal Revenue Code of 1986 (relating to list of exempt organizations) is amended by adding at the end the following new sentence: “For purposes of providing for the payment of sick and accident benefits to members of such an association and their dependents, the term ‘dependents’ shall include any individual who is an eligible beneficiary (within the meaning of section 106(g), as determined under the terms of a medical benefit, health insurance, or other program under which members and their dependents are entitled to sick and accident benefits.”

(d) FLEXIBLE SPENDING ARRANGEMENTS AND HEALTH REIMBURSEMENT ARRANGEMENTS.—The Secretary of Treasury shall issue guidance of general applicability providing that medical expenses that otherwise qualify—

(1) for reimbursement from a flexible spending arrangement under regulations in effect on the date of the enactment of this Act may be reimbursed from an employee’s flexible spending arrangement, notwithstanding the fact that such expenses are attributable to an individual who is not the employee’s spouse or dependent (within the meaning of section 105(b) of the Internal Revenue Code of 1986) but is an eligible beneficiary (within the meaning of section 106(g) of such Code) under the flexible spending arrangement with respect to the employee, and

(2) for reimbursement from a health reimbursement arrangement under regulations in effect on the date of the enactment of this Act may be reimbursed from an employee’s health reimbursement arrangement, notwithstanding the fact that such expenses are attributable to an individual who is not a spouse or dependent (within the meaning of section 105(b) of such Code) but is an eligible beneficiary (within the meaning of section 106(g) of such Code) under the flexible spending arrangement with respect to the employee.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2009.

DIVISION B—M A R I C A R E AND M EDICAID IMPROVEMENTS

SEC. 1001. T A B L E OF CONTENTS OF DIVISION.

The table of contents of this division is as follows:

TITLE I—IMPROVING HEALTH CARE VALUE

Subtitle A—Provisions Related to Medicare

Part A

Part 1—Market Basket Updates

Sec. 1101. Skilled nursing facility payment update.

Sec. 1102. Inpatient rehabilitation facility payment update.

Sec. 1103. Incorporating productivity improvements into market basket updates that do not already incorporate such improvements.

Part 2—Other Medicare Part A Provisions

Sec. 1111. Payments to skilled nursing facilities.

Sec. 1112. Medicare DSH report and payment adjustments in response to coverage expansion.

Sec. 1113. Extension of hospice regulation moratorium.

Sec. 1114. Permitting physician assistants to order post-hospital extended care services and to provide for recognition of attending physicians as attending physicians to serve hospice patients.

Subtitle B—Provisions Related to Part B

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Sec. 1121. Resource-based feedback program for physicians in Medicare.

Sec. 1122. Misvalued codes under the physician fee schedule.

Sec. 1123. Payments for efficient areas.

Sec. 1124. Modifications to the Physician Quality Reporting Initiative.

Sec. 1125. Adjustment to Medicare payment localities.

Part 2—Market Basket Updates

Sec. 1131. Incorporating productivity improvements into market basket updates that do not already incorporate such improvements.

Part 3—Other Provisions

Sec. 1141. Rental purchase of power wheelchairs.

Sec. 1141A. Election to take ownership, or to decline ownership, of a certain item of complex durable medical equipment after the 13-month capped rental period ends.

Sec. 1142. Extension of payment rule for brachytherapy.

Sec. 1143. Home infusion therapy report to Congress.

Sec. 1144. Requirement of ambulatory surgical centers (ASCs) to submit cost data and other data.

Sec. 1145. Treatment of certain cancer hospitals.

Sec. 1146. Payment for imaging services.

Sec. 1147. Durable medical equipment program improvements.

Sec. 1148. MedPAC study and report on bone mass measurement.

Sec. 1149. Timely access to post-mastectomy prostheses.

Sec. 1149A. Payment for biosimilar biological products.

Sec. 1149B. Study and report on DME competitive bidding process.

Subtitle C—Provisions Related to Medicare Parts A and B

Sec. 1151. Reducing potentially preventable hospital readmissions.

Sec. 1152. Post acute care services payment reform plan and bundling pilot program.

Sec. 1153. Home health payment update for 2013.

Sec. 1154. Payment adjustments for home health care.

Sec. 1155. Incorporating productivity improvements into market basket update for home health services.

Sec. 1155A. MedPAC study on variation in home health margins.

Sec. 1155B. Permitting home health agencies to assign the most appropriate skilled services to make the initial assessment visit under a Medicare home health plan of care for rehabilitation cases.

Sec. 1156. Limitation on Medicare exceptions to the prohibition on certain physician referrals made to hospitals.

Sec. 1157. Institute of Medicine study of geographic adjustment factors under Medicare.

Sec. 1158. Revision of Medicare payment systems to address geographic inequities.

Sec. 1159. Institute of Medicine study of geographic variation in health care spending and promoting high-value health care.

Sec. 1160. Implementation, and Congressional review, of proposal to revise Medicare payments to promote high value health care.

Subtitle D—Medicare Advantage Reforms

Part 1—Payment and Administration

Sec. 1161. Phase-in of payment based on fee-for-service costs; quality bonus payments.

Sec. 1162. Authority to Secretarial coding intensity adjustment authority.

Sec. 1163. Simplification of annual beneficiary eligibility determination.

Sec. 1164. Extension of reasonable cost contracts.

Sec. 1165. Limitation of waiver authority for employer group plans.

Sec. 1166. Improving risk adjustment for payments.

Sec. 1167. Elimination of MA Regional Plan Stabilization Fund.

Sec. 1168. Study regarding the effects of calculating Medicare Advantage payment rates on a regional average of Medicare fee for service rates.

Part 2—Beneficiary Protections and Anti-Fraud

Sec. 1171. Limitation on cost-sharing for individual health services.

Sec. 1172. Continuous open enrollment for enrollees in plans with enrollment suspensions.

Sec. 1173. Information for beneficiaries on MA plan administrative costs.

Sec. 1174. Strengthening audit authority.

Sec. 1175. Authority to deny plan bids.

Sec. 1175A. State authority to enforce standardized marketing requirements.

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Sec. 1176. Limitation on enrollment outside open enrollment period of individuals into chronic care specialized MA plans for special needs individuals.

Sec. 1177. Extension of authority of special needs plans to restrict enrollment; service area moratorium for certain SNPs.

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Sec. 1183. Repeal of provision requiring submission of claims by pharmacies located in or contracting with long-term care facilities.

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Sec. 1185. No mid-year formulary changes permitted.

Sec. 1186. Negotiation of lower covered part D drug prices on behalf of Medicare beneficiaries.

Sec. 1187. Accurate dispensing in long-term care facilities.

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Sec. 1189. State certification prior to waiver of licensure requirements under Medicare prescription drug program.

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Sec. 1192. Extension of outpatient hold harmless.

Sec. 1193. Extension of section 508 hospital reclassifications.
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Sec. 1195. Extension of payment for technical component of certain pharmacy services.
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TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS

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Sec. 1306. Waiver of deductible for colorectal cancer screening tests regardless of coding, subsequent diagnosis, or ancillary tissue removal.
Sec. 1307. Excluding clinical social worker services from coverage under the Medicare skilled nursing facility prospective payment system and consolidated payment.
Sec. 1308. Coverage of marriage and family therapist services and mental health counselor services.
Sec. 1309. Extension of physician fee schedule with add-ons.
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Sec. 1441. Establishment of national priorities for improvement.
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Sec. 1451. Reports on financial relationships between manufacturers and distributors of covered drugs, devices, biologicals, or medical supplies under Medicare, Medicaid, or CHIP and physicians and other health care entities and between physicians and other health care entities.

Subtitle E—Public Reporting on Health Care-Associated Infections

Sec. 1461. Requirement for public reporting by hospital and ambulatory surgical centers on health care-associated infections.

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Sec. 1501. Distribution of unused residency positions.
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Sec. 1615. Enhanced penalties for individuals excluded from program participation.
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Sec. 1636. Maximum period for submission of Medicare claims reduced to not more than 12 months.
Sec. 1637. Physicians who order durable medical equipment or home health services required to be Medicare eligible physicians or eligible professionals.
Sec. 1638. Requirements for physicians to provide documentation on referrals to programs at high risk of waste and abuse.
Sec. 1639. Face-to-face encounter with patient required before eligibility certification for home health services or durable medical equipment.
1395w(j)(3)(C)) is amended by striking “and 2009” and inserting “and through 2010”.

(b) DELAYED EFFECTIVE DATE.—The amendment made by subsection (a) shall not apply to payment units occurring before January 1, 2010.

SEC. 1103. INTEGRATING PRODUCTIVITY IMPROVEMENTS INTO MARKET BASED SYSTEMS THAT DO NOT ALREADY INCORPORATE SUCH IMPROVEMENTS.

(a) INPATIENT ACUTE HOSPITALS.—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)) is amended—

(1) in clause (ii), by striking “(iii) For purposes of this subparagraph,” and inserting “(iii) For purposes of this subparagraph, subject to the productivity adjustment described in subsection (f);”.

(b) by adding at the end the following new subsection:

“(II) The productivity adjustment described in this clause, with respect to an increase or change for a fiscal year or year or cost reporting period, or other annual period, is a productivity offset in the form of a reduction in such increase or change equal to the percentage change in the 10-year moving average of annual economy-wide private nonfarm business multi-factor productivity (as recently published in final form before the promulgation or publication of such increase for the year or period involved). Except as otherwise provided, any reference to the promulgation or publication of such increase shall be subject to the productivity adjustment described in subsection (d)(2)(B)(i)(II)).”.

(c) FISCAL HOSPICE.—Subclause (VII) of section 1814(i)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1395ww(j)(3)(C)) is amended by inserting after “(market basket percentage increase)” the following: “which is subject to the productivity adjustment described in section 1886(b)(3)(B)(i)(II)).”.

(g) EFFECTIVE DATES.—

(1) IPPS.—The amendments made by subsection (a) shall apply to annual increases effected for fiscal years beginning with fiscal year 2010, but only with respect to discharges occurring on or after January 1, 2010.

(2) SNF AND IRF.—The amendments made by subsections (b) and (d) shall apply to annual increases for fiscal years beginning with fiscal year 2011.

(h) HOSPICE CARE.—The amendment made by subsection (f) shall apply to annual increases for fiscal years beginning with fiscal year 2010, but only with respect to days of care occurring on or after January 1, 2010.

PART 2—OTHER MEDICARE PART A PROVISIONS

SEC. 1111. PAYMENTS TO SKILLED NURSING FACILITIES.

(a) CHANGE IN RECALIBRATION FACTOR.—

(1) ANALYSIS.—The Secretary of Health and Human Services shall conduct, using calendar year 2006 claims data, an initial analysis comparing total payments under title XVIII of the Social Security Act for skilled nursing facility services under the RUG-3 and under the RUG-4 classification systems.

(2) ADJUSTMENT IN RECALIBRATION FACTOR.—Based on the initial analysis under paragraph (1), the Secretary shall adjust the case mix indexes under section 1886(e)(4)(G)(1) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(G)(1)) for fiscal year 2010 by the appropriate recalibration factor as proposed in the final rule for Medicare skilled nursing facilities issued by such Secretary on August 11, 2009 (74 Federal Register 40267 et seq.).

(b) CHANGE IN PAYMENT FOR NONTHERAPY ANCILLARY (NTA) SERVICES AND THERAPY SERVICES.

(1) CHANGES UNDER CURRENT SNF CLASSIFICATION SYSTEM.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall adjust the current payment for therapy services described in subsection (b) of section 1886(e)(4)(G)(1) and for non-therapy ancillary services (as specified by the Secretary in the notice issued on November 27, 1998 (63 Federal Register 61297 et seq.)).

(B) EFFECTIVE DATE.—The changes in payment described in paragraph (A) shall apply for days on or after April 1, 2010, and until the Secretary implements an alternative case mix classification system for skilled nursing facilities services and non-therapy ancillary services under section 1886(e) of the Social Security Act (42 U.S.C. 1395yy(e)).

(2) OUTFITTERS.—Notwithstanding any other provision of law, the Secretary may implement by program instruction or otherwise the provisions of this paragraph.

(3) IMPLEMENTATION.—The Secretary may make a prospective payment adjustment for such year without such rules being implemented to apply to services furnished during a fiscal year beginning with fiscal year 2011.

(b) BUDGET NEUTRALITY.—The Secretary shall implement changes described in subparagraph (A) in a manner such that the estimated expenditures under such future skilled nursing facility service classification system shall be equal to the estimated expenditures that would otherwise occur under title XVIII of the Social Security Act under such future skilled nursing facility service classification system for such year without such changes.

(c) OUTLIER POLICY FOR NTA AND THERAPY SERVICES.—Section 1886(e)(1) of the Social Security Act (42 U.S.C. 1395yy(e)(1)) is amended by inserting at the end the following new paragraph:

“(iii) may provide for such an addition or adjustment to the payment amount otherwise made under this section with respect to non-therapy ancillary services in the case of such outliers; and

(iv) may provide for such an addition or adjustment to the payment amount otherwise made under this section with respect to non-therapy ancillary services in the case of such outliers; and

(B) OUTLIERs BASED ON AGGREGATE COSTS.—Outlier adjustments or additional payments described in subparagraph (A) shall be based on aggregate costs during a stay in a skilled nursing facility and not on the number of days in such stay.

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct, using data for non-therapy ancillary services under a future skilled nursing facility classification system to ensure the accuracy of payment for non-therapy ancillary services. Such analysis shall consider use of appropriate predictors which may include age, physical and mental status, ability to perform activities of daily living, length of stay, diagnoses, broad RUG category, and a proxy for length of stay.

(ii) APPLICATION.—Such analysis shall be conducted in a manner such that the future skilled nursing facility classification system is implemented to apply to services furnished during a fiscal year beginning with fiscal year 2011.

(b) CONSULTATION.—In conducting the analysis under subparagraph (A), the Secretary shall consult with interested parties including the Medicare Payment Advisory Commission and other interested stakeholders, to identify appropriate predictors of nontherapy ancillary costs.
“(C) Budget Neutrality.—The Secretary shall reduce estimated payments that would otherwise be made under the prospective payment system under this subsection with respect to a fiscal year by 2 percent. The total amount of the additional payments or payment adjustments for outliers made under this paragraph with respect to a fiscal year shall not exceed 1 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection for the fiscal year.

(d) Definitions.—In this section, section 1886(e)(3) of such Act (42 U.S.C. 1395y(e)(3)) is amended—

(1) in subparagraph (A)—

(A) by striking ‘‘and’’ before ‘‘adjustments’’; and

(B) by inserting ‘‘and adjustment under section 1112(a) of the Affordable Care Act’’ before the semicolon at the end;

(2) in subparagraph (B), by striking ‘‘and’’;

(3) in subparagraph (C), by striking the period and inserting ‘‘; and’’; and

(4) by adding at the end the following new subparagraph:

‘‘(D) the establishment of outliers under paragraph (13).’’.

SEC. 1112. MEDICARE DSH REPORT AND PAYMENT ADJUSTMENTS IN RESPONSE TO COVERAGE EXPANSION.

(a) DSH Report.—

(1) In General.—Not later than January 1, 2011, the Secretary of Health and Human Services shall submit to Congress a report on Medicare DSH taking into account the impact of the health care reforms carried out under division A in reducing the number of uninsured individuals. The report shall include recommendations relating to the following:

(A) The appropriate amount, targeting, and distribution of Medicare DSH to compensate for higher Medicare costs associated with serving low-income beneficiaries (taking into account variations in the empirical justification for Medicare DSH attributable to hospital characteristics, including bed size), consistent with the original intent of Medicare DSH.

(B) The appropriate amount, targeting, and distribution of Medicare DSH to hospitals given their continued uncompensated care costs, or in part, to physicians, by means that provide—

(i) attribute items and services, in whole or in part, to physicians;

(ii) identify appropriate physicians for purposes of comparison under subparagraph (B)(ii); and

(iii) aggregate items and services, or in part, to physicians;

(C) Coordination with Medicaid DSH report.—The Secretary shall coordinate the report under this subsection with the report on Medicaid DSH under section 1170A(a).

(b) Payment Adjustments in Response to Coverage Expansion.—

(1) In General.—There is a significant decrease in the national rate of uninsurance as a result of this Act (as determined under paragraph (2)(A)), the Secretary of Health and Human Services shall, beginning in fiscal year 2017, implement the following adjustments to Medicare DSH:

(A) In lieu of the amount of Medicare DSH payments otherwise provided by the hospital based on criteria for uncompensated care as determined by the Secretary, which shall exclude bad debt.

(B) Subject to paragraph (3), make an additional payment to a hospital by an amount that is estimated based on the amount of uncompensated care furnished by the hospital based on criteria for uncompensated care as determined by the Secretary, which shall exclude bad debt.

(C) Significant decrease in national rate of uninsurance as a result of this Act.—For purposes of this subsection—

(a) In General.—There is a ‘‘significant decrease in the national rate of uninsurance as a result of this Act’’ if there is a decrease in the national rate of uninsurance (as defined in subparagraph (B)) from 2012 to 2014 that exceeds 8 percentage points.

(b) National Rate of Uninsurance Defined.—The term ‘‘national rate of uninsurance’’ means, for each such rate for the under-55 population for the year as determined and published by the Bureau of the Census in its Current Population Survey in or about September of the succeeding year.

(c) Effective Date.—The amendments made by this subsection shall apply to items and services furnished on or after January 1, 2010.

Subtitle B—Provisions Related to Part B

PART I—PHYSICIANS’ SERVICES

SEC. 1121. RESOURCE-BASED FEEDBACK PROGRAM FOR PHYSICIANS IN MEDICARE.

(a) In General.—Not later than January 1, 2011, the Secretary of Health and Human Services shall submit to Congress a report on Medicare DSH taking into account the impact of the health care reforms carried out under division A in reducing the number of uninsured individuals. The report shall include recommendations relating to the following:

(1) establishing a framework to measure the impact of the health care reforms on the number of uninsured individuals;

(2) identifying the appropriate payment adjustments for Medicare DSH attributable to hospital characteristics, including bed size, consistent with the original intent of Medicare DSH;

(3) identifying the appropriate amount, targeting, and distribution of Medicare DSH attributable to hospital characteristics, including bed size, consistent with the original intent of Medicare DSH.

(b) Coordination with Medicaid DSH report.—The Secretary shall coordinate the report under this section with the report on Medicaid DSH under section 1170A(a).

(c) Effective Date.—The amendments made by this subsection shall apply to items and services furnished on or after January 1, 2010.

Subtitle B—Provisions Related to Part B

PART I—PHYSICIANS’ SERVICES

SEC. 1121. RESOURCE-BASED FEEDBACK PROGRAM FOR PHYSICIANS IN MEDICARE.

(a) In General.—Not later than January 1, 2011, the Secretary of Health and Human Services shall submit to Congress a report on Medicare DSH taking into account the impact of the health care reforms carried out under division A in reducing the number of uninsured individuals. The report shall include recommendations relating to the following:

(1) establishing a framework to measure the impact of the health care reforms on the number of uninsured individuals;

(2) identifying the appropriate payment adjustments for Medicare DSH attributable to hospital characteristics, including bed size, consistent with the original intent of Medicare DSH;

(3) identifying the appropriate amount, targeting, and distribution of Medicare DSH attributable to hospital characteristics, including bed size, consistent with the original intent of Medicare DSH.

(b) Coordination with Medicaid DSH report.—The Secretary shall coordinate the report under this section with the report on Medicaid DSH under section 1170A(a).

(c) Effective Date.—The amendments made by this subsection shall apply to items and services furnished on or after January 1, 2010.

Subtitle B—Provisions Related to Part B

PART I—PHYSICIANS’ SERVICES

SEC. 1121. RESOURCE-BASED FEEDBACK PROGRAM FOR PHYSICIANS IN MEDICARE.

(a) In General.—Not later than January 1, 2011, the Secretary of Health and Human Services shall submit to Congress a report on Medicare DSH taking into account the impact of the health care reforms carried out under division A in reducing the number of uninsured individuals. The report shall include recommendations relating to the following:

(1) establishing a framework to measure the impact of the health care reforms on the number of uninsured individuals;

(2) identifying the appropriate payment adjustments for Medicare DSH attributable to hospital characteristics, including bed size, consistent with the original intent of Medicare DSH;

(3) identifying the appropriate amount, targeting, and distribution of Medicare DSH attributable to hospital characteristics, including bed size, consistent with the original intent of Medicare DSH.

(b) Coordination with Medicaid DSH report.—The Secretary shall coordinate the report under this section with the report on Medicaid DSH under section 1170A(a).

(c) Effective Date.—The amendments made by this subsection shall apply to items and services furnished on or after January 1, 2010.

Subtitle B—Provisions Related to Part B

PART I—PHYSICIANS’ SERVICES

SEC. 1121. RESOURCE-BASED FEEDBACK PROGRAM FOR PHYSICIANS IN MEDICARE.

(a) In General.—Not later than January 1, 2011, the Secretary of Health and Human Services shall submit to Congress a report on Medicare DSH taking into account the impact of the health care reforms carried out under division A in reducing the number of uninsured individuals. The report shall include recommendations relating to the following:

(1) establishing a framework to measure the impact of the health care reforms on the number of uninsured individuals;

(2) identifying the appropriate payment adjustments for Medicare DSH attributable to hospital characteristics, including bed size, consistent with the original intent of Medicare DSH;

(3) identifying the appropriate amount, targeting, and distribution of Medicare DSH attributable to hospital characteristics, including bed size, consistent with the original intent of Medicare DSH.

(b) Coordination with Medicaid DSH report.—The Secretary shall coordinate the report under this section with the report on Medicaid DSH under section 1170A(a).

(c) Effective Date.—The amendments made by this subsection shall apply to items and services furnished on or after January 1, 2010.
‘(i) EXPANSION.—Taking into account the cost of each method specified in subparagraph (D), the Secretary shall develop a plan to disseminate reports under this subsection in a manner that reaches in the reasonable cost cities of the country with the highest utilization of services under this title. To the extent practicable, reports under this subsection shall be disseminated to increasing numbers of physicians each year, such that during 2014 and subsequent years, reports are disseminated at least to physicians with utilization rates among the highest 5 percent of the nation, subject the authority to focus under paragraph (4).

‘(F) IMPLEMENTATION.—

‘(i) Chapter 35 of title 44, United States Code shall not apply to this paragraph.

‘(ii) Notwithstanding any other provision of law, the Secretary may implement the provisions of this paragraph by program instruction or otherwise.’.

SEC. 1122. MISVALUED CODES UNDER THE PHYSICIAN SERVICE CODE.

(a) In general.—Section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w-4(c)(2)) is amended by adding at the end the following new subparagraphs:

‘(K) POTENTIALLY MISVALUED CODES.—

‘(I) In general.—The Secretary shall—

‘(i) periodically identify services as being potentially misvalued under subparagraph (I)(I), including with respect to codes with low relative values described in clause (i)(I), conduct the validation under this subparagraph in a manner that reaches in the reasonable cost cities of the country with the highest utilization of services under this title, and

‘(ii) review and make appropriate adjustments to the services identified as being potentially misvalued under subparagraph (I)(I).

‘(ii) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued services pursuant to clause (i)(I), the Secretary shall examine (and families of codes as appropriate) for which there has been the fastest growth; (codes and families of codes as appropriate) that have experienced substantial changes in practice expenses; codes for new technologies or services within an appropriate period (such as three years) after the relative values are initially established for such codes; multiple codes that are frequently billed in conjunction with furnishing a single service; codes with low relative value and stress due to risk involved with furnishing a service and may include validation of the procedure, post, and in-service components of work.

‘(iii) SCOPE OF CODES.—The validation of work relative value units shall include a sampling of codes for services that is the same as the codes listed under subparagraph (K)(i).

‘(IV) METHODS.—The Secretary may conduct the validation under this subparagraph using methods described in subclauses (I) through (V) of subparagraph (K)(iii) as the Secretary determines to be appropriate.

‘(V) ADJUSTMENTS.—The Secretary shall make appropriate adjustments to the work relative value units under the fee schedule under subsection (b). The provisions of subparagraph (B)(ii)(II) shall apply to adjustments to relative value units made pursuant to this subparagraph in the same manner as such provisions apply to adjustments under subparagraph (B)(ii)(II).’.

(b) IMPLEMENTATION.—

‘(1) FUNDING.—For purposes of carrying out the provisions of subparagraphs (K) and (L) of 1848(c) of the Social Security Act, as added by subsection (a), in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services for the Center for Medicare & Medicaid Services Program Management Office, for the fiscal year ending September 30, 2011, and each subsequent fiscal year. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.

‘(2) ADMINISTRATION.—

‘(A) Chapter 35 of title 44, United States Code and the provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to this section or the amendment made by this section.

‘(B) Notwithstanding any other provision of law, the Secretary may implement subparagraphs (K) and (L) of 1848(c) of the Social Security Act, as added by subsection (a), by program instruction or otherwise.

‘(C) Section 4555(d) of the Balanced Budget Act of 1997 is amended by adding at the end the following new subparagraph:

‘(D) Except for provisions related to confidentiality of information, the provisions of the Federal Acquisition Regulation shall not apply to this section or the amendment made by this section.

‘(E) FOCUSING CMS RESOURCES ON POTENTIALLY MISVALUED CODES.—Section 1848(a) of the Social Security Act (42 U.S.C. 1395w(a)) is repealed.

SEC. 1125. PAYMENTS FOR EFFICIENT AREAS.

(a) In general.—Section 1848(m) of the Social Security Act (42 U.S.C. 1395w-4(m)) is amended by adding at the end the following new subsection:

‘(X) INCENTIVE PAYMENTS FOR EFFICIENT AREAS.—

‘(I) In general.—In the case of services furnished under the physician fee schedule under section 1848 on or after January 1, 2011, and before January 1, 2013, by a supplier that is paid under such fee schedule in an efficient area (as identified under paragraph (2)), in addition to the amount that would otherwise be made for such services under this part, there also shall be paid (on a monthly or quarterly basis) an amount that would otherwise be made for such services provided in the most recent year for which data are available as of the date of the enactment of this subsection, as standardized to eliminate the effect of geographic adjustments in payment rates.

‘(II) IDENTIFICATION OF EFFICIENT AREAS.—

‘(A) IN GENERAL.—Based upon data available, the Secretary shall identify those counties or equivalent areas in the United States in the lowest fifth percentile of utilization of services furnished under this part and part A for services provided in the most recent year for which data are available as of the date of the enactment of this subsection, as standardized to eliminate the effect of geographic adjustments in payment rates.

‘(B) IDENTIFICATION OF COUNTIES WHERE SERVICE IS FURNISHED.—For purposes of paying the additional amount specified in paragraph (1), if the Secretary uses the 5-digit postal ZIP Code where the service is furnished, the Secretary shall use the postal ZIP Code (as determined by the United States Postal Service, or otherwise) shall be used to determine whether the postal ZIP Code corresponds to a county described in subparagraph (A).

‘(C) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1839, 1878, or otherwise of paragraph (1).

‘(i) the identification of a county or other area under subparagraph (A); or

‘(ii) the assignment of a postal ZIP Code to a county or other area under subparagraph (B).

‘(D) PUBLICATION OF LIST OF COUNTIES; POSTING ON WEBSITE.—With respect to a year for which a county or area is identified under this paragraph, the Secretary shall identify such counties or areas as part of the proposed and final rule to implement the physician fee schedule under section 1849 for the applicable year. The Secretary shall post the list of counties identified under this paragraph on the Internet website of the Centers for Medicare & Medicaid Services.’.”

SEC. 1124. MODIFICATIONS TO THE PHYSICIAN QUALITY REPORTING INITIATIVE

(a) Feedback.—Section 1848(m)(5) of the Social Security Act (42 U.S.C. 1395w-4(m)(5)) is amended by adding at the end the following new subparagraph:

‘(B) FEEDBACK.—The Secretary shall provide timely feedback to eligible professionals on the performance of the eligible professional with respect to satisfactorily submitting data on quality measures under this subsection.’.

(b) Appeals.—Such section is further amended—

‘(1) in subparagraph (E), by striking ‘‘There shall be’’ and inserting ‘‘Except as provided in subparagraph (I), there shall be’’; and

‘(2) by adding at the end the following new subparagraph:

‘(I) INFORMAL APPEALS PROCESS.—By not later than January 1, 2011, the Secretary shall establish and have in place an informal process for eligible professionals to seek a review of the determination that an eligible professional did not satisfactorily submitting data on quality measures under this subsection.’.

‘(C) INTEGRATION OF PHYSICIAN QUALITY REPORTING INITIATIVE WITH EHR REPORTING AND EHR REPORTING.—Not later than January 1, 2012, the Secretary shall develop a plan to integrate clinical reporting on
quality measures under this subsection with reporting requirements under subsection (o) relating to the meaningful use of electronic health records. Such integration shall consist of the following:

“(A) The development of measures, the reporting of which would both demonstrate

(i) meaningful use of an electronic health record system for purposes of subsection (o); and

(ii) clinical quality of care furnished to an individual.

(B) The collection of data to identify disparities in the quality and coordination of care for individuals eligible for benefits under this part.

(C) The other activities as specified by the Secretary.

(d) EXTENSION OF INCENTIVE PAYMENTS.—

Section 1848(m)(1) of such Act (42 U.S.C. 1395w-4(a)) is amended by adding at the end the following new paragraph:

“(6) TRANSITION TO USE OF MSAs AS FEE SCHEDULE AREAS IN CALIFORNIA.—

(A) IN GENERAL.—Section 1848(e) of the Social Security Act (42 U.S.C. 1395w-4(e)) is amended by adding after the period at the end the following new subparagraph:

“(B) By inserting ‘‘2010’’ and inserting ‘‘2012’’; and

(C) by striking ‘‘2009’’ and inserting ‘‘for each of the years 2009 through 2012’’.

SEC. 1125. ADJUSTMENT TO MEDICARE PAYMENT LOCALITIES.

(a) IN GENERAL.—Section 1848(e) of the Social Security Act (42 U.S.C. 1395w-4(e)) is amended by adding after the period at the end the following new subparagraph:

“(B) By inserting ‘‘2010’’ and inserting ‘‘2012’’; and

(C) by striking ‘‘2009’’ and inserting ‘‘for each of the years 2009 through 2012’’.

SEC. 1125. ADJUSTMENT TO MEDICARE PAYMENT LOCALITIES.

(a) IN GENERAL.—Section 1848(e) of the Social Security Act (42 U.S.C. 1395w-4(e)) is amended by adding after the period at the end the following new subparagraph:

“(B) By inserting ‘‘2010’’ and inserting ‘‘2012’’; and

(C) by striking ‘‘2009’’ and inserting ‘‘for each of the years 2009 through 2012’’.

(a) IN GENERAL.—Section 1848(e) of the Social Security Act (42 U.S.C. 1395w-4(e)) is amended by adding after the period at the end the following new subparagraph:

“(B) By inserting ‘‘2010’’ and inserting ‘‘2012’’; and

(C) by striking ‘‘2009’’ and inserting ‘‘for each of the years 2009 through 2012’’.

PART 2—MARKET BASKET UPDATES

SECTION 1131. INCORPORATING PRODUCTIVITY IMPROVEMENTS INTO MARKET BASKET UPDATES THAT DO NOT ALREADY INCORPORATE SUCH IMPROVEMENTS.

(a) OUTPUTS NOTailles.—

(1) IN GENERAL.—Section 1833(h)(3)(C)(iv) of the Social Security Act (42 U.S.C. 1395m(a)(7)(A)(iii)) is amended—

(A) in the first sentence—

(i) by inserting ‘‘(which is subject to the productivity adjustment described in subsection (ii) of such section)’’ after ‘‘1886(b)(3)(B)(h)(ii)’’; and

(ii) by inserting ‘‘(but not below 0)’’ after ‘‘reduced’’; and

(B) in the second sentence, by inserting ‘‘and which is subject, beginning with 2010, to the productivity adjustment described in section 1886(b)(3)(B)(h)(ii)’’.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to increases in productivity resulting from increases in productivity that occur on or after January 1, 2010.

PART 3—OTHER PROVISIONS

SECTION 1141A. ELECTION TO TAKE OWNERSHIP, OR TO DECLINE OWNERSHIP, OF A CERTAIN DURABLE MEDICAL EQUIPMENT AFTER THE 13-MONTH CAPPED RENTAL PERIOD ENDS.

(a) IN GENERAL.—Section 1834(a)(7)(A) of the Social Security Act (42 U.S.C. 1395m(a)(7)(A)) is amended—

(1) by adding, after ‘‘(A)’’ and (2) by striking ‘‘rental’’; and

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on January 1, 2010, and apply to all power-driven wheelchairs furnished on or after such date. Such amendments shall not apply to contracts entered into under section 1887 of the Social Security Act (42 U.S.C. 1395w-3) pursuant to a bid submitted under such section before October 1, 2010, under subsection (a)(1), (b)(1), or (c)(1) of such section.

SEC. 1141A. ELECTION TO TAKE OWNERSHIP, OR TO DECLINE OWNERSHIP, OF A CERTAIN ITEM OF DURABLE MEDICAL EQUIPMENT AFTER THE 13-MONTH CAPPED RENTAL PERIOD ENDS.

(a) IN GENERAL.—Section 1834(a)(7)(A) of the Social Security Act (42 U.S.C. 1395m(a)(7)(A)) is amended—

(1) by striking ‘‘rental’’; and

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on January 1, 2010, and apply to all power-driven wheelchairs furnished on or after such date. Such amendments shall not apply to contracts entered into under section 1887 of the Social Security Act (42 U.S.C. 1395w-3) pursuant to a bid submitted under such section before October 1, 2010, under subsection (a)(1), (b)(1), or (c)(1) of such section.

SEC. 1141A. ELECTION TO TAKE OWNERSHIP, OR TO DECLINE OWNERSHIP, OF A CERTAIN DURABLE MEDICAL EQUIPMENT AFTER THE 13-MONTH CAPPED RENTAL PERIOD ENDS.

(a) IN GENERAL.—Section 1834(a)(7)(A) of the Social Security Act (42 U.S.C. 1395m(a)(7)(A)) is amended—

(1) by striking ‘‘rental’’; and

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on January 1, 2010, and apply to all power-driven wheelchairs furnished on or after such date. Such amendments shall not apply to contracts entered into under section 1887 of the Social Security Act (42 U.S.C. 1395w-3) pursuant to a bid submitted under such section before October 1, 2010, under subsection (a)(1), (b)(1), or (c)(1) of such section.
month during which payment is made for the rental of the Group 3 Support Surface under clause (i). Such title shall be transferred to the individual only if the individual notifies the supplier of title to the Group 3 Support Surface in the manner set forth in this subclause, the individual shall be deemed to have rejected transfer of title. If the individual accepts the transfer of title to the Group 3 Support Surface, the supplier shall transfer such title to the individual on the first day that begins after the 13th continuous month during which payment is made for the rental of the Group 3 Support Surface under clause (i).

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished under the Group 3 Support Surface equipment not later than January 1, 2011.

SEC. 1142. EXTENSION OF PAYMENT RULE FOR BRACHYTHERAPY.

Section 1833(k)(16)(C) of the Social Security Act (42 U.S.C. 1395t(b)(16)(C)), as amended by section 142 of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended by striking, the first place it appears, “January 1, 2010” and inserting “January 1, 2012”.

SEC. 1143. HOSPITAL INFUSION THERAPY REPORT TO CONGRESS.

Not later than July 1, 2011, the Medicare Payment Advisory Commission shall submit to Congress a report on the following:

(1) The scope of coverage for home infusion therapy in the fee-for-service Medicare program under title XVIII of the Social Security Act, Medicare Advantage under part C of such title, the veteran’s health care program under chapter 17 of title 38, United States Code, and among private payers, including an analysis of services provided by home infusion therapy providers to their patients in such programs.

(2) The benefits and costs of providing such coverage under the Medicare program, including a calculation of the potential savings achieved through avoided or shortened hospital and nursing home stays as a result of Medicare coverage of home infusion therapy.

(3) An assessment of sources of data on the costs of home infusion therapy that might be used to construct payment mechanisms in the Medicare program.

(4) Recommendations, if any, on the structure of a payment system under the Medicare program for home infusion therapy, including an analysis of the payment methodologies used under Medicare Advantage plans and private health plans for the provision of home infusion therapy and their applicability to the Medicare program.

SEC. 1144. REQUIRE AMBULATORY SURGICAL CENTERS (ASCs) TO SUBMIT COST DATA AND OTHER DATA.

(a) COST REPORTING.—

(1) IN GENERAL.—Section 1833(i) of the Social Security Act (42 U.S.C. 1395l(i)), is amended by adding at the end the following new paragraph:

“(9) The Secretary shall require, as a condition of the agreement described in section 1833(a)(2)(F)(1), the submission of such cost report as the Secretary may specify, taking into account the requirements for such reports under section 1815 in the case of a hospital.”.

(2) DEVELOPMENT OF COST REPORT.—Not later than 3 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall develop a cost report form for use under section 1833(i)(9) of the Social Security Act, as added by paragraph (1).

(b) AUDIT REQUIREMENT.—The Secretary shall provide for periodic auditing of cost reports submitted under section 1833(i)(9) of the Social Security Act, as added by paragraph (1).

(c) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to agreements applicable to cost reporting periods beginning 18 months after the date the Secretary develops the cost report form for use under section 1833(i)(9) of the Social Security Act, as added by paragraph (1).

Sec. 1145. TREATMENT OF CERTAIN CANCER HOSPITALS.

Section 1833(t)(i) of the Social Security Act (42 U.S.C. 1395t(i)) is amended by adding at the end the following new paragraph:

“(18) AUTHORIZATION OF ADJUSTMENT FOR CANCER HOSPITALS.—

(A) STUDY.—The Secretary shall conduct a study to determine if, under the system used in this subsection, costs incurred by hospitals described in section 1886(d)(1)(B)(v) with respect to ambulatory payment classification groups exceed those costs incurred by other hospitals furnishing services under this subsection (as determined appropriate by the Secretary).

(B) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines to be appropriate, the Secretary shall provide for an appropriate adjustment under paragraph (2)(E) to reflect those costs effective for services furnished on or after January 1, 2011.”.

Sec. 1146. PAYMENT FOR IMAGING SERVICES.

(a) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT A PRESUMED LEVEL OF UTILIZATION.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(1) in subsection (b)(4)—

(A) in subparagraph (A), by inserting “or, in the case of an imaging service included in a single-session imaging procedure, such additional charge is to be added by the end of the following new subparagraph:

“(B) ADJUSTMENT IN TECHNICAL COMPONENT DISCOUNT ON SINGLE-SESSION IMAGING INVOLVING CONSECUTIVE BODY PARTS.—Section 1848 of such Act (42 U.S.C. 1395w–4) is further amended—

(1) in subsection (b)(4), by adding at the end the following new subparagraph:

“(D) ADJUSTMENT IN TECHNICAL COMPONENT DISCOUNT ON SINGLE-SESSION IMAGING INVOLVING CONSECUTIVE BODY PARTS.—For services furnished on or after January 1, 2011, the Secretary shall increase the reduction in expenditures attributable to the multiple procedure payment reduction applicable to the technical component discount on an imaging service, as determined under the final rule published by the Secretary in the Federal Register on November 21, 2005 (part
(2) by striking the period at the end of paragraph (4) and inserting “as such paragraph (4) is applied to a single source drug; and

(3) in subparagraph (B), by striking the period at the end; and

(b) EFFECTIVE DATE.—This amendment shall apply not later than January 1, 2011.

SEC. 1149A. PAYMENT FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) IN GENERAL.—Section 1847A of the Social Security Act (42 U.S.C. 1395w–3a) is amended—

(1) in subsection (b)(1)—

(A) in paragraph (A), by striking “or” at the end;

(B) in subparagraph (B), by striking the period at the end and inserting “; or”; and

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

“(i) the average sales price as determined using the methodology described in paragraph (6) applied to such interchangeable and reference products for all National Drug Codes assigned to such products in the same manner as such paragraph (6) is applied to multiple source drugs; and

“(ii) 6 percent of the amount determined under subparagraph (I); and

“(D) in the case of a biosimilar biological product (as defined in subsection (c)(6)(H)), the sum of—

“(i) the average sales price as determined using the methodology described in paragraph (4) applied to such biosimilar biological product for all National Drug Codes assigned to such product in the same manner as such paragraph (4) is applied to a single source drug; and

“(ii) 6 percent of the amount determined under subparagraph (C)(i) as the case may be, for the reference biological product (as defined in subsection (c)(6)(J)); or

“(E) in the case of a reference biological product for both an interchangeable biological product and a biosimilar product, the amount determined in subparagraph (C); and

(2) in subsection (c)(5) (A) by amending subparagraph (D)(1) to read as follows:

“(i) a biological, including a reference biological product for a biosimilar product, but excluding—

“(I) a biosimilar biological product;

“(II) an interchangeable biological product;

“(III) a reference biological product for an interchangeable biological product; and

“(IV) a reference biological product for both an interchangeable biological product and a biosimilar product; or;

and

(B) by adding at the end the following new subparagraphs:

“(H) BIOSIMILAR BIOLOGICAL PRODUCT.—The term ‘biosimilar biological product’ means a biological product licensed as a biosimilar biological product under section 351(k) of the Public Health Service Act.

“(I) INTERCHANGEABLE BIOLOGICAL PRODUCT.—The term ‘interchangeable biological product’ means a biological product licensed as an interchangeable biological product under section 351(k) of the Public Health Service Act.

“(J) REFERENCE BIOLOGICAL PRODUCT.—The term ‘reference biological product’ means a biological product referred to in the application for a biosimilar or interchangeable biological product licensed under section 351(k) of the Public Health Service Act.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payments for biosimilar biological products,
interchangeable biological products, and reference biological products beginning with the first day of the second calendar quarter after the date of the enactment of this Act.

SEC. 110B. ANNUAL REPORT ON DURABLE CON-
PETITIVE BIDDING PROCESS.

(a) Study.—The Comptroller General of the United States shall conduct a study to evaluate the establishment of a program under Medicare under title XVIII of the Social Security Act to acquire durable medical equipment and supplies through a competitive bidding process among manufacturers of such equipment and supplies. Such study shall address the following:

(1) Identification of types of durable medical equipment and supplies that are appropriate for bidding under such a program.

(2) Recommendations on how to structure such an acquisition program in order to promote fiscal responsibility while also ensuring beneficiary access to high quality equipment and supplies.

(3) Recommendations on how such a program could be phased-in and on what geographic level would bidding be most appropriate.

(4) In addition to price, recommendations on criteria that could be factored into the bidding process.

(5) Recommendations on how supply chain contracts could be structured for furnishing durable medical equipment and servicing equipment and supplies acquired under such a program.

(6) Comparison of such a program to the current competitive bidding program under Medicare for durable medical equipment, as well as any other similar Federal acquisition programs, such as the General Services Administration’s sole source purchasing program.

(7) Any other consideration relevant to the acquisition, supply, and service of durable medical equipment and supplies that is deemed appropriate by the Comptroller General.

(b) Report.—Not later than 12 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the findings of the study under subsection (a).

Subtitle C—Provisions Related to Medicare Payment and Improvement

SEC. 1151. REDUCING POTENTIALLY PREVENT-
ABLE HOSPITAL READMISSIONS.

(a) Hospitals.—

(1) In general.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 1103(a), is amended by adding at the end the following new subsection:

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under paragraph (4)(B), and applicable periods and applicable conditions under paragraph (4)(C).

"(i)'' the measures of readmissions as described in subparagraph (A)(i), and

"(ii)'' the determination of a targeted hospital under paragraph (8)(B)(1), the increase in payment under paragraph (8)(B)(11), the aggregate readmission rate, and the hospital-specific limit under paragraph (8)(C)(11), and the form of payment made by the Secretary under paragraph (8)(D).

"(7) ASSISTANCE TO CERTAIN HOSPITALS.—(A) IN GENERAL.—For purposes of providing funds to applicable hospitals to take steps pursuant to subparagraph (C), the Secretary shall exclude a period of 1 day from the date the individual is first admitted to a hospital or critical access hospital, the payment amount of the hospital as described in section 1886(p)(2).''.

"(8) ASSISTANCE TO CERTAIN HOSPITALS.—(A) IN GENERAL.—For purposes of providing funds to applicable hospitals to take steps pursuant to subparagraph (C), the determining of a targeted hospital under paragraph (8)(B)(1), the increase in payment under paragraph (8)(B)(11), the aggregate readmission rate, and the hospital-specific limit under paragraph (8)(C)(11), and the form of payment made by the Secretary under paragraph (8)(D).

"(5) PAYMENT ADJUSTMENTS.—(A) IN GENERAL.—(i) For fiscal or rate year 2014, the Secretary shall adjust the applicable post acute care provider) on or after the first day of the fiscal year, beginning on or after October 1, 2011, with respect to the applicable post acute care provider.

"(B) APPLICABLE PERCENT DEFINED.—For purposes of subparagraph (A), the applicable percent is—

(i) for fiscal or rate year 2012 is 0.996;

(ii) for fiscal or rate year 2013 is 0.993; and

(iii) for fiscal or rate year 2014 is 0.994.

"(6) EFFECTIVE DATE.—Subparagraph (1) shall apply to discharges or services furnished (as the case may be with respect to the applicable post acute care provider) on or after the first day of the fiscal year, beginning on or after October 1, 2011, with respect to the applicable post acute care provider.

"(7) DEVELOPMENT AND APPLICATION OF PERFORMANCE MEASURES.—(A) IN GENERAL.—The Secretary of Health and Human Services shall develop appropriate measures of readmissions for post acute care providers. The Secretary shall seek endorsement of such measures by the entity with a contract under section 1890(a) of the Social Security Act.”.
in the same manner as they apply to hospitals under such section.

(3) DEFINITIONS.—For purposes of this subsection:

(A) POST ACUTE CARE PROVIDER.—The term "post acute care provider" means—

(i) a skilled nursing facility (as defined in section 1919(a) of the Social Security Act);

(ii) an inpatient rehabilitation facility (as defined in section 1866(h)(1)(A) of such Act);

(iii) a long term care hospital (as defined in section 1861(s)(1)(A) of such Act); and

(iv) any hospital (as defined in section 1861(c)(2) of such Act).

(B) OTHER TERMS.—The terms "applicable condition", "applicable hospital", and "readmission'' have the meanings given such terms in section 1886(p)(5) of the Social Security Act, as added by subsection (a)(1).

(C) APPLICABLE HOSPITALS.—The term "applicable hospital" means—

(i) a hospital, or physician who sees an individual within the first year after discharge from a hospital or critical access hospital;

(ii) a hospital, hospital based outpatient rehabilitation facility, critical access hospital, hospital inpatient rehabilitation facility, or hospital (as defined in section 1861(s)(1)) that provides services to an individual from a hospital, and such other services as determined appropriate by the Secretary.

(d) PHYSICIANS.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study to determine how the readmissions policy described in the previous subsections could be applied to physicians.

(2) CONSIDERATIONS.—In conducting the study, the Secretary shall consider approaches, including—

(A) creating a new code (or codes) and payment amount (or amounts) under the fee schedule in section 1848 of the Social Security Act and for services furnished by an appropriate physician who sees an individual within the first year after discharge from a hospital or critical access hospital;

(B) developing measures of readmission for individuals treated by physicians;

(C) applying a payment reduction for physicians who treat the patient during the initial admission that results in a readmission; and

(D) methods for attributing payments or payment reductions to the appropriate physician or physician.

(3) REPORT.—The Secretary shall issue a public report on such study not later than the date that is one year after the date of the enactment of this Act.

(e) FUNDING.—For purposes of carrying out the provisions of this section, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services for the Center for Medicare & Medicaid Services Program Management Account $25,000,000 for each of the fiscal years 2010 through 2012.

(f) ADMINISTRATION.—

(1) FUNDING.—For purposes of carrying out this section, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services Program Management Account $15,000,000 for each of the fiscal years 2009 through 2012.

(g) SEC. 1152. POST ACUTE CARE SERVICES PAYMENT REFORM PLAN AND BUNDLING PILOT PROGRAM.

(a) PLAN.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall develop a detailed plan to reform payment for post acute care services under the Medicare program under title XVIII of the Social Security Act (in this section referred to as the "Medicare program"). The goals of such payment reform under this plan shall be—

(A) improve the coordination, quality, and efficiency of such services; and

(B) improve outcomes for individuals such as reducing rehospitalization for readmission to hospitals from providers of such services.

(2) BUNDLING POST ACUTE SERVICES.—The plan described in paragraph (1) shall include details for a bundled payment for post acute services (in this section referred to as the "post acute care bundle"), and may include other approaches determined appropriate by the Secretary.

(b) POST ACUTE SERVICES.—For purposes of this section, the term "post acute services" means services for which payment may be made under the Medicare program that are furnished by skilled nursing facilities, inpatient rehabilitation facilities, long term care hospitals, critical access hospitals, transitional care units, home health agencies to an individual after discharge of such individual from a hospital, and such other services as determined appropriate by the Secretary.

(c) CONSULTATIONS AND ANALYSIS.—

(1) CONSULTATION WITH STAKEHOLDERS.—In developing the plan under subsection (a)(1), the Secretary shall consult with relevant stakeholders and shall consider experience with such research studies and demonstrations that the Secretary determines appropriate.

(2) ANALYSIS AND DATA COLLECTION.—In developing such plan, the Secretary shall—

(A) analyze the issues described in subsection (b) and other issues that the Secretary determines appropriate;

(B) analyze the impacts (including geographic impacts) of post acute service reform approaches, including bundling of such services on individuals, hospitals, post acute care providers, and physicians;

(C) use existing data (such as data submitted on claims) and collect, on a periodic basis, data as the Secretary determines are appropriate to develop such plan required in this section; and

(D) if patient functional status measures are appropriate for the analysis, to the extent practical, build upon the CARE tool being developed pursuant to section 5008 of the Deficit Reduction Act of 2005.

(4) SEC. 1164D. (a) CONVERSION AND EXPANSION TO INCLUDE POST ACUTE SERVICES.

(1) IN GENERAL.—By not later than January 1, 2011, the Secretary shall, for the purpose of promoting the use of bundled payments to promote efficient, coordinated, and high quality delivery of care, convert the Medicare program to a bundled payment program conducted under section 1866C to a pilot program; and

(2) subject to subsection (c), expand such program as so converted to include post acute services and such other services the Secretary determines to be appropriate, which may include transitional services.

(2) BUNDLED PAYMENT PROGRAMS.

(a) IN GENERAL.—In carrying out paragraph (1), the Secretary may apply bundled payments with respect to—

(i) hospitals and physicians;

(ii) hospitals and post acute care providers;
(iii) hospitals, physicians, and post-acute care providers; or

(iv) combinations of post-acute providers.

(B) FURTHER APPLICATION.

(i) EVALUATION ON COST AND QUALITY OF CARE.—The Secretary shall conduct an evaluation of the pilot program under subsection (a) to study the effect of such program on the costs and quality of such evaluations shall be included in the final report required under section 1125(e)(2) of the Affordable Health Care for America Act.

(ii) ADJUNCTIVE PAYMENT AND EPISODE-BASED PAYMENT FOR PHYSICIANS’ SERVICES.

(1) IN GENERAL.—The Secretary shall provide for a study of the potential of testing additional ways to increase bundling of payments for physicians in connection with an episode of care, such as in connection with outpatient hospital services or services rendered in physicians’ offices, other than those provided under the pilot program.

(2) APPLICATION.—The Secretary may implement such a plan through a demonstration program.

(C) CONTINUING CARE HOSPITAL DEFINED.—For purposes of this subparagraph, the term ‘continuing care hospital’ means an entity that has demonstrated the ability to meet patient care and patient safety standards and that provides under common management, control, and supervision of care and patient safety standards provided in inpatient rehabilitation hospitals and that provides under common management, control, and supervision of care and patient safety standards provided in inpatient rehabilitation hospitals and long-term care hospitals (as defined in section 1866(d)(1)(B)(ii)), and long-term care hospitals (as defined in section 1866(d)(1)(B)(ii)).

(b) SCOPE.—The Secretary shall set specific goals for the number of acute and post-acute bundling test sites under the pilot program and that over time the pilot program is of sufficient size and scope to—

(1) test the approaches under the pilot program in a variety of settings, including urban, rural, and underserved areas;

(2) include geographic areas and additional conditions that account for significant program spending, as defined by the Secretary; and

(3) subject to subsection (d), disseminate the pilot program rapidly on a national basis.

To the extent that the Secretary finds inpatient and post acute care bundling to be successful in improving quality and reducing costs, the Secretary shall implement such mechanisms and reforms under the pilot program on a large geographic scale as practical and consistent with the principles set forth in this section.

(c) LIMITATION.—The Secretary shall only expand the pilot program under subsection (a) if the Secretary finds that—

(1) the demonstration program under section 1866C and pilot program under this section meet the quality of care received by individuals enrolled under this title; and

(2) such demonstration program and pilot program expand program expenditures and, based on the certification under subsection (d), that the expansion of such pilot program would result in estimated spending that would be less than what spending would otherwise be in the absence of this section.

(d) CERTIFICATION.—For purposes of subsection (c), the Secretary shall certify that the expansion of the pilot program under this section would result in estimated spending that would be less than what spending would otherwise be in the absence of this section

(e) VOLUNTARY PARTICIPATION.—Nothing in this paragraph shall be construed as requiring the participation of an entity in the pilot program under this section.

(f) SPECIAL RULE IN CASE OF INABILITY TO ENTER INTO DUAL ELIGIBILITY AGREEMENTS.—For purposes of this subparagraph, the term ‘dual eligibility’ means an entity that provides comprehensive care and patient safety standards provided in inpatient rehabilitation hospitals and long-term care hospitals (as defined in section 1866(d)(1)(B)(ii)), and long-term care hospitals (as defined in section 1866(d)(1)(B)(ii)).

(g) FURTHER APPLICATION.—Section 1886(d)(1)(B)(iv)(I)) is amended—

(i) IN GENERAL.—The Secretary shall provide for a study of the potential of testing additional ways to increase bundling of payments for physicians in connection with an episode of care, such as in connection with outpatient hospital services or services rendered in physicians’ offices, other than those provided under the pilot program.

(ii) APPLICATION.—The Secretary may implement such a plan through a demonstration program.

(h) CONFORMING AMENDMENT.—Section 1866D, the Secretary shall apply bundled payment amounts in a manner so as to include collection, costs, and quality of care. The findings of such evaluation shall be included in the final report required under section 1125(e)(2) of the Affordable Health Care for America Act.

(i) ADJUNCTIVE PAYMENT AND EPISODE-BASED PAYMENT FOR PHYSICIANS’ SERVICES.

(1) IN GENERAL.—The Secretary shall provide for a study of the potential of testing additional ways to increase bundling of payments for physicians in connection with an episode of care, such as in connection with outpatient hospital services or services rendered in physicians’ offices, other than those provided under the pilot program.

(2) APPLICATION.—The Secretary may implement such a plan through a demonstration program.

(i) APPLICABILITY.—Section 1895(b)(3)(B) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)) is amended—

(A) by striking ‘‘Subject to section 1866D, the Secretary’’.

SEC. 1155. HOME HEALTH PAYMENT UPDATE FOR 2010.

Section 1895(b)(3)(B)(1) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)(1)) is amended—

(1) in subclause (IV), by striking ‘‘and’’;

(2) by redesignating subclause (V) as subclause (VI); and

(3) by inserting after subclause (IV) the following new subclauses:

‘‘(V) 2007, 2008, and 2009, subject to clause (v), the home health market basket percentage increase;’’;

‘‘(VI) 2010, subject to clause (v), 0 percent; and’’;

SEC. 1154. PAYMENT ADJUSTMENTS FOR HOME HEALTH CARE.

(a) ACCELERATION OF ADJUSTMENT FOR CASE MIX CHANGES.—Section 1895(b)(3)(B) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)) is amended—

(1) in clause (iv), by striking ‘‘insofar as’’ and inserting ‘‘Subject to clause (vi), insofar as’’; and

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

‘‘(vi) SPECIAL RULE FOR CASE MIX CHANGES FOR 2011.—’’.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to home health payments in years beginning with 2011.

SEC. 1155A. MEDICAID STUDY ON VARIATION IN HOME HEALTH MARGINS.

(a) IN GENERAL.—The Medicaid Payment Advisory Commission shall conduct a study regarding variation in performance of home health agencies in an effort to explain variation in Medicare margins for such agencies.

(b) REPORT.—The amendments made by subsection (a) shall apply to home health payments in years beginning with 2011.
in the report the Commission’s conclusions and recommendations, if appropriate, regarding each of the issues described in paragraphs (1), (2) and (3) of such subsection.

SEC. 1155B. REQUIREMENTS FOR CERTAIN PHYSICIAN REFERRALS MADE TO HOSPITALS.

(a) In general.—Notwithstanding section 1866 in effect on such date.

(b) Rule of Construction.—Nothing in this subsection is subject to a civil money penalty of not more than $10,000 for each day for which reporting is required to have been made.

(c) Failure to Report or Disclose Information.—(i) Any ownership or investment interests that the hospital offers to a physicist are to be reported at the end of the period described in subsection (i)(1); the hospital meets the requirements of subsection (i)(1).

(d) Disclosure.—Any physician who is required, but fails to meet a disclosure requirement of paragraph (1) and (2)(A) of subsection (i) is subject to a civil money penalty of not more than $10,000 for each day for which reporting is required to have been made.

(e) Patient Safety.—In the case of a hospital that does not offer emergency services, the hospital has the capacity to treat the emergency in the hospital has the capacity to—

(1) provide assessment and initial treatment of the injury or illness on the physician or investor is directly proportional to the ownership or investment interest is obtained.

(2) REQUIREMENTS TO QUALIFY FOR RURAL PROVIDER AND HOSPITAL OWNERSHIP EXCEPTIONS TO SELF-REFERRAL PROHIBITION.—For purposes of subsection (i)(3)(D), the requirements described in this paragraph are as follows:

(1) PROVIDER AGREEMENT.—The hospital had—

(iv) Physician owners and investors do not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other owners or investors in the hospital or located near the premises of the hospital.

(vii) The hospital does not offer a physician owner or investor the opportunity to purchase or lease any property under the control of the hospital or any other owner or investor of the hospital or in comparable terms than the terms offered to a person who is not a physician owner or investor.

The hospital is subject to a civil money penalty of not more than $10,000, for each day for which reporting is required to have been made.

(viii) Exception to Prohibition on Expansion of Facility Capacity.—The hospital was not converted from an ambulatory surgical center to a hospital on or after the date of enactment of this subsection.

(4) LIMITATION ON APPLICATION TO CERTAIN CONVERTED FACILITIES.—The hospital was not converted from a hospital on or after the date of enactment of this subsection.

(5) Failure to Report or Disclose Information.—(a) Reporting.—Any person who is required, but fails to meet a disclosure requirement of subsection (i)(1) and (2)(A) of subsection (i) is subject to a civil money penalty of not more than $10,000 for each day for which reporting is required to have been made.

(b) Disclosure.—Any physician who is required, but fails to meet a disclosure requirement of subsection (i)(1) and (2)(A) of subsection (i) is subject to a civil money penalty of not more than $10,000 for each day for which reporting is required to have been made.

(c) Failure to Report or Disclose Information.—(i) Any ownership or investment interests that the hospital offers to a physician are to be reported at the end of the period described in subsection (i)(1); the hospital meets the requirements of subsection (i)(1).

(d) Rule of Construction.—Nothing in this subsection is subject to a civil money penalty of not more than $10,000 for each day for which reporting is required to have been made.

(e) Patient Safety.—In the case of a hospital that does not offer emergency services, the hospital has the capacity to treat the emergency in the hospital has the capacity to—

(1) provide assessment and initial treatment of the injury or illness on the physician or investor is directly proportional to the ownership or investment interest is obtained.

(2) REQUIREMENTS TO QUALIFY FOR RURAL PROVIDER AND HOSPITAL OWNERSHIP EXCEPTIONS TO SELF-REFERRAL PROHIBITION.—For purposes of subsection (i)(3)(D), the requirements described in this paragraph are as follows:

(1) PROVIDER AGREEMENT.—The hospital had—

(iv) Physician owners and investors do not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other owners or investors in the hospital or located near the premises of the hospital.

(vii) The hospital does not offer a physician owner or investor the opportunity to purchase or lease any property under the control of the hospital or any other owner or investor of the hospital or in comparable terms than the terms offered to a person who is not a physician owner or investor.

The hospital is subject to a civil money penalty of not more than $10,000, for each day for which reporting is required to have been made.
which the hospital applying for an exception is located with the opportunity to provide input with respect to the application.

(iii) TIMING FOR IMPLEMENTATION.—The Secretary may not implement the process described in clause (i) on the date that is one month after the promulgation of regulations described in clause (iv).

(iv) REGULATIONS.—Not later than the first day of the month beginning 18 months after the date of the enactment of this subsection, the Secretary shall promulgate regulations describing the process described in clause (i). The Secretary may issue such regulations as interim final regulations.

(3) PROCEDURE ROOMS, OR BEDS.—In this subsection, the term ‘procedure rooms’ includes rooms in which the following:

(A) Angiographies, angiograms, and endoscopies are furnished, but such term shall not include emergency rooms or departments (except for rooms in which the detection of radiographic lesions is conducted), catheterizations and angiographies, angiograms, and endoscopies are furnished.

(B) SPECIAL RULE FOR A HIGH MEDICAID FACILITY.—A hospital described in this subparagraph is a hospital located with the opportunity to provide input to the Secretary an application for an exception to the extent such increase would result in the number of operating rooms, procedure rooms, or beds of a hospital exceeding 200 percent of the baseline number of operating rooms, procedure rooms, or beds of the hospital as of the date of enactment of this subsection.

(C) PERMITTED INCREASE.—

(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), a hospital granted an exception under the process described in subparagraph (A) may increase the number of operating rooms, procedure rooms, or beds of the hospital above the baseline number of operating rooms, procedure rooms, or beds, respectively, of the hospital after the application, approval, and determination of the most recent increase under such an exception.

(ii) TECHNICAL AMENDMENTS.—In subparagraph (i), the term ‘procedure rooms’ includes rooms in which catheterizations, angiographies, angiograms, and endoscopies are furnished, but such term shall not include emergency rooms or departments (except for rooms in which the detection of radiographic lesions is conducted), catheterizations and angiographies, angiograms, and endoscopies are furnished.

(D) LIMITATION FOR FACILITIES ON THE MAIN CAMPUS OF THE HOSPITAL.—Any increase in the number of operating rooms, procedure rooms, or beds of a hospital under clause (i) to the extent such increase would result in the number of operating rooms, procedure rooms, or beds of the hospital exceeding 200 percent of the baseline number of operating rooms, procedure rooms, or beds of the hospital.

(E) BASELINE NUMBER OF OPERATING ROOMS, PROCEDURE ROOMS, OR BEDS.—In this paragraph, the term ‘baseline number of operating rooms, procedure rooms, or beds’ means the number of operating rooms, procedure rooms, or beds of a hospital as of the date of enactment of this subsection.

(F) APPROVAL OF AN INCREASE IN FACILITY CAPACITY.—The Secretary may grant an exception under the process described in subparagraph (A) only to a hospital described in subparagraph (P) or a hospital—

(i) that is located in a county in which the percentage increase in the population during the most recent 5-year period for which data are available is estimated to be at least 150 percent of the percentage increase in the population growth of the State in which the hospital is located during the same period, as estimated by Bureau of the Census and available to the Secretary;

(ii) whose annual percent of total inpatient admissions that represent inpatient admissions under the program under title XIX that is determined by the Secretary to be attributable to such admissions is estimated to be equal to or greater than the average percent with respect to such admissions for all hospitals located in the county in which the hospital is located;

(iii) that does not discriminate against beneficiaries of Federal health care programs and does not permit physical barriers or procedures at the hospital to discriminate against such beneficiaries;

(iv) that is located in a State in which the average percent occupancy in the State is estimated to be less than the national average bed capacity;
rules shall be contained in the next rule-making cycle following the submission to the Secretary of the report described in section 1157.

(b) PAYMENT ADJUSTMENTS.—

(1) FUNDING FOR IMPROVEMENTS.—For years before 2014, the Secretary shall ensure that the adjustments resulting from the implementation of the provisions of this section, as estimated by the Secretary, do not exceed $8,000,000,000, and do not exceed half of such amount in any payment year.

(2) HOLD HARMLESS.—In carrying out this subsection—

(A) for payment years before 2014, the Secretary shall implement the geographic adjustment in a manner that does not result in any net change in aggregate expenditures under title XVIII of the Social Security Act from the amount of such expenditures that the Secretary estimates would have occurred if no geographic adjustment had occurred in such section.

(b) Medicare Improvement Fund.—

(1) Amounts in the Medicare Improvement Fund under section 1899 of the Social Security Act (42 U.S.C. 1395iii(b)) shall be available to the Secretary to make changes to the geographic adjustments factors as described in subsections (a) and (b) with respect to payments furnished before January 1, 2014. No more than one-half of such amounts shall be available with respect to services furnished in any one payment year.

(2) Section 1898(b) of the Social Security Act (42 U.S.C. 1395f(b)) is amended—

(A) by amending paragraph (1)(A) to read as follows—

"(A) the period beginning with fiscal year 2011 and ending with fiscal year 2019, $8,000,000,000; and "; and

(B) by adding at the end the following new paragraph:

"(5) ADJUSTMENT FOR UNDERFUNDING.—For fiscal year 2014 or a subsequent fiscal year specified by the Secretary, the amount available to the fund under subsection (a) shall be increased by the Secretary’s estimate of the amount (based on data on actual expenditures) which—

(A) the additional expenditures resulting from the implementation of subsection (a) of section 1158 of the Affordable Health Care for America Act for the period before fiscal year 2014 is less than

(B) the maximum amount of funds available under subsection (a) of such section for funding for such expenditures."

SEC. 1159. INSTITUTE OF MEDICINE STUDY OF GEOGRAPHIC VARIATION IN HEALTH CARE SPENDING AND PROMOTING HIGH-VALUE HEALTH CARE.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section and the succeeding sections as the “Secretary”) shall enter into an agreement with the Institute of Medicine of the National Academies (referred to in this section as the “Institute”) to conduct a study on geographic variation and growth in volume and intensity of services in per capita health care spending under parts A and B of title XVIII of such Act and Medicaid, privately insured and uninsured populations. Such study may draw on recent relevant reports of the Institute and shall include—

(1) An evaluation of the extent and range of such variation using various units of geographic measurement, including micro areas within a county or state.

(2) An evaluation of the extent to which geographic variation can be attributed to differences in input prices; health status; practice patterns; access to medical services; supply of medical services; socio-economic factors, including race, ethnicity, gender, age, income, and payer organizational models.

(3) An evaluation of the extent to which variations in spending are correlated with geographic variation or efforts to promote high-value care to address variation or promote high-value care.

(4) Empowering patients to make value-based care decisions.

(5) Leveraging the use of health information technology.

(6) The role of financial and other incentives affecting provision of care.

(7) Variation in input costs.

(8) The characteristics of the patient population, including socio-economic factors (including race, ethnicity, gender, age, income and educational status), and whether the beneficiaries are dually eligible for the Medicare program and Medicaid under title XVIII of such Act, and whether beneficiaries are enrolled in fee-for-service Medicare or Medicaid programs.

(9) Other topics the Institute deems appropriate.

(b) In making such recommendations, the Institute shall consider the experience of government and community-based programs that promote high-value care.

(c) The Institute shall consider the experience of government and community-based programs that promote high-value care.

(d) The Institute shall consider the experience of government and community-based programs that promote high-value care.

(e) Appropriations.—There is appropriated from amounts in the general fund of the Treasury and otherwise authorized $10,000,000 to carry out this section. Such sums are authorized to remain available until expended.

SEC. 1160. IMPLEMENTATION, AND CONGRESSIONAL REVIEW, OF PROPOSAL TO REVISE MEDI CARE PAYMENTS TO PROMOTE HIGH VALUE CARE.

(a) PREPARATION AND SUBMISSION OF IMPLEMENTATION PLANS.—

(1) Final implementation plan.—Not later than 240 days after the date of receipt by the Secretary and each House of Congress of the report under section 1158(e)(1), the Secretary shall submit to each such House a final implementation plan describing proposed changes to payment for items and services under parts A and B of title XVIII of such Act and Medicaid, and the effects of such proposals on providers and beneficiaries.

(b) Payment reductions.—In so doing, the Secretary shall specify the payment reductions that would adjust provider payments on a regional or provider-level basis. If the Secretary finds that such payments would result in significant changes to the payment system that would adjust provider payments on a regional or provider-level basis, the Secretary shall implement such changes.

(2) Responsibility for payment reductions.—The Secretary shall use the data collected and analyzed in this section to issue a subsequent report, or series of reports, on how best to address geographic variation or efforts to promote high-value care.

(c) In making such recommendations, the Institute shall consider the experience of government and community-based programs that promote high-value care.

(d) The Institute shall consider the experience of government and community-based programs that promote high-value care.

(e) Appropriations.—There is appropriated from amounts in the general fund of the Treasury and otherwise authorized $10,000,000 to carry out this section. Such sums are authorized to remain available until expended.

SEC. 1166. IMPLEMENTATION, AND CONGRESSIONAL REVIEW, OF PROPOSAL TO REVISE MEDI CARE PAYMENTS TO PROMOTE HIGH VALUE CARE.

(a) PREPARATION AND SUBMISSION OF IMPLEMENTATION PLANS.—

(1) Final implementation plan.—Not later than 240 days after the date of receipt by the Secretary and each House of Congress of the report under section 1158(e)(1), the Secretary shall submit to each such House a final implementation plan describing proposed changes to payment for items and services under parts A and B of title XVIII of such Act and Medicaid, and the effects of such proposals on providers and beneficiaries.

(2) Responsibility for payment reductions.—In so doing, the Secretary shall specify the payment reductions that would adjust provider payments on a regional or provider-level basis. If the Secretary finds that such payments would result in significant changes to the payment system that would adjust provider payments on a regional or provider-level basis, the Secretary shall implement such changes.

(3) In making such recommendations, the Institute shall consider the experience of government and community-based programs that promote high-value care.

(4) Appropriations.—There is appropriated from amounts in the general fund of the Treasury and otherwise authorized $10,000,000 to carry out this section. Such sums are authorized to remain available until expended.
information technology, as specified in sections 1866(d)(5)(F), 1866(d)(5)(B), 1866(h), 1848(o), and 1866(n), respectively, of the Social Security Act) taking into consideration, as appropriate, such plan and the plan submitted under subsection (a)(1) and the changes to the payment systems made by this Act. To the extent such implementation plan requires a substantial change to the payment system, it shall include a transition phase-in that takes into consideration possible disruption to provider participants in the Medicare program under title XVIII of the Social Security Act and preserves access for care for Medicare beneficiaries.

(2) IMPLEMENTATION PLAN.—Not later than 90 days after the date the Institute of Medicine submits to each House of Congress the report under section 1159(e)(1), the Secretary shall submit to each House of Congress a preliminary version of the implementation plan provided for under paragraph (1)(A).

(3) NO INCREASE IN BUDGET EXPENDITURES.—The Secretary shall include with the submission of the final implementation plan under paragraph (1) a certification by the Chief Actuary of the Medicare Board of Trustees that any additional costs to the Medicare program under title XVIII of the Social Security Act under such a plan shall not be in order.

(4) WAIVERS REQUIRED.—To the extent the final implementation plan under paragraph (1) proposes changes that are not otherwise permissible under the Medicare statute (as applicable to the date on which such proposed changes are made) the Secretary shall specify in the plan the specific waivers required under such a plan and the waiver authority provided under subsection (a)(1).

(5) ASSESSMENT OF IMPACT.—In addition, both the preliminary and final implementation plans under this subsection shall include a detailed assessment of the effects of the proposed payment changes by provider or supplier type and State relative to the payments that would otherwise apply.

(b) A schedule of the time for the committees of the Senate and House of Representatives.

(1) IN GENERAL.—The Secretary shall include in the final implementation plan submitted under subsection (a)(1), and the waivers specified in subsection (a)(4) to the extent required for such a change to be effective, unless a joint resolution (described in subsection (d)(5)(A)) with respect to such plan is enacted by not later than such deadline.

(2) CONGRESSIONAL ACTION DEADLINE.—For purposes of this section, the term "congressional action deadline" means, with respect to a final implementation plan under subsection (a)(1), May 31, 2012, or, if later, the date that is 145 days after the date of receipt of the report submitted under section 1159(e)(1) and the changes to the payment systems made by this Act. To the extent such implementation plan requires a substantial change to the payment system, it shall include a transition phase-in that takes into consideration possible disruption to provider participants in the Medicare program under title XVIII of the Social Security Act and preserves access for care for Medicare beneficiaries.

(3) NO INCREASE IN BUDGET EXPENDITURES.—The Secretary shall include with the submission of the final implementation plan under paragraph (1) a certification by the Chief Actuary of the Medicare Board of Trustees that any additional costs to the Medicare program under title XVIII of the Social Security Act under such a plan shall not be in order.

(4) WAIVERS REQUIRED.—To the extent the final implementation plan under paragraph (1) proposes changes that are not otherwise permissible under the Medicare statute (as applicable to the date on which such proposed changes are made) the Secretary shall specify in the plan the specific waivers required under such a plan and the waiver authority provided under subsection (a)(1).

(5) ASSESSMENT OF IMPACT.—In addition, both the preliminary and final implementation plans under this subsection shall include a detailed assessment of the effects of the proposed payment changes by provider or supplier type and State relative to the payments that would otherwise apply.

(c) IMPLEMENTATION.—

(1) IN GENERAL.—The Secretary shall include in the final implementation plan submitted under subsection (a)(1), and the waivers specified in subsection (a)(4) to the extent required for such a change to be effective, unless a joint resolution (described in subsection (d)(5)(A)) with respect to such plan is enacted by not later than such deadline.

(2) CONGRESSIONAL ACTION DEADLINE.—For purposes of this section, the term "congressional action deadline" means, with respect to a final implementation plan under subsection (a)(1), May 31, 2012, or, if later, the date that is 145 days after the date of receipt of the report submitted under section 1159(e)(1) and the changes to the payment systems made by this Act. To the extent such implementation plan requires a substantial change to the payment system, it shall include a transition phase-in that takes into consideration possible disruption to provider participants in the Medicare program under title XVIII of the Social Security Act and preserves access for care for Medicare beneficiaries.

(3) NO INCREASE IN BUDGET EXPENDITURES.—The Secretary shall include with the submission of the final implementation plan under paragraph (1) a certification by the Chief Actuary of the Medicare Board of Trustees that any additional costs to the Medicare program under title XVIII of the Social Security Act under such a plan shall not be in order.

(4) WAIVERS REQUIRED.—To the extent the final implementation plan under paragraph (1) proposes changes that are not otherwise permissible under the Medicare statute (as applicable to the date on which such proposed changes are made) the Secretary shall specify in the plan the specific waivers required under such a plan and the waiver authority provided under subsection (a)(1).

(5) ASSESSMENT OF IMPACT.—In addition, both the preliminary and final implementation plans under this subsection shall include a detailed assessment of the effects of the proposed payment changes by provider or supplier type and State relative to the payments that would otherwise apply.

(d) CONGRESSIONAL PROCEDURES.—

(1) IN GENERAL.—The Secretary shall include in the final implementation plan submitted under subsection (a)(1), and the changes to the payment systems made by this Act. To the extent such implementation plan requires a substantial change to the payment system, it shall include a transition phase-in that takes into consideration possible disruption to provider participants in the Medicare program under title XVIII of the Social Security Act and preserves access for care for Medicare beneficiaries.

(2) CONGRESSIONAL ACTION DEADLINE.—For purposes of this section, the term "congressional action deadline" means, with respect to a final implementation plan under subsection (a)(1), May 31, 2012, or, if later, the date that is 145 days after the date of receipt of the report submitted under section 1159(e)(1) and the changes to the payment systems made by this Act. To the extent such implementation plan requires a substantial change to the payment system, it shall include a transition phase-in that takes into consideration possible disruption to provider participants in the Medicare program under title XVIII of the Social Security Act and preserves access for care for Medicare beneficiaries.

(3) NO INCREASE IN BUDGET EXPENDITURES.—The Secretary shall include with the submission of the final implementation plan under paragraph (1) a certification by the Chief Actuary of the Medicare Board of Trustees that any additional costs to the Medicare program under title XVIII of the Social Security Act under such a plan shall not be in order.

(4) WAIVERS REQUIRED.—To the extent the final implementation plan under paragraph (1) proposes changes that are not otherwise permissible under the Medicare statute (as applicable to the date on which such proposed changes are made) the Secretary shall specify in the plan the specific waivers required under such a plan and the waiver authority provided under subsection (a)(1).

(5) ASSESSMENT OF IMPACT.—In addition, both the preliminary and final implementation plans under this subsection shall include a detailed assessment of the effects of the proposed payment changes by provider or supplier type and State relative to the payments that would otherwise apply.

(e) IMPLEMENTATION.—

(1) IN GENERAL.—The Secretary shall include in the final implementation plan submitted under subsection (a)(1), and the waivers specified in subsection (a)(4) to the extent required for such a change to be effective, unless a joint resolution (described in subsection (d)(5)(A)) with respect to such plan is enacted by not later than such deadline.

(2) CONGRESSIONAL ACTION DEADLINE.—For purposes of this section, the term "congressional action deadline" means, with respect to a final implementation plan under subsection (a)(1), May 31, 2012, or, if later, the date that is 145 days after the date of receipt of the report submitted under section 1159(e)(1) and the changes to the payment systems made by this Act. To the extent such implementation plan requires a substantial change to the payment system, it shall include a transition phase-in that takes into consideration possible disruption to provider participants in the Medicare program under title XVIII of the Social Security Act and preserves access for care for Medicare beneficiaries.

(3) NO INCREASE IN BUDGET EXPENDITURES.—The Secretary shall include with the submission of the final implementation plan under paragraph (1) a certification by the Chief Actuary of the Medicare Board of Trustees that any additional costs to the Medicare program under title XVIII of the Social Security Act under such a plan shall not be in order.

(4) WAIVERS REQUIRED.—To the extent the final implementation plan under paragraph (1) proposes changes that are not otherwise permissible under the Medicare statute (as applicable to the date on which such proposed changes are made) the Secretary shall specify in the plan the specific waivers required under such a plan and the waiver authority provided under subsection (a)(1).

(5) ASSESSMENT OF IMPACT.—In addition, both the preliminary and final implementation plans under this subsection shall include a detailed assessment of the effects of the proposed payment changes by provider or supplier type and State relative to the payments that would otherwise apply.

(f) IMPLEMENTATION.—

(1) IN GENERAL.—The Secretary shall include in the final implementation plan submitted under subsection (a)(1), and the waivers specified in subsection (a)(4) to the extent required for such a change to be effective, unless a joint resolution (described in subsection (d)(5)(A)) with respect to such plan is enacted by not later than such deadline.

(2) CONGRESSIONAL ACTION DEADLINE.—For purposes of this section, the term "congressional action deadline" means, with respect to a final implementation plan under subsection (a)(1), May 31, 2012, or, if later, the date that is 145 days after the date of receipt of the report submitted under section 1159(e)(1) and the changes to the payment systems made by this Act. To the extent such implementation plan requires a substantial change to the payment system, it shall include a transition phase-in that takes into consideration possible disruption to provider participants in the Medicare program under title XVIII of the Social Security Act and preserves access for care for Medicare beneficiaries.

(3) NO INCREASE IN BUDGET EXPENDITURES.—The Secretary shall include with the submission of the final implementation plan under paragraph (1) a certification by the Chief Actuary of the Medicare Board of Trustees that any additional costs to the Medicare program under title XVIII of the Social Security Act under such a plan shall not be in order.
rules only to the extent that it is inconsistent with such rules; and
(ii) with full recognition of the constitutional right of either House to change the rules as relating to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.
(3) DETERMINATION OF QUALITY PERFORMANCE SORE.—For purposes of this section:
((A) QUALITY PERFORMANCE.—The Secretary shall provide for the calculation of a quality performance score for each Medicare Advantage plan to be applied for each year.
(B) COMPUTATION OF SCORE.—
(1) QUALITY PERFORMANCE SCORE.—For years before a year specified by the Secretary, the quality performance score for a Medicare Advantage plan shall be computed based on a blend (as designated by the Secretary) of the plan’s performance on—
(A) HEDIS effectiveness of care quality measures;
(B) CAHPS quality measures; and
(C) such other measures of clinical quality as the Secretary determines.
Such measures shall be risk-adjusted as the Secretary deems appropriate.
(II) ESTABLISHMENT OF OUTCOME-BASED MEASURES.—By not later than for a year specified by the Secretary, the Secretary shall implement performance requirements for quality under this section on measures selected under clause (1) that reflect the outcomes of care experienced by individuals enrolled in Medicare Advantage plans (in addition to measures described in clause (i)). Such measures may include—
(1) measures of rates of admission and readmission to a hospital;
(2) measures of prevention quality, such as those established by the Agency for Healthcare Research and Quality (that includes hospital admission rates for specified conditions);
(3) measures of patient mortality and morbidity following surgery;
(4) measures of health functioning (such as limitations on activities of daily living) and survival for patients with chronic diseases;
(5) measures of patient safety; and
(6) other measures of outcomes and patient quality of life as determined by the Secretary.
Such measures shall be risk-adjusted as the Secretary deems appropriate. In determining the measure(s) to be used to measure the outcomes that are covered by this section, the Secretary shall take into consideration the recommendations of the Medicare Payment Advisory Commission in its report to Congress under section 1853(b)(2) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) and shall provide preference to measures used in measuring quality under parts A and B.
(III) RULES FOR SELECTION OF MEASURES.—The Secretary shall select measures for purposes of clause (ii) consistent with the following:
(1) The Secretary shall provide preference to clinical quality measures that have been endorsed by the entity with a contract with the Medicare program of the information described in the previous sentence.
(2) AUTHORITY TO DISQUALIFY DEFICIENT PLANS.—The Secretary may determine that a Medicare Advantage plan is not a qualifying plan if the Secretary has identified deficiencies in the plan’s compliance with rules for Medicare Advantage plans under this part.

SEC. 1162. AUTHORITY FOR SECRETARIAL CODING INTENSITY ADJUSTMENT AUTHORITY.
Section 1853(a)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(C)(ii)) is amended—
((1) in the matter before subclause (1), by striking “through 2010” and inserting “and each subsequent year”; and
((2) in subclause (2), by inserting “periodically” before “conduct an analysis;” and
((B) by inserting “on a timely basis” after “are incorporated”; and
((C) by striking “only for 2008, 2009, and 2010” and inserting “for 2008 and subsequent years”.)}
SEC. 1161. SIMPLIFICATION OF ANNUAL BENEFICIARY ELECTION PERIODS.
(a) 2-Week Processing Period for Annual Enrollment Period (AEP).—Paragraph (3)(B) of section 1829(h)(5) of the Social Security Act (42 U.S.C. 1395w–2(h)(5)) is amended—
(1) by striking “and” at the end of clause (iii); and
(2) by striking the period at the end and inserting “, and”.

(b) Transition.—Any amount contained in the MA Regional Plan Stabilization Fund as of the date of the enactment of this Act shall be transferred to the Federal Supplementary Medical Insurance Trust Fund.

SEC. 1162. STUDY REGARDING THE EFFECTS OF CALCULATING MEDICARE ADVANTAGE PAYMENT RATES ON A REGIONAL AVERAGE OF MEDICARE FEE FOR SERVICE RATES.
(a) In general.—The Administrator of the Centers for Medicare and Medicaid Services shall conduct a study to determine the potential effects of calculating Medicare Advantage payment rates on a more aggregated geographic area (such as a metropolitan statistical area or other regional delineations) rather than using county boundaries. In conducting such study, the Administrator shall consider the following:
(1) The quality of care received by Medicare Advantage enrollees.
(2) The impact on Medicare Advantage plans, including any implications for providers contracting with Medicare Advantage plans.
(3) The predictability of benchmark amounts for Medicare advantage plans.
(b) Consultations.—In conducting the study, the Administrator shall consult with the following:
(1) Experts in health care financing.
(2) Representatives of foundations and other entities that have conducted or supported research on Medicare financing issues.
(3) Representatives from Medicare Advantage plans.
(4) Such other entities or persons as determined by the Secretary.
(c) Report.—Not later than one year after the date of enactment of this Act, the Administrator shall submit a report to the Congress on the study conducted under this section. The report shall contain a detailed statement of findings and conclusions of the study, together with its recommendations for such legislation and administrative actions as the Administrator considers appropriate.

PART 2—BENEFICIARY PROTECTIONS AND ANTI-FRAUD
SEC. 1171. LIMITATION ON COST-SHARING FOR INDIVIDUAL HEALTH SERVICES.
(a) In general.—Section 1852(a)(1) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)) is amended by adding at the end the following:
(1) Permitting use of flat copayment or per diem rate.—Nothing in clause (i) shall be construed as prohibiting a Medicare Advantage plan from using a flat copayment or per diem rate, in lieu of the cost-sharing that would otherwise be imposed under such program option.
(2) Limitation for dual eligibles and qualified Medicare beneficiaries.—Section 1852(a)(7) of such Act is amended to read as follows:
(1) Limitation on cost-sharing for dual eligibles and qualified Medicare beneficiaries.—Notwithstanding the meaning given such term by the Secretary, the amount of cost-sharing that would be permitted with respect to the individual under this title and title XIX if the individual were not enrolled with such plan.

SEC. 1172. INFORMATION FOR BENEFICIARIES ON MA PLAN ADMINISTRATIVE COSTS.
(a) Disclosure of medical loss ratios and other cost-related information.—Section 1857(g) of the Social Security Act (42 U.S.C. 1395w–21) is amended by adding at the end the following:
(1) Limitation for dual eligibles and qualified Medicare beneficiaries.—Section 1852(a)(7) of such Act is amended to read as follows:
(1) Limitation on cost-sharing for dual eligibles and qualified Medicare beneficiaries.—Notwithstanding the meaning given such term by the Secretary, the amount of cost-sharing that would be permitted with respect to the individual under this title and title XIX if the individual were not enrolled with such plan.

SEC. 1173. LIMITATION ON COST-SHARING FOR DUAL ELIGIBLES AND QUALIFIED MEDICARE BENEFICIARIES.—Section 1852(a)(1) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)) is amended by adding at the end the following:
(1) Limitation on cost-sharing for dual eligibles and qualified Medicare beneficiaries.—Notwithstanding the meaning given such term by the Secretary, the amount of cost-sharing that would be permitted with respect to the individual under this title and title XIX if the individual were not enrolled with such plan.

SEC. 1174. LIMITATION ON COST-SHARING FOR DUAL ELIGIBLES AND QUALIFIED MEDICARE BENEFICIARIES.—Section 1852(a)(1) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)) is amended by adding at the end the following:
(1) Limitation on cost-sharing for dual eligibles and qualified Medicare beneficiaries.—Notwithstanding the meaning given such term by the Secretary, the amount of cost-sharing that would be permitted with respect to the individual under this title and title XIX if the individual were not enrolled with such plan.

SEC. 1175. LIMITATION ON COST-SHARING FOR DUAL ELIGIBLES AND QUALIFIED MEDICARE BENEFICIARIES.—Section 1852(a)(1) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)) is amended by adding at the end the following:
(1) Limitation on cost-sharing for dual eligibles and qualified Medicare beneficiaries.—Notwithstanding the meaning given such term by the Secretary, the amount of cost-sharing that would be permitted with respect to the individual under this title and title XIX if the individual were not enrolled with such plan.
the following new paragraph:

"(1) by striking "The standards" and inserting "Sec-

tion 1177. EXTENSION OF AUTHORITY OF SPE-

CIAL NEEDS PLANS TO RESTRICT ENROLLMENT; SERVICE AREA MOR-

ATORIUM FOR CERTAIN SNPS.

(b) EXTENSION OF CERTAIN PLANS.—

(i) In GENERAL.—Section 1857(e) of the Social Security Act (42 U.S.C. 1395w–27(e)) is amended—

(ii) RESPONSE TO RECOMMENDATION.—Not later than 30 days after receipt of a request for a recommendation under subsection (I) from a State, the Secretary shall respond in writing to the State regarding the progress of any investigation involving such violation, whether the Secretary intends to pursue the recommendation from the State, and if the case that an action has been initiated against a Medicare Advantage organization, PDP sponsor, or agent or broker of such an organization or sponsor for a violation described in such clause.

(iii) NON-DUPLICATION OF PENALTIES.—In the case that an action has been initiated against a Medicare Advantage organization, PDP sponsor, or agent or broker of such an organization or sponsor for a violation described in such clause, after such period.

(iv) CONSTRUCTION.—Nothing in this sub-

paragraph shall be construed as affecting any State authority to regulate brokers described in this paragraph or any other conduct of a Medicare Advantage organization or PDP sponsor.

PART 5—TREATMENT OF SPECIAL NEEDS PLANS

SEC. 1176. LIMITATION ON ENROLLMENT OUT-

SIDE OPEN ENROLLMENT PERIOD OF MEDICARE ADVANTAGE OR MEDICARE ADVANTAGE SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.

Section 1859(f)(4) of the Social Security Act (42 U.S.C. 1395w–28(f)(4)) is amended by adding at the end the following new paragraph:

"(i) The plan does not enroll an individual or on or after January 1, 2011, other than—

"(ii) during a special election period consisting of the period for which the individual has a chronic condition that qualifies the individual as a dual eligible as described in subsection (b)(6)(B), and (d)(2), and (d)(3) of section 1851 and section 1857(g)(1)(A).

"(3) by inserting after "section 1858(c))" the fol-

lowing new subparagraph:

"(B) ENSURANCE OF FEDERAL STANDARDS PERMITTED.

"(I) In GENERAL.—Subject to the subse-

quent provision of this subparagraph, nothing in this title shall be construed to pro-
hibit a State from conducting a market con-

dition.".'
SEC. 1181. ELIMINATION OF COVERAGE GAP.

(a) IMMEDIATE REDUCTION IN COVERAGE GAP IN 2010.—Section 1860D-2(b) of the Social Security Act (42 U.S.C. 1395w–2(b)) is amended—

(1) in paragraph (3)(A), by striking “paragraph (4)” and inserting “paragraphs (4) and (7);” and

(2) by adding at the end the following new paragraph:

“(7) INCREASE IN INITIAL COVERAGE LIMIT.—

“(i) IN GENERAL.—For a year beginning with 2011, the Secretary shall increase the initial coverage limit otherwise computed without regard to this paragraph by the amount by which the cumulative ICL phase-in percentage for the year exceeds the annual ICL phase-in percentage, as determined for the year pursuant to paragraph (5), for the year.”

(b) ADDITIONAL CLOSURE IN GAP BEGINNING IN 2011.—Section 1860D-2(b) of such Act (42 U.S.C. 1395w–2(b)) as amended by section (a), is further amended—

(1) in paragraph (3)(A), by striking “(7)” and inserting “(7),” and “(8);” and

(2) by adding at the end the following new paragraph:

“(8) PHASE-IN ELIMINATION OF COVERAGE GAP.—

“(A) IN GENERAL.—For each year beginning with 2011, the Secretary shall increase the initial coverage limit otherwise computed without regard to this paragraph by the amount by which the cumulative ICL phase-in percentage for the year exceeds the annual ICL phase-in percentage, as determined for the year pursuant to paragraph (5), for the year, except that for purposes of this paragraph, the initial coverage limit shall include an amount by which the annual out-of-pocket threshold for the year exceeds the amount otherwise determined for purposes of paragraph (7).”

SEC. 1182. EXTENSION OF MEDICARE SENIOR HOUSING PLANS.

Section 1882 of the Social Security Act (42 U.S.C. 1396w–28) is amended by adding at the end the following new subsection:

“(g) SPECIAL RULES FOR SENIOR HOUSING FACILITY PLANS.—

“(1) IN GENERAL.—Notwithstanding any other provision of this part, in the case of a Medicare Advantage senior housing facility plan described in subparagraph (2) and for periods before January 1, 2013—

“(A) the service area of such plan may be limited to a senior housing facility in a geographic area;

“(B) the service area of such plan may not be expanded; and

“(C) additional senior housing facilities may not be serviced by such plan.

“(2) MEDICARE ADVANTAGE SENIOR HOUSING FACILITY PLAN DESCRIBED.—For purposes of this subsection, a Medicare Advantage senior housing facility plan is a Medicare Advantage plan that—

“(A)(i) restricts enrollment of individuals under this part to individuals who reside in a continuing care retirement community (as defined in section 1852(d)(4)(B));

“(ii) provides primary care services onsite and home visits or accessible providers to beneficiaries that the Secretary determines is adequate, taking into consideration the number of residents onsite, the health needs of those residents, and the accessibility of providers onsite; and

“(iii) provides transportation services for beneficiaries to providers outside of the facility;

“(B) is offered by a Medicare Advantage organization that has offered at least 1 plan described in subparagraph (A) for at least 1 year prior to January 1, 2010, under a demonstration project established by the Secretary.”

Subtitle E—Improvements to Medicare Part D

SECTION 1183. PROVIDE DRUG MANUFACTURERS TO PROVIDE DRUG REBATES FOR REBATE ELIGIBLE INDIVIDUALS.

(1) IN GENERAL.—Section 1860D-2 of the Social Security Act (42 U.S.C. 1395w–102) is amended—

(A) in subsection (e)(3), in the matter before paragraph (A), by inserting “subsection (f)” after “this paragraph;” and

(B) by adding at the end the following new subsection:

“(f) PRESCRIPTION DRUG REBATE AGREEMENTS FOR REBATE ELIGIBLE INDIVIDUALS.—

“(1) REQUIREMENT.—

“(A) IN GENERAL.—For plan years beginning on or after January 1, 2011, in this part, the term ‘covered part D drug’ does not include any drug or biological product that is manufactured by a manufacturer that has not entered into and have in effect a rebate agreement described in paragraph (2).”

“(B) 2010 PLAN YEAR REQUIREMENT.—Any drug or biological product manufactured by a manufacturer that declines to enter into a rebate agreement described in paragraph (2) for the period beginning on January 1, 2010, and ending on December 31, 2010, shall not be included as a ‘covered part D drug’ for the subsequent plan year.

“(2) REBATE AGREEMENT.—A rebate agreement under this subsection shall require the
manufacturer to provide to the Secretary a rebate for each rebate period (as defined in paragraph (6)(B)) ending after December 31, 2009, in the amount specified in paragraph (3) for any other covered drug of the drug class for which payment was made under part D or a MA organization under part C for such period, including payments passed through the low-income and reinsurance subsidies under sections 1927(b)(3), 1927(c), and 1927(f)(3), respectively. Such rebate shall be paid by the manufacturer to the Secretary not later than 30 days after the date of receipt of the information described in section 1861D-12(b)(7), including as such section is applied under section 1957(f)(3), or 30 days after the receipt of information under subparagraph (D) of paragraph (3), as determined by the Secretary.

Insofar as not inconsistent with this subsection, the Secretary shall establish terms and conditions of such agreement relating to compliance, penalties, and program evaluations, investigations, and audits that are similar to the terms and conditions for rebates entered into under paragraphs (3) and (4) of section 1927(b).

(3) Rebate for rebate eligible Medicare drug plan enrollees.—

(A) IN GENERAL.—The amount of the rebate specified under this paragraph for a manufacturer for a rebate period, with respect to each dosage form and strength of any other covered drug provided by a manufacturer under part C for such period, including payments passed through the low-income and reinsurance subsidies under sections 1927(b)(3), 1927(c), and 1927(f)(3), respectively, and

(ii) the amount (if any) by which—

(i) the Medicaid rebate amount (as defined in subparagraph (C)) for such form, strength, and period, exceeds

(ii) the average Medicare drug program rebate eligible rebate amount (as defined in subparagraph (C)) for such form, strength, and period.

(B) MEDICAID REBATE AMOUNT.—For purposes of this subsection, the term ‘rebate eligible rebate amount’ means, with respect to each dosage form and strength of a covered part D drug provided by a manufacturer for a rebate period, the sum, for all PDP sponsors under part D or a MA organization under part C for the rebate period, including payments passed through the low-income and reinsurance subsidies under sections 1927(b)(3), 1927(c), and 1927(f)(3), respectively, of

(i) the total number of units of such dosage form and strength of the drug dispensed during the rebate period to rebate eligible individuals enrolled in the prescription drug plans administered by PDP sponsors under part D or the MA–PD plans managed by MA organizations; and

(ii) the total number of units of such dosage form and strength of the drug dispensed during the rebate period to rebate eligible individuals enrolled in all prescription drug plans administered by PDP sponsors and all MA–PD plans managed by MA organizations.

(C) USE OF ESTIMATES.—The Secretary may establish a methodology for estimating the average Medicare drug program rebate eligible rebate amount for each rebate period based on bid and utilization information under this part and may use these estimates as the basis for determining the rebates under this section. If the Secretary elects to estimate the average Medicare drug program rebate eligible rebate amounts, the Secretary shall adopt the methodology for estimating the rebate amount in the same manner as such methodology relates to this section, and to determine the amount of the rebate required under this section, for such form, strength, and period.

Such report shall be in a form consistent with any standard reporting format established by the Secretary.

(D) CONFIDENTIALITY OF INFORMATION.—The provisions of subparagraph (D) of section 1927(b)(3), relating to confidentiality of information, shall apply to information reported by PDP sponsors under this paragraph in the same manner that such provisions apply to information disclosed by manufacturers or wholesalers under such section, except—

(i) that any reference to ‘this section’ in clause (ii) of such subparagraph shall be treated as being a reference to this section;

(ii) that the reference to the Director of the Congressional Budget Office in clause (ii) of such subparagraph shall be treated as being a reference to the Medicare Payment Advisory Commission; and

(iii) that clause (iv) of such subparagraph shall not apply to such information.

(E) OVERSIGHT.—Information reported under this paragraph may be used by the Inspector General of the Department of Health and Human Services and any authorized purposes of audit, investigation, and evaluations.

(F) PENALTIES FOR FAILURE TO PROVIDE TIMELY INFORMATION AND PROVISION OF FALSE INFORMATION.—In the case of a PDP sponsor—

(i) that fails to provide information required under subparagraph (B) on a timely basis, the sponsor is subject to a civil money penalty in the amount of $10,000 for each day in which such information has not been provided; or

(ii) that knowingly (as defined in section 1128A) provides false information under such subparagraph, the sponsor is subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information.

Such civil money penalties are in addition to any other civil money penalty under this section, for each item of false information.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).


(4) LENGTH OF AGREEMENT.—The provisions of paragraph (4) of section 1927(b) (other than clauses (iv) and (v) of subparagraph (B)) shall apply to rebate agreements entered into under this subsection in the same manner as such provisions apply to information reported under subparagraph (B) to the Secretary for the purpose of audit oversight and evaluation.

(5) OBLIGATIONS TO PROVIDE INFORMATION.—Any information, shall apply to information reported by PDP sponsors under this paragraph in the same manner that such provisions apply to information disclosed by manufacturers or wholesalers under such section, except—

(i) that any reference to ‘this section’ in clause (ii) of such subparagraph shall be treated as being a reference to this section;

(ii) that the reference to the Director of the Congressional Budget Office in clause (ii) of such subparagraph shall be treated as being a reference to the Medicare Payment Advisory Commission; and

(iii) that clause (iv) of such subparagraph shall not apply to such information.

(6) DEFINITIONS.—In this subsection and section 1860D–12(b)(7),

(A) REBATE ELIGIBLE INDIVIDUAL.—The term ‘rebate eligible individual’—

(i) means a full-benefit dual eligible individual (as defined in section 1856(c)(6)); and

(ii) includes a covered part D drug dispensed after December 31, 2014, a subsidy eligible individual (as defined in section 1861D–1(a)(3)(A)).

(B) REBATE PERIOD.—The term ‘rebate period’ has the meaning given such term in section 1927(c)(8).

(7) WAIVER.—Chapter 35 of title 44, United States Code, shall not apply to the requirements under this subsection for the period beginning on January 1, 2010, and ending on December 31, 2010.

(2) REPORTING REQUIREMENT FOR THE DETERMINATION AND PAYMENT OF REBATES BY MANUFACTURERS RELATED TO REBATE FOR ELIGIBLE MEDICARE DRUG PLAN ENROLLEES.—

(A) REQUIREMENTS FOR PDP SPONSORS.—Section 1860D–12(b) of the Social Security Act (42 U.S.C. 1395w–112(b)) is amended by adding at the end the following new paragraph:

(7) REPORTING REQUIREMENT FOR THE DETERMINATION AND PAYMENT OF REBATES BY MANUFACTURERS RELATED TO REBATE FOR ELIGIBLE MEDICARE DRUG PLAN ENROLLERS.—

(A) IN GENERAL.—For purposes of the rebate under section 1860D–2(f) for contract years beginning on or after January 1, 2011, the Secretary shall require each applicable PDP sponsor under this part with respect to a prescription drug plan shall require that the sponsor comply with subparagraphs (B) and (C).

(B) REPORT FORM AND CONTENTS.—Not later than a date specified by the Secretary, each applicable PDP sponsor shall report to each manufacturer—

(i) information (by National Drug Code number) on the total number of units of each dosage, form, and strength of each covered drug of such sponsor dispensed to PDP and MA–PD enrollees under any prescription drug plan operated by the PDP sponsor during the rebate period;

(ii) information on the price discounts, price concessions, and rebates for such drugs for such form, strength, and period;

(iii) information on the extent to which such price discounts, price concessions, and rebates apply equally to rebate eligible Medicare drug plan enrollees and PDP enrollees who are not rebate eligible individuals; and

(iv) additional information that the Secretary determines is necessary to enable the Secretary to calculate the average Medicare drug program rebate eligible rebate amount for each rebate period based on bid and utilization information under this part and may use these estimates as the basis for determining the rebates under this section. If the Secretary elects to estimate the average Medicare drug program rebate eligible rebate amounts, the Secretary shall adopt the methodology for estimating the rebate amount in the same manner as such methodology relates to this section, and to determine the amount of the rebate required under this section, for such form, strength, and period.

Such report shall be in a form consistent with any standard reporting format established by the Secretary.

(C) SUBMISSION TO SECRETARY.—Each PDP sponsor shall promptly transmit a copy of the information required under subparagraph (B) to the Secretary for the purpose of audit oversight and evaluation.

(D) CONFIDENTIALITY OF INFORMATION.—The provisions of subparagraphs (A) and (B) of section 1927(b)(3), relating to confidentiality of information, shall apply to information reported by PDP sponsors under this paragraph in the same manner that such provisions apply to information disclosed by manufacturers or wholesalers under such section, except—

(i) that any reference to ‘this section’ in clause (ii) of such subparagraph shall be treated as being a reference to this section;

(ii) that the reference to the Director of the Congressional Budget Office in clause (ii) of such subparagraph shall be treated as being a reference to the Medicare Payment Advisory Commission; and

(iii) clause (iv) of such subparagraph shall not apply to such information.

(E) OVERSIGHT.—Information reported under this paragraph may be used by the Inspector General of the Department of Health and Human Services and any authorized purposes of audit, investigation, and evaluations.

(F) PENALTIES FOR FAILURE TO PROVIDE TIMELY INFORMATION AND PROVISION OF FALSE INFORMATION.—In the case of a PDP sponsor—

(i) that fails to provide information required under subparagraph (B) on a timely basis, the sponsor is subject to a civil money penalty in the amount of $10,000 for each day in which such information has not been provided; or

(ii) that knowingly (as defined in section 1128A) provides false information under such subparagraph, the sponsor is subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information.

Such civil money penalties are in addition to any other civil money penalty under this section, for each item of false information.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).
(B) APPLICATION TO MA ORGANIZATIONS.—Section 1860D-2(f)(3) of the Social Security Act (42 U.S.C. 1395w-27(f)(3)) is amended by adding at the end the following:

"(B) APPLICATION TO MA ORGANIZATIONS.—Section 1860D-2(b)(7)."

(3) DISCOUNT FOR QUALIFYING ENROLLEES.—Section 1860D-2(b)(7) is amended by adding at the end the following new paragraph:

"(A) DISCOUNT AMOUNT.—The amount of the discount specified in this paragraph for a discount period for a plan is equal to 50 percent of the amount of the drug-component negotiated price for qualifying drugs for the period involved.

(4) ADDITIONAL TERMS.—In the case of a discount provided under this subsection with respect to a PDP sponsor or an MA–PD plan offered by an MA organization, if a qualified enrollee purchases the qualified drug—

"(A) insofar as the individual is in the original gap in coverage for the period beginning January 1, 2010, and ending December 31, 2010, after January 1, 2010, in an MA–PD plan or an MA–PD plan involved.

"(B) collect the necessary information from prescription drug plans and MA–PD plans to calculate the discount amount described in paragraph (A) and (C) provide the discount described in such paragraph to beneficiaries as close as practicable to the point of service.

"(7) WAIVER.—Chapter 35 of title 44, United States Code, shall not apply to the requirements under this subsection for the period beginning January 1, 2010, and ending on December 31, 2010.".

SEC. 1184. REPEAL OF PROVISION RELATING TO SUBMISSION OF CLAIMS BY PHARMACIES LOCATED IN OR CONTRACTING WITH LONG-TERM CARE FACILITIES.

(a) PART D SUBMISSION.—Section 1860D–12(b) of the Social Security Act (42 U.S.C. 1395w–12(b)), as amended by section 172(a)(1) of Public Law 110–275, is amended by striking paragraph (5) and redesigning paragraph (6) and paragraph (7), as added by section 1181(c)(2)(A), as paragraph (5) and paragraph (6), respectively.

(b) SUBMISSION TO MA–PD PLANS.—Section 1860D–12(b)(1) of the Social Security Act (42 U.S.C. 1395w–12(b)(1)), as added by section 171(b) of Public Law 110–275 and amended by section 172(a)(2) of such Public Law and section 1181 of this Act, is amended by striking subparagraphs (C) and (D) as subparagraphs (B) and (C), respectively.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply for contract years beginning with 2010.
(3) by adding at the end the following new clause:

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(ii) CHANGE IN FORMULARY ONLY.
This subsection applies to a covered part D drug plan under subsection (g) of section 1395w of the Social Security Act (42 U.S.C. 1395w-112(c)), if the Secretary determines that the plan is not in compliance with the requirements of that section at the time of its submission to the Secretary by the plan sponsor.
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(4) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on the date of the enactment of this Act and shall be effective as if such amendments had been in effect on the date of the enactment of the Social Security Act (42 U.S.C. 1221).
“(I) ensure that each member has prior experience with the practice of telemedicine or telehealth;

(II) give preference to individuals who are currently involved in telemedicine or telehealth services or who are involved in telemedicine or telehealth programs;

(III) ensure that the membership of the Advisory Committee represents a balance of specialties and geographic regions; and

(IV) take into account the recommendations of stakeholders.

(B) Terms.—The members of the Advisory Committee shall serve for such term as the Secretary may specify.

(C) OBJECTS OF INTEREST.—An advisory committee member may not participate with respect to a particular matter considered in an advisory committee meeting if such member (or an immediate family member of such member) has a financial interest that could be affected by the advice given to the Secretary with respect to such matter.

(3) MEETINGS.—The Advisory Committee shall meet twice each calendar year and at such other times as the Secretary may provide.

(4) PERMANENT COMMITTEE.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Advisory Committee.

(b) FOLLOWING RECOMMENDATIONS.—Section 183(m)(4)(F) of such Act (42 U.S.C. App.) shall not apply to the Advisory Committee.

(3) IMPLEMENTATION OF THE TELEHEALTH ADVISORY COMMITTEE.—In making determinations under clauses (i) and (ii), the Secretary shall take into account the recommendations of the Telehealth Advisory Committee (established under section 1868(c)) when adding or deleting services (and HCPCS codes) and in establishing policies of the Centers for Medicare & Medicaid Services regarding the delivery of telehealth services. If the Secretary does not implement such a recommendation, the Secretary shall publish in the Federal Register a statement regarding the reason such recommendation was not implemented.

3. WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary of Health and Human Services shall establish the Telehealth Advisory Committee under the amendment made by paragraph (i)(3) of subsection (a) to section 1868(c)(6) (as added by division B of the American Recovery and Reinvestment Act of 2009) (42 U.S.C. 1395m(h)(6)) that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services) otherwise.

(b) HOSPITAL CREDENTIALING OF TELEMEDICINE PHYSICIANS AND PRACTITIONERS.—

(1) GENERAL.—Not later than 60 days after the date of enactment of this Act, the Secretary of Health and Human Services shall issue guidance for hospitals (as defined in section 1881(h)(4)) to simplify requirements regarding compiling practitioner credentials for the purpose of rendering a medical staff privileging decision (under bylaws of the type described in section 1881(e)(3) of the Social Security Act) for physicians and practitioners (as defined in paragraph (4)) delivering telehealth services that are furnished via a telecommunications system.

(2) FLEXIBILITY IN ACCEPTING CREDENTIALING BY ANOTHER MEDICARE PARTICIPATING HOSPITAL.—

(A) IN GENERAL.—Such guidance shall permit a hospital to accept credentialing packages compiled by another hospital participating under Medicare with regard to physicians and practitioners who seek medical staff privileges in the hospital to provide telehealth services via a telecommunications system from a site other than the hospital where services are furnished.

(B) CONSTRUCTION.—Nothing in this subsection shall be construed to require a hospital to accept the credentialing package compiled by another facility.

(C) NO OVERSIGHT REQUIRED.—If a hospital does accept the credentialing materials prepared by another hospital the hospital shall not be required to exercise oversight over the other hospital’s process for compiling and verifying credentials.

(D) CONSTRUCTION.—This paragraph shall only apply to credentialing and does not relieve a hospital from any applicable privileging requirements.

(2) CONSTRUCTION.—This subsection shall not be construed as limiting the ability of the Secretary to issue additional guidance regarding the requirements for the compilation of credentials for practitioners not described in paragraph (1).

(1) DEFINITIONS.—In this subsection:

(A) The term “hospital” has the meaning given such term in subsection (e) of section 1861 of the Social Security Act (42 U.S.C. 1395x) and includes a critical access hospital (as defined in subsection (mm)(1) of such section)

(B) The term “physician” has the meaning given such term in subsection (r) of such section.

(C) The term “practitioner” means a practitioner described in section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)).

 SEC. 1192. EXTENSION OF OUTPATIENT HOLD HARMLESS PROVISION.

Section 1833(t)(7)(D)(i) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)) is amended by adding at the end the following new clause:

(2) in subclause (II),

(A) in the first sentence, by striking “2010” and inserting “2012”, and

(B) in the second sentence, by striking “or 2009” and inserting “, 2009, 2010, or 2011”; and

(2) in subclause (III), by striking “January 1, 2010”, and inserting “January 1, 2012”.

SEC. 1193. EXTENSION OF SECTION 508 HOSPITAL RECLASSIFICATIONS.


(b) USE OF PARTICULAR WAGE INDEX FOR WORK.—

Section 1864(b)(2)(A) of the Social Security Act (42 U.S.C. 1395u(b)(2)(A)) is amended—


(2) in subparagraph (A), by inserting “before January 1, 2012” after “2011”; and

(3) in paragraph (2), by striking “2010” and inserting “2011”.

SEC. 1194. EXTENSION OF GEOGRAPHIC FLOOR FOR WORK.


SEC. 1195. EXTENSION OF PAYMENT FOR TECHNICAL COMPONENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.

Section 542(e) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106–554) is amended by striking “2007” and inserting “2009”. The amendments made by this section apply to amounts determined without regard to the life insurance policy exclusion provided under subsection (d) of section 1861 of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(i)) determined before January 1, 2012.

SEC. 1196. EXTENSION OF AMBULANCE ADD-ONS.

(a) IN GENERAL.—Section 1833(i)(13) of the Social Security Act (42 U.S.C. 1395n(i)(13)) is amended—

(1) by inserting paragraph (A); and

(A) in the matter preceding clause (i), by striking “before January 1, 2010” and inserting “before January 1, 2012”.

(b) in subsection (A), by striking “before January 1, 2010” and inserting “before January 1, 2012”.

 SEC. 1197. AIR AMBULANCE IMPROVEMENTS.

(a) IN GENERAL.—The Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking “ending on December 31, 2011” and inserting “ending on December 31, 2012”.

TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS

Subtitle A—Improving and Simplifying Financial Assistance for Low Income Medicare Beneficiaries

SEC. 1201. IMPROVING ASSETS TESTS FOR MEDICARE SAVINGS PROGRAM AND LOW-INCOME SUBSIDY PROGRAM.

(a) APPLICATION OF HOSPITALS PERMITTED UNDER LIS TO ALL SUBELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—Section 1860D–14(a)(1) of the Social Security Act (42 U.S.C. 1395w– 14(a)(1)) is amended in the matter before subparagraph (A), by inserting “or, beginning with 2012, paragraph (3)(E)” after paragraph (3)(D).

(b) ANNUAL INCREASE IN LIS RESOURCE TEST.—Section 1860D–14(a)(3)(E)(i) of such Act (42 U.S.C. 1395w–14(a)(3)(E)(i)) is amended—

(1) by striking “and” at the end of subclause (I);

(B) in subclause (II), by inserting “before 2012” after “subsequent year”; and

(C) by striking the period at the end of subclause (II) and inserting a semicolon;

(D) by inserting after subclause (II) the following new subclauses:

(III) for a subsequent year, the dollar amounts specified in this subclause (or subclause (III)) for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year; and

(E) in the last sentence, by inserting “or (IV)” after “subclause (II)”.

(b) APPLICATION OF LIS RESOURCE TEST UNDER MEDICARE SAVINGS PROGRAM.—Section 1922(p)(1)(C) of such Act (42 U.S.C. 1396d(p)(1)(C)) is amended—

(A) by striking “effective beginning with January 1, 2010” and inserting “effective for the period beginning with January 1, 2010, and ending with December 31, 2011”; and

(B) by inserting before the period at the end the following: “or, effective beginning with January 1, 2012, whose resources (as so determined) do not exceed the maximum resource level applied for the year under subparagraph (E) of section 1860D–14(a)(5) determined without regard to the life insurance policy exclusion provided under subparagraph (G) of such section) applicable to an individual or to the individual and the individual’s spouse (as the case may be).”.

(2) EFFECTIVE DATE.—The amendments made by this section shall apply to eligibility determinations for income-related premium subsidies and medicare cost-sharing furnished for periods beginning on or after January 1, 2012.
SEC. 1202. ELIMINATION OF PART D COST-SHARING FOR CERTAIN NON-INSTITUTIONALIZED FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.

(a) In General.—Section 1860D–14(a)(1)(D)(i) of the Social Security Act (42 U.S.C. 1395w–14(a)(1)(D)(i)) is amended—

(1) by striking “INSTITUTIONALIZED INDIVIDUALS.” and inserting “ELIMINATION OF COST-SHARING FOR CERTAIN FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—”;

(2) by adding at the end the following new subsections:

“(II) CERTAIN OTHER INDIVIDUALS.—In the case of an individual who is a full-benefit dual eligible individual and with respect to whom there has been a determination that but for the provision of home and community based care (whether under section 1915, 1917, or under a waiver under section 1115) the individual would require in-home care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded or care of a retroactively eligible third party, the Secretary shall—

(A) determine the amount of cost-sharing attributable to services furnished under the State plan under title XIX, the elimination and reduction of which would enable the individual to avoid a determination that the individual is institutionalized under the State plan as measured by quality ratings established under section 1860D–2(b)(2)(A) for the fiscal year ending with the fiscal year beginning in 2011; and

(B) subject to subparagraph (B)(i), on or before January 1, 2011, the Secretary shall report to the House of Representatives and the Senate, and the congressional committees with jurisdiction over health care, the following:

(i) the amount of cost-sharing attributable to services furnished under the State plan for covered prescription drug benefits available to individual’s under section 1860D–14(a)(1)(D)(i); and

(ii) the amount of cost-sharing attributable to services furnished under the State plan for covered prescription drug benefits available to individuals under section 1860D–14(a)(1)(D)(ii) and subparagraph (B)(ii).

(3) Certification of Income and Resources.—For purposes of applying this section—

(A) in the case of an individual who is a full-benefit dual eligible individual and with respect to whom there has been a determination that but for the provision of home and community based care (whether under section 1915, 1917, or under a waiver under section 1115) the individual would require in-home care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded or care of a retroactively eligible third party, the Secretary shall—

(i) determine the amount of cost-sharing attributable to services furnished under the State plan under title XIX, the elimination and reduction of which would enable the individual to avoid a determination that the individual is institutionalized under the State plan as measured by quality ratings established under section 1860D–2(b)(2)(A) for the fiscal year ending with the fiscal year beginning in 2011; and

(ii) on or before January 1, 2011, the Secretary shall report to the House of Representatives and the Senate, and the congressional committees with jurisdiction over health care, the following:

(I) the amount of cost-sharing attributable to services furnished under the State plan for covered prescription drug benefits available to individuals under section 1860D–14(a)(1)(D)(i); and

(II) the amount of cost-sharing attributable to services furnished under the State plan for covered prescription drug benefits available to individuals under section 1860D–14(a)(1)(D)(ii) and subparagraph (B)(ii).
(a) **SPECIAL ENROLLMENT PERIOD.**—Section 1860D–1(b)(3)(D) of the Social Security Act (42 U.S.C. 1395w–101(b)(3)(D)) is amended to read as follows:

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(3) (A) SUBSIDY ELIGIBLE INDIVIDUALS.—In the case of an individual (as determined by the Secretary of Health and Human Services) who is eligible for a special enrollment period described in paragraph (B) of section 1860D–14(a)(3) to be a subsidy eligible individual.
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(b) **AUTOMATIC ENROLLMENT.**—Section 1860D–1(b)(4) of the Social Security Act (42 U.S.C. 1395w–101(b)(4)) is amended by adding at the end the following new subparagraph:

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(4) (D) The extent to which providers under Parts A and B of title XVIII of the Social Security Act, MA organizations offering Medicare Advantage plans under part C of such title and PDP sponsors of a prescription drug plan under part D of such title utilize, offer, or make available language services for beneficiaries with limited English proficiency.
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(G) The nature and type of language services provided by States under title XIX of the Social Security Act (including the costs of providing interpreters who work as independent contractors who work for agencies that provide on-site interpretation, pursuant to which such interpreters could directly bill Medicare for the services provided in support of physician office services for an LEP Medicare patient.

(H) How each of options described in a previous paragraph would be funded and how such funding would affect physician payments, a physician’s practice, and beneficiaries costs.

(I) The extent to which interpreters and translators providing services to Medicare beneficiaries under title XVIII of such Act are trained or accredited.

(J) Providing language services including such factors as—

(A) the type of language services provided (such as in-person, telephonic, video interpretation);

(B) the methods and costs of providing language services (including the costs of providing language services with internal staff or through contract with external independent contractors or agencies, or both);

(C) the methods and costs of providing language services (including the costs of providing language services with internal staff);

(D) providing services for languages not frequently encountered in the United States; and

(E) providing services in rural areas.

4. **REPORT.**—The Secretary shall submit a report on the study conducted under subsection (a) to appropriate committees of Congress not later than 12 months after the date of the enactment of this Act.

5. **EXEMPTION FROM PAPERWORK REDUCTION ACT.**—Chapter 35 of title 44, United States Code (commonly known as the “Paperwork Reduction Act”), shall not apply for purposes of carrying out this subsection.

6. **AUTHORIZATION OF APPROPRIATIONS.**—The Secretary shall provide for the transfer, from the Federal Medical Care Trust Fund under section 1411 of the Social Security Act (42 U.S.C. 1395t) of $2,000,000 for purposes of carrying out this subsection.

7. **HEALTH PLANS.**—Section 1375(g)(1) of the Social Security Act (42 U.S.C. 1395w–27(g)(1)) is amended:

(A) by striking “or” at the end of subparagraph (B); and

(B) by adding “and” at the end of subparagraph (G); and

(C) the feasibility of Medicare contracting directly with agencies that provide off-site interpretation including telephonic and video interpretation pursuant to which such interpreters could directly bill Medicare for the services provided in support of physician office services for an LEP Medicare patient.

8. **DEMONSTRATION TO PROMOTE ACCESS FOR MEDICARE BENEFICIARIES WITH LIMITED ENGLISH PROFICIENCY BY PROVIDING REIMBURSEMENT FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES.**—(a) **IN GENERAL.**—Not later than 6 months after the date of the completion of the study described in section 1221(a) of this Act, the Secretary, acting through the Centers for Medicare & Medicaid Services and the Center for Medicare & Medicaid Innovation established under section 1115A of the Social Security Act (as added by section 1907) and consistent with the applicable provisions of such section, shall carry out a demonstration program under which the Secretary shall award not fewer than 24 3-year grants to eligible Medicare service providers (as described in subsection (b)(1)) to improve effective communication between such providers and Medicare beneficiaries who are living in communities where racial and ethnic minorities, including populations that face language barriers, are underserved with respect to such services. In designing and carrying out the demonstration the Secretary shall take into consideration of the study conducted under section 1221(a) of this Act and, as appropriate, the distribution of grants so as to better target Medicare beneficiaries who are in the greatest need of language services. The Secretary shall not authorize a grant larger than $500,000 over three years for any grantee.

(b) **Eligibility.**—(1) **ELIGIBILITY.**—To be eligible to receive a grant under subsection (a) an entity shall—

(A) be—

(i) a provider of services under part A of title XVIII of the Social Security Act;

(ii) a service provider under part B of such title;

(iii) a part C organization offering a Medicare care plan under part C of such title; or

(iv) a PDP sponsor of a prescription drug plan under part D of such title; and

(B) prepare and submit to the Secretary an application, at such time, in such manner, and accompanied by such additional information that the Secretary may require.

(2) **PRIORITY.**—(A) DISTRIBUTION.**—To the extent feasible, in awarding grants under this section, the Secretary shall award grants—

(i) at least 6 grants to providers of services described in paragraph (1)(A)(i); and

(ii) at least 6 grants to service providers described in paragraph (1)(A)(ii); and

(iii) at least 6 grants to organizations described in paragraph (1)(A)(iii); and

(iv) at least 6 grants to organizations described in paragraph (1)(A)(iv);

(B) FOR COMMUNITY ORGANIZATIONS.**—The Secretary shall give priority to applicants that have developed partnerships with community organizations and with agencies with experience in language access.

(C) **VARIATION IN GRANTEES.**—The Secretary shall also ensure that the grantees under this section represent, among other factors—

(i) different types of language services provided and of service providers and organizations under parts A through D of title XVIII of such Act;

(ii) in at least 2 geographic regions, as defined by the Secretary; and

(iii) in at least 2 large metropolitan statistical areas with diverse populations.

(2) **USE OF FUNDS.**—(A) **IN GENERAL.**—A grantee shall use grant funds received under this section to pay for...
the provision of competent language services to Medicare beneficiaries who are limited English proficient. Competent interpreter services may be provided through on-site interpreter services, off-site interpreter services, telephonic interpretation or direct provision of health care or health care related services by a bilingual health care provider. A grantee may use grant funds to pay for competent translation services. A grantee may use up to 10 percent of the grant funds to pay for costs associated with the provision of competent language services and for reporting required under subsection (e).

(2) Other requirements.—Grantees that are part C organizations or PDP sponsors must ensure that their network providers receive at least 50 percent of the grant funds to pay for the provision of competent language services to Medicare beneficiaries who are limited English proficient, including physicians and pharmacies.

(3) Determination of payments for language services.—Payments to grantees shall be calculated based on the estimated numbers of limited English proficient Medicare beneficiaries in a grantee’s service area utilizing language services.

(a) Data on the numbers of limited English proficient individuals who speak English less than "fluently" or who are English proficient, bilingual staff or competent interpreter or translation services shall be provided to the Secretary.

(b) The grantee's own data on the availability of language services provided through the demonstration project.

(c) The types of language services provided and costs associated with the provision of language services.

(d) The language spoken by the beneficiaries in the grantee's service area.

(e) The number of language services providers.

(f) An estimate of the number of beneficiaries who spoke a language other than English.

(g) The number of beneficiaries who received language services.

(h) The number of beneficiaries who were not able to receive language services.

(i) The number of beneficiaries who were able to receive language services.

(j) The percentage of beneficiaries who were able to receive language services.

(k) The number of beneficiaries who were not able to receive language services.

(l) The number of beneficiaries who were able to receive language services.

(m) The number of beneficiaries who were not able to receive language services.

(n) The number of beneficiaries who were able to receive language services.

(o) The number of beneficiaries who were not able to receive language services.

(p) The number of beneficiaries who were able to receive language services.

(q) The number of beneficiaries who were not able to receive language services.

(r) The number of beneficiaries who were able to receive language services.

(s) The number of beneficiaries who were not able to receive language services.

(t) The number of beneficiaries who were able to receive language services.

(u) The number of beneficiaries who were not able to receive language services.

(v) The number of beneficiaries who were able to receive language services.

(w) The number of beneficiaries who were not able to receive language services.

(x) The number of beneficiaries who were able to receive language services.

(y) The number of beneficiaries who were not able to receive language services.

(z) The number of beneficiaries who were able to receive language services.

(A) primary language data are collected for recipients of language services and are consistent with standards developed under section 1709(b)(3)(B)(v) of the Public Health Service Act, as added by section 2402 of this Act, to the extent such standards are available upon the initiation of the demonstration.

(B) consistent with the privacy protections provided under the regulations promulgated pursuant to section 294(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note), if the recipient of language services is a minor or is incapacitated, the primary language of the patient or legal guardian is collected and utilized.

(3) The types of language services provided (such as provision of services directly in non-English language by a bilingual health care provider or use of an interpreter).

(4) Type of interpretation (such as in-person, telephonic, or video interpretation).

(5) The methods of providing language services (such as on-site, off-site, or through external independent contractors or agencies).

(6) The length of time for each interpretation encounter.

(7) The cost of providing language services (which may be actual or estimated, as determined by the Secretary).

(8) An account of the training or accreditation of interpreters, translators providing services under this demonstration.

(9) No cost sharing.—Limited English proficient Medicare beneficiaries shall not have to pay cost-sharing or co-pays for language services provided through this demonstration program.

(10) Exception and report.—The Secretary shall conduct an evaluation of the demonstration program under this section and shall submit to the appropriate committees of the Senate and of the House an evaluation report within 3 years after the completion of the program. The report shall include the following:

(a) An analysis of the patient outcomes and costs of furnishing care to the limited English proficient Medicare beneficiaries participating in the project as compared to furnish care to beneficiaries from limited English proficient Medicare beneficiaries not participating.

(b) The effect of delivering culturally and linguistically appropriate services on beneficiary access to, utilization of services, efficiency and cost-effectiveness of health care delivery, patient satisfaction, and health outcomes.

(c) The extent to which bilingual staff, interpreters, and translators providing services which demonstrated or accredited and the nature of accreditation or training needed by type of provider, service, or other category as determined by the Secretary to ensure the provision of high-quality interpretation, translation, or other language services to Medicare beneficiaries if such services are expanded pursuant to this section.

(d) Recommendations, if any, regarding the extension of such project to the entire Medicare program.

(11) Accreditation or training for providers of interpretation, translation or language services in Medicare.—

(A) In general.—

(i) Designation of standards.—If the Secretary, pursuant to section 1907(c) of this Act, expands the model initially developed through the demonstration program established under this section, the Secretary shall use the results of the study under section 1211 and the demonstration under this section to designate standards for training or accreditation. The Secretary may designate one or more training or accreditation organizations, as appropriate for the nature and type of language services, to provide training or accreditation for certain languages, including languages of lesser diffusion. The Secretary must ensure that the accepted training or accreditation providers are not available in all languages for which payment may be initiated, the Secretary shall not designate standards for training or accreditation for certain languages, including languages of lesser diffusion. The Secretary must ensure that the accepted training or accreditation providers are not available in all languages.

(ii) Standards for training or accreditation.—The Secretary shall ensure that training or accreditation programs are acceptable to training or accreditation for certain languages, including languages of lesser diffusion. The Secretary must ensure that the accepted training or accreditation providers are not available in all languages.

(iii) The determination that the interpreter is proficient and able to communicate information and instructions in the language for which interpreting is needed; and

(iv) An attestation from the interpreter to comply with and adhere to the role of an interpreter as defined by the National Council on Care at Home and community Health and the English standards developed under section 1907(c)(5) of this Act.

(B) Alternatives to training or accreditation.—If the Secretary designates one or more training or accreditation organizations but determines that accreditation is not available in all languages for which payment may be initiated, the Secretary shall provide payment for interpreting services by trained or accredited language services providers.

(C) Modifications, add-ons, and other forms of payment.—If the Secretary decides that modifications, add-ons, or other forms of payment may be made for the provision of services directly by bilingual providers, the Secretary shall designate standards to ensure the competency of such providers delivering bilingual care services.

(D) Consultation with stakeholders and considerations for accreditation or training.—

(i) Consultation.—In designating accreditation or training requirements under this subsection, the Secretary shall consult with
patients, providers, organizations that advocate on behalf of limited English proficient individuals, and other individuals or entities determined appropriate by the Secretary.

(2) REQUIREMENTS.—The Secretary, in designating any training or accreditation requirements under this section, the Secretary shall consider, as appropriate:

(i) standards for qualifications of health care interpreters who interpret infrequently encountered languages;

(ii) standards for qualifications of health care interpreters who interpret in languages of lesser diffusion;

(iii) standards for training of interpreters;

and

(iv) standards for continuing education of interpreters.

(1) GENERAL PROVISIONS.—Nothing in this section shall be construed to limit otherwise existing obligations of recipients of Federal financial assistance under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000(d) et seq.) or any other statute.

(i) APPROPRIATIONS.—There are appropriated to carry out this section, in equal parts from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, $15,000,000 for each fiscal year of the demonstration program.

SEC. 1223. IOM REPORT ON IMPACT OF LANGUAGE SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall enter into an arrangement with the Institute of Medicine entitled to receive funding under this Act, the applicable appropriation to carry out this section, and such other funds as may be appropriated to carry out this section, in equal parts from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, $15,000,000 for each fiscal year of the demonstration program.

(b) CONTENTS.—Such report shall include—

(1) BILINGUAL.—The term "bilingual" with respect to an individual means an individual who speaks a primary language other than English and who cannot speak, read, write or understand the English language at a level that permits the individual to effectively communicate with clinical or nonclinical staff at an entity providing health care or health care related services.

(2) MEDICARE PROGRAM.—The term "Medicare beneficiary" means an individual entitled to benefits under part A of title XVIII of the Social Security Act, and entitled to receive such benefits.

(3) MEDICARE PROGRAM.—The term "Medicare beneficiary" means an individual entitled to receive benefits under part A of title XVIII of the Social Security Act for the complete package of benefits under such part for purposes of receiving coverage of such drugs under this part.

(4) EXTENSION OF PROVISIONS TO OTHER DRUGS.—Section 1836 of such Act (42 U.S.C. 1395y(b)(1)(C)) is amended by adding at the end the following new sentence: "With respect to immunosuppressive drugs furnished on or after the date of the enactment of the Affordable Health Care for America Act, this subparagraph shall be applied without regard to any time limitation.".

(b) MEDICARE COVERAGE FOR ESRD PATIENTS.—Section 1881 of such Act is further amended—

(i) by striking "November 8, 1996" and inserting "January 1, 2011";

(ii) by striking "December 31, 2009" and inserting "December 31, 2011".

SEC. 1232. EXTENDED MONTHS OF COVERAGE OF IMMUNOSUPPRESSIVE DRUGS FOR KIDNEY TRANSPLANT PATIENTS AND OTHER RENAL DIALYSIS PROVIDERS.

(a) PROVISION OF APPROPRIATE COVERAGE.—Section 1833(g)(5) of the Social Security Act (42 U.S.C. 1395l(g)(5)), as amended by section 226A(b)(2) of the Affordable Care Act, is amended by adding at the end the following new sentence: "With respect to immunosuppressive drugs furnished on or after the date of the enactment of the Affordable Health Care for America Act, this subparagraph shall be applied without regard to any time limitation.

(ii) by striking "November 8, 1996" and inserting "January 1, 2011";
professionals across the continuum of care.’’

Regarding life sustaining treatment, is signed
communicates the individual’s preferences re-

section no more than once every 5 years un-

will; and

is—

treatment or similar orders, in States where

physician orders regarding life sustaining

such services and supports that are available

palliative care and hospice, and benefits for

proxy and of the continuum of end-of-life

the role and responsibilities of a health care

consultation’ means an optional consulta-

the term ‘voluntary advance care planning care planning
consultation’ means an optional consulta-

payer advance care planning consultation means an optional consulta-

physician’s preferences regardless of whether or not covered under such section;’’; and

(2) in paragraph (7), by striking ‘‘or (K)’’ and inserting ‘‘(K), or (P)’’.

(2) by adding the following new subparagraph:

(FH) voluntary advance care planning consultation (as defined in para-

subject to paragraphs (3) and (4), the term ‘voluntary advance care planning consultation’ means an optional consulta-

between the individual and a practition-

A practitioner described in paragraph (2) regarding advance care planning. Such consultation may include the following, as specified by the Secretary:

‘‘(A) An explanation by the practitioner of the role and responsibilities of a health care proxy and of the continuum of end-of-life care planning consultation means an optional consulta-

(b) by adding paragraph (r1):

‘‘(A) a physician (as defined in subsection

(b) another health care professional (as specified by the Secretary and who has the authority under State law to sign orders for life sustaining treatment, such as a nurse practitioner or physician assistant).

(3) An individual may receive the vol-

untary advance care planning consultation provided for under this sub-

section no more than once every 5 years un-

less there is a significant change in the health or health-related condition of the individual.

(4) For purposes of this section, the term ‘‘order regarding life sustaining treatment’’ means, with respect to an individual, an ac-

tional medical order relating to the treat-

ment of that individual that effectively com-

municates the individual’s preferences re-

garding the manner of such treatment, is signed and dated by a practitioner, and is in a form that permits it to be followed by health care professionals across the continuum of care.’’.

(b) Construction.—The voluntary advance care planning consultation described in section 1861(hhh) of the Social Security Act, as added by subsection (a), shall be completely optional.

(1) require an individual to complete an ad-

(directive, an order for life sustaining treatment, or other advance care planning documentation

(2) require an individual to consent to re-

strictions on the amount, duration, or scope of medical benefits an individual is entitled to receive under this title.

or (3) encourage the promotion of suicide or assisted suicide.

(c) Payment.—Section 1848(j)(3) of such Act (42 U.S.C. 1395w-4(j)(3)) is amended by insert-

‘‘(2)FF,’’ after ‘‘(2)(EE),’’.

(2) by adding at the end the following new subparagraph:

‘‘(FF) voluntary advance care planning consultation (as defined in para-

subject to paragraphs (3) and (4), the term ‘voluntary advance care planning consultation’ means an optional consulta-

between the individual and a practition-

A practitioner described in paragraph (2) regarding advance care planning. Such consultation may include the following, as specified by the Secretary:

‘‘(A) An explanation by the practitioner of the role and responsibilities of a health care proxy and of the continuum of end-of-life care planning consultation means an optional consulta-

(b) by adding paragraph (r1):

‘‘(A) a physician (as defined in subsection

(b) another health care professional (as specified by the Secretary and who has the authority under State law to sign orders for life sustaining treatment, such as a nurse practitioner or physician assistant).

(3) An individual may receive the vol-

untary advance care planning consultation provided for under this sub-

section no more than once every 5 years un-

less there is a significant change in the health or health-related condition of the individual.

(4) For purposes of this section, the term ‘‘order regarding life sustaining treatment’’ means, with respect to an individual, an ac-

tional medical order relating to the treat-

ment of that individual that effectively com-

municates the individual’s preferences re-

garding the manner of such treatment, is signed and dated by a practitioner, and is in a form that permits it to be followed by health care professionals across the continuum of care.’’.

(b) Construction.—The voluntary advance care planning consultation described in section 1861(hhh) of the Social Security Act, as added by subsection (a), shall be completely optional.

(1) require an individual to complete an ad-

(directive, an order for life sustaining treatment, or other advance care planning documentation

(2) require an individual to consent to re-

strictions on the amount, duration, or scope of medical benefits an individual is entitled to receive under this title.

or (3) encourage the promotion of suicide or assisted suicide.

(c) Payment.—Section 1848(j)(3) of such Act (42 U.S.C. 1395w-4(j)(3)) is amended by insert-

‘‘(2)FF,’’ after ‘‘(2)(EE),’’.

(2) by adding at the end the following new subparagraph:

‘‘(FF) voluntary advance care planning consultation (as defined in para-

subject to paragraphs (3) and (4), the term ‘voluntary advance care planning consultation’ means an optional consulta-

between the individual and a practition-

A practitioner described in paragraph (2) regarding advance care planning. Such consultation may include the following, as specified by the Secretary:

‘‘(A) An explanation by the practitioner of the role and responsibilities of a health care proxy and of the continuum of end-of-life care planning consultation means an optional consulta-

(b) by adding paragraph (r1):

‘‘(A) a physician (as defined in subsection

(b) another health care professional (as specified by the Secretary and who has the authority under State law to sign orders for life sustaining treatment, such as a nurse practitioner or physician assistant).

(3) An individual may receive the vol-

untary advance care planning consultation provided for under this sub-

section no more than once every 5 years un-

less there is a significant change in the health or health-related condition of the individual.

(4) For purposes of this section, the term ‘‘order regarding life sustaining treatment’’ means, with respect to an individual, an ac-

tional medical order relating to the treat-

ment of that individual that effectively com-

municates the individual’s preferences re-

garding the manner of such treatment, is signed and dated by a practitioner, and is in a form that permits it to be followed by health care professionals across the continuum of care.’’.

(b) Construction.—The voluntary advance care planning consultation described in section 1861(hhh) of the Social Security Act, as added by subsection (a), shall be completely optional.

(1) require an individual to complete an ad-

(directive, an order for life sustaining treatment, or other advance care planning documentation

(2) require an individual to consent to re-

strictions on the amount, duration, or scope of medical benefits an individual is entitled to receive under this title.

or (3) encourage the promotion of suicide or assisted suicide.
the beneficiary may have with respect to the medical care of the condition involved and to assist the beneficiary in thinking through how their preferences and concerns relate to their physical care.

(2) PAYMENT FOR FOLLOW-UP COUNSELING VISIT.—The Secretary shall establish procedures for making payments for such counseling visits to Medicare beneficiaries under the program. Such procedures shall provide for the establishment—

(A) of a code (or codes) to represent such services;

(B) of a single payment amount for such service that includes the professional time of the health provider and a portion of the reasonable costs of the infrastructure of the eligible provider such as would be made under the applicable payment systems to that provider for similar covered services;

(C) Costs of Aims.—An eligible provider participating in the program shall be responsible for the costs of selecting, purchasing, and incorporating such patient decision aids into the provider’s practice, and reporting data on quality and outcome measures under the program.

(e) FUNDING.—The Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1861 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the program.

(D) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq. and 1395 et seq.) as may be necessary for the purpose of carrying out the program.

(g) REPORT.—Not later than 12 months after the date of completion of the program, the Secretary shall submit to Congress a report on such program, together with recommend legislation and administrative action as the Secretary determines to be appropriate. The final report shall include an evaluation of the impact of the use of the program on health quality, utilization of health care services, and on improving the quality of life of such beneficiaries.

(b) Definitions.—In this section:

(1) ELIGIBLE PROVIDER.—The term ‘‘eligible provider’’ means the following:

(A) A primary care practice.

(B) A specialty practice.

(C) A multispecialty group practice.

(D) A hospital.

(E) A rural health clinic.

(F) A Federally qualified health center (as defined in section 1861(aa)(4) of the Social Security Act (42 U.S.C. 1395xvaa(4)).

(G) An integrated delivery system.

(H) A State cooperative entity that includes the State government and at least one other health care provider which is set up for the purpose of providing shared decision making and patient decision aids.

(2) PATIENT DECISION AIDS.—The term ‘‘patient decision aids’’ means a collaborative process between patient and clinician that engages the patient in decision making, provides patients with information about treatment options, and facilitates the incorporation of patient preferences and values into the medical plan.

(3) SHARED DECISION MAKING.—The term ‘‘shared decision making’’ means a collaborative process between patient and clinician that facilitates the incorporation of patient preferences and values into the medical plan.
(ii) LIMITATION.—The Secretary shall limit incentive payments to each qualifying ACO under this paragraph as necessary to ensure that the aggregate expenditures with respect to applicable beneficiaries for such ACOs under this title inclusive of incentive payments would not exceed the amount that the Secretary estimates would be expended for such ACO for such beneficiaries for such year if the pilot program were not implemented, as estimated by the Secretary.

(3) OTHER PAYMENT MODELS.—

(A) In the case of a partial capitation model described in subparagraph (B), the Secretary may develop other payment models that meet the goals of this pilot program to improve quality and efficiency in the delivery of services.

(B) NO ADDITIONAL PROGRAM EXPENDITURES.—Subparagraph (B) of paragraph (2) shall apply to a payment model under subparagraph (A) to the extent such payment model replaces the payments described in this subparagraph.

(4) QUALIFYING ACO FOR THE PROGRAM.—In this section, the term ‘qualified ACO’ means—

(A) a public entity or a combination of public entities, including a public health system, or a private entity in coordination with a public entity or a combination of public entities, or both, with a demonstrated ability to improve quality and reduce costs of care for the population covered by the entity or the entities,

(B) which has demonstrated experience in managing the performance of a large population of beneficiaries, or

(C) that agrees to participate in the pilot program.

(5) ADMINISTRATION.—Chapter 35 of title 44 United States Code shall not apply to this section.

(6) EVALUATION; MONITORING.—

(C) A pilot agreement and is consistently meeting performance targets described in subsection (g), the Secretary may extend the duration of the agreement for such ACO under the pilot program as the Secretary determines appropriate.

(D) decisions about the extension of the program under subsection (b), expansion of the program under subsection (i) or extensions under subsections (j) or (k).

(7) TERMINATION.—The Secretary may terminate an agreement with a qualifying ACO under the pilot program if such agreement—

(A) is terminated by the Secretary; or

(B) the selection of qualifying ACOs for the pilot program.

(8) MONITORING.—The Secretary shall periodically rebase the base expenditure amount described in clause (ii).

(C) A partial capitation model described in this paragraph (in this paragraph referred to as a ‘partial capitation model’) is a model in which a specified percentage of payment would be made to an ACO recognizing that the ACO will share in the gains or losses that result from the ACO’s performance.

(D) the expansion of the program under subsection (i) or extensions under subsections (j) or (k).

(E) decisions about the extension of the program under subsection (b), expansion of the program under subsection (i) or extensions under subsections (j) or (k).

(F) administrative provisions with respect to whether savings have been achieved and the amount of savings;
and to targeted high need beneficiaries (as defined in subsection (c)(1)(C)).

(2) SCOPE.—Subject to subsection (g), the Secretary shall set specific goals for the number of practices and communities, and the number of patients served, under the pilot program in the initial tests to ensure that the pilot program is of sufficient size and scope to afford the practice the opportunity to evaluate the feasibility and advisability of reimbursing qualified patient-centered medical homes for furnishing medical home services' means services that—

(i) all the requirements of this section are met; and

(ii) the physician assistant is acting in a manner that is consistent with State law.

(4) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—

(A) Nothing in this section shall be construed as preventing a physician assistant from participating in a patient centered medical home so long as—

(1) all the requirements of this section are met; and

(2) the physician assistant is acting in a manner that is consistent with State law.

(5) FUNDING.—For purposes of administration and carrying out the pilot program, other than for payments for items and services furnished under this title and incentive payments under subsection (c), in addition to funds made available under subsection (d)(1), the Secretary may enter into an agreement with an entity to provide health care items or services under the pilot program, or with an entity to administer the program, under such terms and conditions as the Secretary deems appropriate.

(6) NO DUPLICATION IN PAYMENTS TO PHYSICIANS IN MULTIPLE PILOTS.—The Secretary shall not make payments under this section to any physician group that is paid under section 1866A of this title under the physician group practice demonstration pursuant to section 1866A as a year for which an incentive payment is made under such section, as long as the requirements of the demonstration pursuant to section 1866A meets the criteria under subsection (b)(2).

(k) ADDITIONAL PROVISIONS.—

(1) AUTHORITY FOR SEPARATE INCENTIVE ARRANGEMENTS.—The Secretary may create separate incentive arrangements (including using multiple years of data, varying thresholds, varying shared savings amounts, and varying shared savings limits) for different categories of qualifying ACOs to reflect variation in average annual attributable expenditures and other matters the Secretary deems appropriate.

(2) ENCOURAGEMENT OF PARTICIPATION OF SMALLER ORGANIZATIONS.—In order to encourage the participation of smaller accountable care organizations under the pilot program, the Secretary may limit a qualifying ACO's exposure to high cost patients under the program.

(3) INVOLVEMENT IN PRIVATE PAYER AND OTHER THIRD PARTY ARRANGEMENTS.—The Secretary shall give preference to ACOs who are participating in similar arrangements with other payers.

(4) ANTIDISCRIMINATION LIMITATION.—The Secretary shall not enter into an agreement with an entity to provide health care items or services under the pilot program, or with an entity to administer the program, under such terms and conditions as the Secretary deems appropriate, there are sufficient safeguards that it will not deny, limit, or condition the coverage or provision of benefits under the program, for individuals eligible to be enrolled under such program, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

(5) FUNDING.—For purposes of administration and carrying out the pilot program, other than for payments for items and services furnished under this title and incentive payments under subsection (c), in addition to funds made available under subsection (d)(1), the Secretary may enter into an agreement with an entity to provide health care items or services under the pilot program, or with an entity to administer the program, under such terms and conditions as the Secretary deems appropriate.
(D) AMOUNT OF PAYMENT.—In determining the amount of such fee, the Secretary shall consider the following:

(i) The clinical work and practice expenses provided for the medical home services provided by the independent patient-centered medical home (such as providing increased access, care coordination, population disease management, and teaching self-care skills for managing chronic illnesses) for which payment is not made under this title as of the date of the enactment of this section.

(ii) Allow for differential payments based on capabilities of the independent patient-centered medical home.

(iii) Use appropriate risk-adjustment in determining the amount of the per beneficiary per month payment under this paragraph that ensures that higher risk payments are made for higher risk beneficiaries.

(iv) Encouraging participation of variety of practices.—The pilot program under this subsection shall be designed to include the participation of physicians in practices with fewer than 10 full-time equivalent physicians in large practices, particularly in underserved and rural areas, as well as federally qualified health centers, and rural health centers.

(v) COMMUNITY-BASED MEDICAL HOME MODEL.—

(1) IN GENERAL.—

(A) PAYMENT FOR PAYMENTS.—Under the community-based medical home model under this subsection (in this section referred to as the ‘CBMH model’), the Secretary shall make payments for the furnishing of medical home services through a community-based medical home (as defined in paragraph (5)(B)) pursuant to paragraph (5)(B) for beneficiaries.

(B) COMMUNITY-BASED MEDICAL HOME DEFINED.—In this section, the term ‘community-based medical home’ means a nonprofit community-based or State-based organization or a State that is certified under paragraph (2) as meeting the following requirements:

(i) The organization provides beneficiary medical home services.

(ii) The organization provides medical home services under the supervision of, and in close collaboration with, the primary care or principal care physician, nurse practitioner, or physician assistant designated by the beneficiary or her community-based medical home provider.

(iii) The organization employs community health workers, including nurses or other professional practitioners, paraprofessionals, or other persons as determined appropriate by the Secretary, that assist the primary or principal care physician, nurse practitioner, or physician assistant in chronic care management activities such as teaching self-care skills for managing chronic illnesses, transitional care services, care plan setting, counseling, medication therapy management services for patients with multiple chronic diseases, or help beneficiaries access the health care and community-based resources in their local geographic area.

(iv) The organization meets such other requirements as the Secretary may specify.

(2) QUALIFICATION PROCEDURE FOR COMMUNITY-BASED MEDICAL HOMES.—The Secretary shall establish a process to provide for the review and qualification of community-based medical homes pursuant to criteria established by the Secretary.

(3) DURATION.—The pilot program for community-based medical homes under this subsection shall continue no later than 2 years after the date of the enactment of this section. Each demonstration site under the pilot program shall operate for a period of up to 5 years after the initial implementation phase, without regard to the receipt of an initial implementation funding under paragraph (6).

(4) PREFERENCE.—In selecting sites for the CBMH model, the Secretary shall give preference to applications which seek to eliminate disparities as defined in section 317I of the Public Health Service Act and may give preference to any of the following:

(A) Applications that propose to coordinate services under this title for chronically ill beneficiaries who rely, for primary care, on small physician or nurse practitioner practices, federally qualified health centers, rural health clinics, or other settings with limited resources and scope of services.

(B) Applications that include other third-party payers that furnish medical home services for chronically ill patients covered by such third-party payers.

(C) Applications from States that propose to use the medical home model to coordinate health care services for:

(i) Individuals enrolled under this title;

(ii) Individuals enrolled under title XIX; and

(iii) Full-benefit dual eligible individuals (as defined in section 1935(c)(6)), with chronicities across a variety of health care settings.

(5) PAYMENTS.—

(A) ESTABLISHMENT OF METODOLOGY.—The Secretary shall establish a methodology for the payment for medical home services furnished under the CBMH model.

(B) PER BENEFICIARY PER MONTH PAYMENTS.—Under such payment methodology, the Secretary shall make two separate monthly payments for each beneficiary who consents to receive medical home services through such medical home, as follows:

(i) PAYMENT TO COMMUNITY-BASED ORGANIZATION.—One monthly payment to a community-based or State-based organization or State.

(ii) PAYMENT TO PRIMARY OR PRINCIPAL CARE PRACTICE.—One monthly payment to the primary or principal care practice for such beneficiary.

(C) PROSPECTIVE PAYMENT.—The payments under subparagraph (B) shall be paid on a prospective basis.

(D) AMOUNT OF PAYMENT.—In determining the amount of such payment under subparagraph (B), the Secretary shall consider the following:

(i) The clinical work and practice expenses involved in providing the medical home services provided by the primary or principal care practice (such as providing increased access, care coordination, planning, population disease management, and teaching self-care skills for managing chronic illnesses) for which payment is not made under this title as of the date of the enactment of this section.

(ii) Use appropriate risk-adjustment in determining the amount of the per beneficiary per month payment under this paragraph.

(iii) In the case of the models described in subparagraphs (B) and (C) of paragraph (4), the Secretary may determine an appropriate payment amount.

(6) INITIAL IMPLEMENTATION FUNDING.—The Secretary may make available initial implementation funding to a nonprofit community based or State-based organization or State that is participating in the pilot program under this subsection. Such organization shall provide the Secretary with a detailed implementation plan that includes the following:

(A) A demonstration that the Secretary shall select a territory of the United States as one of the locations in which to implement the pilot program under this subsection, unless no organization in a territory is able to comply with the requirements under paragraph (1)(B).

(7) EXPANSION OF PROGRAM.—

(a) IN GENERAL.—Subject to the results of the evaluation under paragraph (1) and subparagraph (B), the Secretary may make payments for the furnishing of medical home services to an individual.

(b) Certification of models or States.—In determining the amount of, payment for medical visits made under this title as of the date of the enactment of this section.

(8) ADMINISTRATIVE PROVISIONS.—

(a) No duplication in payments for individuals in medical homes.—During any month, the Secretary may not make payments under this section for more than one model or through more than one medical home under any model for the furnishing of medical home services to an individual.

(b) Effect on payment for medical visits.—Payments made under this section are in addition to, and have no effect on the payment for medical visits made under this title.

(c) Administrative.—Chapter 35 of title 44, United States Code shall not apply to this section.

(d) No duplication in physician pilot participation.—The Secretary shall not...
make payments to an independent or community based medical home both under this section and section 166E or 166G, unless the pilot program under this section has been implemented, or a permanent basis under subsection (e)(3).

(5) Waiver.—The Secretary may waive such provisions of this title and title XI of the Social Security Act that the Secretary determines necessary in order to implement this section.

(g) Funding.—

(1) Operational Costs.—For purposes of administering and carrying out the pilot program (including the design, implementation, technical assistance for and evaluation of such program), in addition to funds otherwise available, there shall be transferred from the Federal Supplementary Medical Insurance Trust Fund under section 1841 to the Secretary for the Centers for Medicare & Medicaid Services, from the Federal Supplementary Medical Insurance Trust Fund account $6,000,000 for each of fiscal years 2010 through 2014. Amounts appropriated under this paragraph for a fiscal year shall be available until expended.

(2) Patient-Centered Medical Home Services.—In addition to funds otherwise available, there shall be available to the Secretary for Medicare & Medicaid Services, from the Federal Supplementary Medical Insurance Trust Fund under section 1841:

(A) $200,000,000 for each of fiscal years 2010 through 2014 for payments for medical home services under subsection (c)(3); and

(B) $15,000,000 for each of fiscal years 2012 through 2016, for payments under subsection (d)(5).

Amounts available under this paragraph for a fiscal year shall be available until expended.

(3) Initial Implementation.—In addition to funds otherwise available, there shall be available to the Secretary for the Centers for Medicare & Medicaid Services, from the Federal Supplementary Medical Insurance Trust Fund under section 1841, $2,500,000 for each of fiscal years 2010 through 2012, under subsection (d)(6). Amounts available under this paragraph for a fiscal year shall be available until expended.

(h) Treatment of TRHCA Medicare Medical Home Demonstration Funding.—

(1) In addition to funds otherwise available for payment of medical home services under such subsections, the amount payable under such subsections shall not be taken into account in determining the amounts that the Secretary determines necessary in subsection (c) for a payment under such subsections.

(2) Effect of Section 1848(m)(5)(B) of such Act (42 U.S.C. 1395w–4(m)(5)(B)) is amended by inserting “(p),” after “(m).”.

(i) Section 1848(v)(1)(B)(iv) of such Act (42 U.S.C. 1395w–4(o)(1)(B)(iv)) is amended by inserting “primary care” before “health professional shortage area.”

SEC. 1304. INCREASED MEDICARE PAYMENT RATE FOR CERTIFIED NURSE-MIDWIVES.

(a) In General.—Section 1335(a)(1)(K) of the Social Security Act (42 U.S.C. 1395l(a)(1)(K)) is amended by striking “(but in no event and all that follows through “performed by a physician”).

(b) Effective Date.—The amendment made by subsection (a) shall apply to services furnished on or after January 1, 2011.

SEC. 1305. COVERAGE AND WAIVER OF COST-SHARING FOR PREVENTIVE SERVICES.

(a) Medicare Covered Preventive Services Defined.—Section 1381 of the Social Security Act, (42 U.S.C. 1395w–29) is amended by inserting “1395l(m)” in place of “1395l(k)” (as defined in subsection (u)) in the first place where such term appears after paragraph (3).

(b) Effective Date.—If the provisions of this subsection shall be taken into account in applying subsection (m) or (u) and any payment under such subsections shall not be taken into account in computing payments under such subsection:

(2) Section 1848(m)(5)(B) of such Act (42 U.S.C. 1395w–4(m)(5)(B)) is amended by inserting “(p),” after “(m).”.

(3) Section 1848(v)(1)(B)(iv) of such Act (42 U.S.C. 1395w–4(o)(1)(B)(iv)) is amended by inserting “primary care” before “health professional shortage area.”

SEC. 1306. INCREASED MEDICARE PAYMENT RATE FOR CERTIFIED NURSE-MIDWIVES.

(a) In General.—Section 1335(a)(1)(K) of the Social Security Act (42 U.S.C. 1395l(a)(1)(K)) is amended by striking “(but in no event and all that follows through “performed by a physician”).

(b) Effective Date.—The amendment made by subsection (a) shall apply to services furnished on or after January 1, 2011.
is computed as a percent of less than 100 percent of an actual charge, fee schedule rate, or other rate, such percentage shall be increased to 100 percent.

(b) Prevention for Sigmoidoscopies and Colonoscopies.—Section 1383(d) of such Act (42 U.S.C. 1395m(d)) is amended—

(1) in paragraph (2)(C), by amending clause (ii) to read as follows: "(ii) No coinsurance.—In the case of a beneficiary who receives services described in clause (i), there shall be no coinsurance applied.

(2) in paragraph (3)(C), by amending clause (ii) to read as follows: "(ii) No coinsurance.—In the case of a beneficiary who receives services described in clause (i), there shall be no coinsurance applied.

(3) by striking "screening mammography" and inserting "diagnostic mammograms and Medicare covered preventive services (as defined in section 1861(i)(1))".

(c) Elimination of Coinsurance in Out-Patient Hospital Settings.—

(A) Exclusion from OPP Fee Schedule.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by striking "screening mammography" and inserting "diagnostic mammograms and Medicare covered preventive services (as defined in section 1861(i)(1))".

(B) Conforming Amendments.—Section 1833(a)(2) of the Social Security Act (42 U.S.C. 1395l(a)(2)) is further amended—

(1) in subparagraph (F), by striking "and" after the semicolon at the end; and

(2) in subparagraph (G), by adding "and" at the end; and

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

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(d) Waiver of Application of Deductible for All Preventive Services.—The first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended—

(1) by striking "items and services described in section 1861(e)(10)(A)" and inserting "Medicare covered preventive services (as defined in section 1861(i)(1))";

(2) by inserting "and" before "(4)"; and

(3) by striking clauses (5) through (8).

(e) Application to Providers of Services.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by inserting "other than for Medicare covered preventive services and" after "for such items and services and".

(f) Effective Date.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2011.

(g) Preventive Services.—

(1) Report to Congress on Barriers to Preventive Services.—Not later than 12 months after the enactment of this Act, the Secretary of Health and Human Services shall report to Congress on barriers, if any, facing Medicare beneficiaries in accessing the benefit to abdominal aortic aneurysm screening and other preventive services through the Welcome to Medicare Physical Exam.

(2) Abdominal Aortic Aneurysm Screen Access.—The Secretary shall, to the extent practical, identify and implement policies promoting proper use of abdominal aortic aneurysm screening among Medicare beneficiaries at risk for such aneurysms.

SEC. 1306. WAIVER OF DEDUCTIBLE FOR COLORECTAL CANCER SCREENING TESTS REGARDLESS OF CODING, SUBSEQUENT DIAGNOSIS, OR ANCILLARY TISSUE REMOVAL.

(a) In General.—Section 1395w of the Social Security Act (42 U.S.C. 1395w(b)), as amended by section 1305(b), is further amended—

(1) in subsection (a), in the sentence added by section 1305(b)(1)(A), by inserting "including services described in the last sentence of section 1833(b)(ii))" after "preventive services";

(2) in subsection (b), by adding at the end the following new sentence: "Clause (1) of the first sentence of this subsection shall apply with respect to a colorectal cancer screening test regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other material necessary for the test that is furnished in connection with, as a result of, and in the same clinical encounter as, the screening test.";

(b) Effective Date.—The amendment made by subsection (a) shall apply to items and services furnished on or after January 1, 2011.

SEC. 1307. EXCLUDING CLINICAL SOCIAL WORKER SERVICES FROM COVERAGE UNDER THE MEDICARE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM AND CONSOLIDATION OF PAYMENT.

(a) In General.—Section 1888(e)(2)(A)(i) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(i)) is amended by inserting "clinical social worker services," after "qualified psychologist services.

(b) Conforming Amendment.—Section 1861(h)(2) of the Social Security Act (42 U.S.C. 1395l(h)(2)) is further amended by striking "and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation".

(c) Effective Date.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2010.

SEC. 1308. COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES.

(a) Coverage of Marriage and Family Therapist Services.—

(1) Coverage of Services.—Section 1861(a)(2) of the Social Security Act (42 U.S.C. 1395x(a)(2)) is amended by adding after "(W)" the following new clause:

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(2) Definition.—Section 1861 of the Social Security Act (42 U.S.C. 1395l(a)(2)) is further amended—

(i) by striking "and" before "(W)"; and

(ii) by striking clauses (5) through (8).

(3) Application to Providers of Services.—Section 1861(a)(2) of the Social Security Act (42 U.S.C. 1395x(a)(2)) is amended by inserting "marriage and family therapist under part B regulatory" after "as defined in subsection [(jj)(1)]".

(b) Effective Date.—The amendments made by this section shall apply to services furnished on or after January 1, 2011.

(c) Waiver of Application of Deductible for All Preventive Services.—The first sentence of section 1861(b) of the Social Security Act (42 U.S.C. 1395x(b)) is amended—

(1) by striking "items and services described in section 1861(e)(10)(A)" and inserting "Medicare covered preventive services (as defined in section 1861(i)(1))";

(2) by inserting "and" before "(4)"; and

(3) by striking clauses (5) through (8).

(d) Application to Providers of Services.—Section 1861(a)(2) of the Social Security Act (42 U.S.C. 1395x(a)(2)) is amended by inserting "other than for Medicare covered preventive services and" after "for such items and services and".

(e) Effective Date.—The amendments made by this section shall apply to services furnished on or after January 1, 2011.

(f) Preventive Services.—

(1) Report to Congress on Barriers to Preventive Services.—Not later than 12 months after the enactment of this Act, the Secretary of Health and Human Services shall report to Congress on barriers, if any, facing Medicare beneficiaries in accessing the benefit to abdominal aortic aneurysm screening and other preventive services through the Welcome to Medicare Physical Exam.

(2) Abdominal Aortic Aneurysm Screen Access.—The Secretary shall, to the extent practical, identify and implement policies promoting proper use of abdominal aortic aneurysm screening among Medicare beneficiaries at risk for such aneurysms.

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mental health counselor (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses which the mental health counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

“(2) The term ‘mental health counselor’ means an individual who—

“(A) possesses a master's or doctor's degree which qualifies the individual for licensure or certification as a mental health counselor in the State in which the services are performed;

“(B) after obtaining such a degree has performed at least 2 years of supervised mental health counselor practice; and

“(C) is licensed or certified as a mental health counselor or professional counselor by the State in which the services are performed.”.

(5) PROVISION FOR PAYMENT UNDER PART B—Section 1832(a)(2)(B) of the Social Security Act (42 U.S.C. 1395b–2(a)(2)(B)), as amended by subsection (a)(3), is further amended—

(A) by striking “and” at the end of clause (iv);

(B) by adding “and” at the end of clause (v); and

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

“(vi) mental health counselor services;”.

(4) AMOUNT OF PAYMENT.—

(A) IN GENERAL.—Section 1888(a)(1) of the Social Security Act (42 U.S.C. 1395f(a)(1)), as amended by subsection (a), is further amended—

(i) by striking “and” before “(X)”; and

(ii) by inserting before the semicolon at the end the following:, and (Y), with respect to mental health counselor services under section 1861(s)(2)(HH), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist under clause (L).

(B) DEEP CRITERIA WITH RESPECT TO CONSULTATION WITH A PHYSICIAN.—The Secretary of Health and Human Services shall, taking into consideration concerns for patient safety, when develop criteria with respect to payment for mental health counselor services for which payment may be made directly to the mental health counselor under part B or the demonstration referred to as the ‘demonstration program’ (as defined in subsection (d)).

(6) EXCLUSION OF MENTAL HEALTH COUNSELORS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)), as amended by subsection (a)(7), is amended by adding at the end the following new clause:

“(iii) A mental health counselor (as defined in section 1861(kkk)(2)).”.

(7) INCLUSION OF MENTAL HEALTH COUNSELORS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)), as amended by subsection (a)(7), is amended by adding at the end the following new clause:

“(viii) A mental health counselor (as defined in section 1861(kkk)(2)).”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2011.

SEC. 1309. EXTENSION OF FEDERAL PER SCHEDULED MENTAL HEALTH ADD-ON.

Section 1383(a)(1) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking “December 31, 2009” and inserting “December 31, 2010”.

SEC. 1310. EXPANDING ACCESS TO VACCINES.

(a) IN GENERAL.—Paragraph (10) of section 1861(n) of the Social Security Act (42 U.S.C. 1395w(n)(10)) is amended to read as follows:

“(10) federally approved and recommended vaccines (as defined in subsection (i)); and their respective administration;

(b) FEDERALLY APPROVED AND RECOMMENDED VACCINES DEFINED.—Section 1861 of such Act is further amended by adding at the end the following new subsection:

“Federally Approved and Recommended Vaccines

(i) The term ‘federally approved and recommended vaccine’ means a vaccine that—

“(I) is licensed under section 351 of the Public Health Service Act, is approved under the Federal Food, Drug, and Cosmetic Act, or authorized for emergency use under section 564 of the Federal, Food, Drug, and Cosmetic Act; and

“(II) is recommended by the Director of the Centers for Disease Control and Prevention.

(c) CONFORMING AMENDMENTS.—

(1) Section 1833 of such Act (42 U.S.C. 1395f) is amended in each of subsections (a)(1)(B), (a)(2)(A), and (a)(4)(A), by striking “1861(s)(10)(A)” and inserting “1861(s)(10)” each place it appears.

(2) Section 1842(o)(1)(A)(iv) of such Act (42 U.S.C. 1395f(o)(1)(A)(iv)) is amended—

(A) by striking “paragraph (A) or (B) of”; and

(B) by inserting before the period the following:

“and before January 1, 2011, and influenza vaccines furnished on or after January 1, 2011.”

(3) Section 1847(a)(6) of such Act (42 U.S.C. 1395w–4(c)(6)) is amended—

(A) in subparagraph (D)(i), by inserting “including a vaccine furnished on or after January 1, 2011,” in paragraphs

(B) by the following new paragraph:

“(H) IMPLEMENTATION.—Chapter 35 of title 44, United States Code shall not apply to circumstances under which payment for information pursuant to section 1927(b)(3)(A)(i) for purposes of implementation of this section.”.

(b) E FFECTIVE DATE.—The amendment made by this section shall apply to payments made under such section and to claims filed before January 1, 2011.

SEC. 1311. EXPANSION OF MEDICARE-COVERED PREVENTIVE SERVICES AT FEDERALLY QUALIFIED HEALTH CENTERS.

(a) IN GENERAL.—Section 1395w–102(e)(3)(A) of the Social Security Act (42 U.S.C. 1395w–102(e)(3)(A)) is amended to read as follows:

“(3) Preven tive Services from Skilled Nursing Facility Providers.—If the Federal, Food, Drug, and Cosmetic Act, or the Federal Food, Drug, and Cosmetic Act, as amended by section 1302, the following new provisions are added:

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

“(E) improving the efficiency of care, such as by reducing duplicative diagnostic and laboratory tests.

“(F) reducing the cost of health care services covered under this title and to applicable beneficiaries (as defined in section 1860B).”.

(b) INDEPENDENCE AT HOME DEMONSTRATION PROGRAM.

Title XVIII of the Social Security Act is amended by inserting after section 1866F, the following new section:

“INDEPENDENCE AT HOME MEDICAL PRACTICE DEMONSTRATION PROGRAM

SEC. 1306(d).—Establishment of the demonstration program.

“(1) IN GENERAL.—The Secretary shall conduct a demonstration program in this section referred to as the ‘demonstration program’ to test a payment incentive and service delivery model that utilizes physician and nurse practitioner directed home-based primary care teams designed to reduce expensive and improve health outcomes in the provision of items and services under section (d) to applicable beneficiaries (as defined in subsection (d)).

“(2) REQUIREMENTS.—The demonstration program shall test whether a model described in paragraph (1), which is accountable for providing comprehensive, coordinated, and accessible care to high-need populations at home and coordinating health care across all treatment settings, results in—

“(A) reducing preventable hospitalizations;

“(B) preventing hospital readmissions;

“(C) reducing emergency room visits;

“(D) improving health outcomes commensurate with the beneficiaries’ stage of chronic illness;

“(E) improving the efficiency of care, such as by reducing duplicative diagnostic and laboratory tests.

“(F) reducing the cost of health care services covered under this title; and

“(G) achieving beneficiary and family caregiver satisfaction.

“(b) INDEPENDENCE AT HOME MEDICAL PRACTICE—.”
(1) INDEPENDENCE AT HOME MEDICAL PRACTICE DEFINED.—In this section:

(A) IN GENERAL.—The term ‘independence at home medical practice’ means a legal entity that:

(i) is comprised of an individual physician or nurse practitioner or group of physicians and nurse practitioners that provides care as part of a team that includes physicians, nurses, physician assistants, pharmacists, and other health and social services staff as appropriate who have experience providing home medical care to applicable beneficiaries, make home visits, and are available 24 hours per day, 7 days per week to carry out plans of care that are tailored to the individual beneficiary’s chronic conditions and are designed to achieve the results in subsection (a);

(ii) is organized in part for the purpose of providing physicians’ services;

(iii) has documented experience in providing home-based primary care services to high cost chronically ill beneficiaries, as determined appropriate by the Secretary;

(iv) includes at least 200 applicable beneficiaries as defined in subsection (d);

(v) has entered into an agreement with the Secretary;

(vi) uses electronic health information systems, remote monitoring, and mobile diagnostic technology; and

(vii) meets such other criteria as the Secretary determines to be appropriate to participate in the demonstration program.

(B) PHYSICIAN.—The term ‘physician’ includes, as determined appropriate by the Secretary, any physician who otherwise provides, any individual who furnishes services for which payment may be made as physicians’ services and has the medical training or experience to fulfill the physician’s role as described in subparagraph (A)(i).

(2) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—Nothing in this section shall be construed as preventing a nurse practitioner or physician assistant from participating in, or leading, a home-based primary care practice as part of an independence at home medical practice if—

(A) all the requirements of this section are met;

(B) the nurse practitioner or physician assistant, if any, is acting consistent with State law; and

(C) the nurse practitioner or physician assistant has the medical training or experience to fulfill the nurse practitioner or physician assistant role described in paragraph (1)(A)(i).

(3) INCLUSION OF PROVIDERS AND PRACTITIONERS.—In this subsection, any nurse practitioner or physician assistant that is affiliated with a practice under part A and B furnished to such beneficiaries that result in high costs under this title as a condition of receiving services from an independence at home medical practice shall be considered as a physician for purposes of this section.

(4) QUALITY AND PERFORMANCE STANDARDS.—

(A) IN GENERAL.—An independence at home medical practice participating in the demonstration program shall report on quality measures in such form, manner, and frequency as the Secretary determines appropriate to monitor and evaluate the demonstration program.

(B) DEVELOPMENT OF QUALITY PERFORMANCE STANDARDS.—The Secretary shall develop quality performance standards for independence at home medical practices participating in the demonstration program.

(C) SHARED SAVINGS PAYMENT METHODOLOGY.—

(1) ESTABLISHMENT OF TARGET SPENDING LEVEL.—The Secretary shall establish annual target spending levels for items and services covered under parts A and B furnished to applicable beneficiaries by qualifying independence at home medical practices under this section. The Secretary shall set the aggregate target spending levels for such item and services under parts A and B furnished to such beneficiaries for such year in an amount that the Secretary determines to be appropriate. The Secretary may periodically adjust or rebase the target spending level for such year.

(2) SHARED SAVINGS AMOUNTS.—

(A) IN GENERAL.—Subject to subparagraph (B), qualifying independence at home medical practices shall receive an incentive payment under this section if aggregate spending for a year for applicable beneficiaries is less than the target spending level for qualifying independence at home medical practices for such year. An incentive payment for such year shall be equal to a portion (as determined by the Secretary) of the aggregate spending for applicable beneficiaries under parts A and B for such year that is estimated to be less than 5 percent less than the target spending level for such year, as determined by the Secretary.

(B) APPORTIONMENT OF SAVINGS.—The Secretary shall designate how, and to what extent, an incentive payment under this section is to be apportioned among qualifying independence at home medical practices, taking into account the characteristics of the individuals enrolled in each practice, performance on quality performance measures, and such other factors as the Secretary determines appropriate.

(5) IMPROVEMENT.—The demonstration program shall begin not later than January 1, 2012. An agreement with an independence at home medical practice under the demonstration program may cover not more than a 3-year period.

(6) NO PHYSICIAN DUPLICATION IN DEMONSTRATION PARTICIPATION.—The Secretary shall give preference to practices that are not also participating in an independent at home medical practice under this section and are participating in the demonstration program for such year. An incentive payment under this section if aggregate spending for such year is less than a 3-year period.

(7) NUMBER OF PRACTICES.—

(A) IN GENERAL.—The Secretary shall give preference to practices that—

(A) located in high-cost areas of the country;

(B) have experience in furnishing health care services to applicable beneficiaries in the home; and

(C) incorporate electronic medical records, health information technology, and individualized plans of care.

(B) LIMITATION.—The Secretary shall give preference to practices that—

(A) in general, subject to subparagraph (B), the Secretary shall enter into agreements with as many independent at home medical practices as practicable and consistent with this subsection to test the potential of the independence at home medical practice model under this section in order to achieve the results described in subsection (d) across practices serving varying numbers of applicable beneficiaries.

(C) NUMBER OF PRACTICES.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall enter into agreements with as many independent at home medical practices as practicable and consistent with this subsection to test the potential of the independence at home medical practice model under this section in order to achieve the results described in subsection (d) across practices serving varying numbers of applicable beneficiaries.

(D) LIMITATION.—In selecting qualified independent at home medical practice to participate in the demonstration program, the Secretary shall limit the number of applicable beneficiaries that may participate in the demonstration program to 10,000.

(E) waiver.—The Secretary may waive such provisions of this title and title XI as the Secretary determines necessary in order to implement the demonstration program.

(F) EFFECT.—Sections 1866A, 1866B, and 1866E of title XVIII, United States Code, shall not apply to this section.
Title IV—Quality

Subtitle A—Comparative Effectiveness Research

SEC. 1401. COMPARATIVE EFFECTIVENESS RESEARCH

(a) In General.—Title XI of the Social Security Act is amended by adding at the end the following new part:

"PART D—COMPARATIVE EFFECTIVENESS RESEARCH

"COMPARATIVE EFFECTIVENESS RESEARCH

"Sec. 1181. (a) CENTER FOR COMPARATIVE EFFECTIVENESS RESEARCH ESTABLISHED.—

"(1) IN GENERAL.—There is established a Center for Comparative Effectiveness Research in the Agency for Healthcare Research and Quality a Center for Comparative Effectiveness Research (in this section referred to as the "Center") to conduct, support, and synthesize research conducted or supported under section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 with respect to the comparative effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically.

"(2) DUTIES.—The Center shall—

"(A) conduct, support, and synthesize research relevant to the comparative effectiveness of the full spectrum of health care items, services and systems, including pharmaceuticals, medical devices, medical and surgical procedures, and other medical interventions;

"(B) conduct and support systematic reviews of clinical research, including original research conducted subsequent to the date of the enactment of this section;

"(C) continuously develop rigorous scientific methodologies for conducting comparative effectiveness studies, and use such methodologies appropriately;

"(D) submit to the Comparative Effectiveness Research Commission, the Secretary, and Congress appropriate reports described in subsection (d)(2);

"(E) not later than one year after the date of the enactment of this section, enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences shall conduct an evaluation and report on standards of evidence for highly credible research;

"(F) encourage, as appropriate, the development and use of clinical registries and the development of clinical effectiveness research data networks from electronic health records, post marketing drug and medical device surveillance efforts, and other forms of electronic health data; and

"(G) appoint clinical perspective advisory panels for research priorities under this section which shall consist of medical and other stakeholders and advise the Center on research questions, methods, and evidence gaps in terms of clinical outcomes for the specific research inquiry to be examined with respect to such priority to ensure that the information produced from such research is clinically relevant to decisions made by clinicians and patients at the point of care.

"(b) OBTAINING OFFICIAL DATA.—The Center may secure directly from any department or agency of the United States government necessary information necessary to enable it to fulfill its objectives. Upon request of the Center, the head of such department or agency shall furnish that information to the Center on an agreed upon schedule.

"(c) DATA COLLECTION.—In order to carry out its functions, the Center shall—

"(i) utilize existing information, both public and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section;

"(ii) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

"(iii) adopt procedures allowing any interested party to submit information for the use by the Center in making reports and recommendations.

"In carrying out clause (ii), the Center may award grants or contracts (or provide for intergovernmental transfers, as applicable) to private entities and governmental agencies with experience in comparative effectiveness research, such as the National Institutes of Health and other relevant Federal health agencies.

"(d) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data of the Center and Commission under subsection (b), immediately upon request.

"(e) PERIODIC AUDIT.—The Center and Commission under subsection (b) shall be subject to periodic audit by the Comptroller General.

"(f) COMPARATIVE EFFECTIVENESS RESEARCH COMMISSION.—

"(1) IN GENERAL.—There is established an independent Comparative Effectiveness Research Commission (in this section referred to as the "Commission") to advise the Center and evaluate the activities carried out by the Center under subsection (a) to ensure that such activities result in highly credible research and information resulting from such research.

"(2) DUTIES.—The Commission shall—

"(A)(i) recommend to the Center national priorities for research described in subsection (a) which shall take into account—

"(I) disease incidence, prevalence, and burden in the United States;

"(II) evidence gaps in terms of clinical outcomes;
(III) variations in practice, delivery, and outcomes by geography, treatment site, provider type, disability, variation in age group (including children, adolescents, adults, and seniors), and racial and ethnic background, gender, and genetic and molecular subtypes, and other appropriate populations or subpopulations; and

(IV) prioritize new evidence concerning certain categories, healthcare services, or treatments to improve patient health and well-being, and the quality of care; and

(V) in making such recommendations consult with a broad array of public and private stakeholders including patients and healthcare providers and payers;

(B) monitor the appropriateness of use of the CERTIF described in subsection (g) with respect to the conduct of comparative effectiveness research recommended to be a national priority under subparagraph (A); and

(C) identify highly credible research methods and standards of evidence for such research to be considered by the Center;

(D) review the methodologies developed by the Center for research; and

(E) support forums to increase stakeholder awareness and permit stakeholder feedback on the efforts of the Center to advance the production of comparative effectiveness research recommended to be a national priority under subparagraph (A); and

(F) make recommendations to the Center for policies that would allow for public access to the Center's findings and studies conducted by the Center under section (a)(2)(C);

(H) at least annually review the processes of the Center and make reports to Congress and the President regarding research conducted, supported, or synthesized by the Center to confirm that the information produced by such research is objective, credible, consistent with standards of evidence developed under this section, and developed through a transparent process that includes consultations with appropriate stakeholders and the public.

(G) make recommendations to the Center for the priority for periodic reviews of previous comparative effectiveness research and studies conducted by the Center under section (a);

(I) at least annually hold a public hearing; and

(J) at least twice each year, hold a public meeting with an opportunity for stakeholder input.

The reports under subparagraph (H) shall not be submitted to the Office of Management and Budget or to any other Federal agency or executive department for any purpose prior to transmittal to Congress and the President. Such reports shall be published on the public internet website of the Commission after the date of such transmittal.

(3) COMMISSION OF COMMISSION.—

(A) IN GENERAL.—The members of the Commission shall consist of—

(i) the Director of the Agency for Healthcare Research and Quality or their designee;

(ii) the Chief Medical Officer of the Centers for Medicare & Medicaid Services or their designee;

(iii) the Director of the National Institutes of Health or their designee; and

(iv) members who shall represent broad constituencies of stakeholders including clinicians, patients, researchers, third-party payers, and consumers of Federal and State beneficiary programs.

Of such members, at least 10 shall be practicing physicians, health care practitioners, consumers, or patients;

(B) QUALIFICATIONS.—

(I) DIVERSE REPRESENTATION OF PERSPECTIVES.—The members of the Commission shall represent perspectives and shall collectively have experience in the following areas:

(1) Epidemiology.

(2) Health services research.

(3) Bioethics.

(4) Decision sciences.

(5) Health economics.

(6) DIVERSE REPRESENTATION OF HEALTH CARE COMMUNITY.—At least one member shall represent each of the following health care communities:

(1) Patients.

(2) Health care consumers.

(3) Practicing Physicians, including surgeons.

(4) Other health care practitioners engaged in clinical care.

(5) Organizations with proven expertise in racial and ethnic minority health research.

(II) EMPLOYEES.—

(6) Physicians.

(7) Public payers.

(VIII) Insurance plans.

(IX) Clinical researchers who conduct research on behalf of pharmaceutical or device manufacturers and such representatives shall be clinical researchers described under subparagraph (B)(ii)(IX).

(D) APPOINTMENT.—The Comptroller General shall appoint the members of the Commission.

(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General may designate another member for the remainder of that member's term.

(E) TERMS.—

(i) 8 shall be appointed for a term of 4 years.

(ii) 8 shall be appointed for a term of 3 years.

(F) COMPENSATION.—While serving on the business of the Commission (including travel time), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the regular place of business, a member may be allowed travel expenses, as authorized by the Director of the Commission.

(G) DUTIES OF STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General deems necessary to assure the efficient administration of the Commission, the Comptroller General may—

(A) appoint and set the compensation for an Executive Director (subject to the approval of the Comptroller General) and such other personnel as Federal employees under section 2105 of title 5, United States Code, as may be necessary to carry out its duties (without regard to the provisions of section 3709 of the Revised Statutes (41 U.S.C. 5));

(B) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

(C) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

(D) make advance, progress, and other payments which relate to the work of the Commission;

(E) provide transportation and subsistence for persons serving without compensation; and

(F) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

(4) REPORTING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable the Commission to carry out its duties. Upon request of the Chairman of the Commission, the head of such department or agency shall furnish the information to the Commission on an agreed upon schedule.

(A) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

(1) COORDINATION.—To enhance effectiveness and coordination, the Secretary is encouraged, to the greatest extent possible, to so coordinate this provision with the National Advisory Council on the Agency for Healthcare Research and Quality.

(2) CONFLICTS OF INTEREST.—

(A) IN GENERAL.—In appointing the members of the Commission or a clinical perspective advisory panel described in subsection (a)(2)(G), the Comptroller General or the Secretary, respectively, shall take into consideration whether any financial prohibition under section 208(b)(1) or 208(b)(3) of title 18, United States Code, or a waiver as referred to in subparagraph (D)(i) will prevent or reduce the likelihood that an appointed individual will later require a written determination as referred to in section 208(b)(1) of title 18, United States Code, a written certification as referred to in section 208(b)(3) of title 18, United States Code, or a waiver as referred to in subparagraph (D)(i) for service on the Commission at a meeting of the Commission.

(B) DETERMINATION; CRITERIA.—When considering an appointment to the Commission or a clinical perspective advisory panel described in subsection (a)(2)(G), the Comptroller General or the Secretary, respectively, shall review the expertise of the individual and the financial disclosure report filed by the individual pursuant to the Ethics in Government Act of 1978 for each individual under consideration for the appointment, so as to reduce the likelihood that an appointed individual will later require a written determination as referred to in section 208(b)(1) of title 18, United States Code, a written certification as referred to in section 208(b)(3) of title 18, United States Code, or a waiver as referred to in subparagraph (D)(i) for service on the Commission at a meeting of the Commission.

(C) DISCLOSURES; PROHIBITIONS ON PARTICIPATION; WAIVERS.—

(I) DISCLOSURE OF FINANCIAL INTEREST.—Prior to a meeting of the Commission or a clinical perspective advisory panel described in subsection (a)(2)(G) regarding a ‘particular matter’ (as that term is used in section 208(a)(1) of title 18, United States Code) each member of the Commission or the clinical perspective advisory panel who is a full-time
Government employee or special Government employee, as applicable, determines it necessary to afford the Commission or a clinical perspective advisory panel described in subsection (a)(2)(G) access to financial information contained in such report shall be—

(A) serve as an available point of contact for patients regarding proposed comparative effectiveness studies by the Center; and

(B) seek, as feasible and appropriate, to include members of such subpopulations as subjects in the research.

(ii) public access to comparative effectiveness information.—

(1) in each case, a relevant report described in paragraph (2) made by the Center, Commission, or advisory panel under this section, appropriate information contained in such report shall be posted on the official public Internet site of the Center and of the Commission, as applicable.

(2) relevant reports described.—For purposes of this section, a relevant report is—

(A) an interim or progress report as described in subsection (c)(3)(B), including any reasons for lack of compliance with such subsection.

(B) The establishment of the agenda and conduct of the research shall be transparent to all stakeholders.

(C) The methods of conducting such research shall be scientifically based.

(D) any applicable law, all aspects of the prioritization of research, conduct of the research, and development of conclusions based on the research shall be transparent to all stakeholders.

(E) Consistent with applicable law, the process and methods for conducting such research shall be publicly documented and available to all stakeholders.

(‘F) Throughout the process of such research, the Center shall provide opportunities for public review and provide public comment on the methods and findings of such research.

(G) Such research shall consider advice given to the Secretary by the clinical perspective advisory panel described in subsection (a)(2)(G) essential expertise, the Comptroller General or Secretary, respectively, or waiver given to the Secretary with respect to such matter, excluding interests exempted in regulations issued by the Director of the Office of Personal and Government Ethics as too remote or impractical to promote the ease of use of such incorporation.

(H) The assist the users of health information technology focused on clinical decision support, stimulates the translation of such findings into clinical practices and promote the use of such incorporation.

(2) dissemination protocols and strategies for the appropriate dissemination of research findings in order to ensure effective communication of findings and the use of recommendations for fair share per capita amount for all-payer financing.

Beginning not later than December 31, 2011, the Secretary shall submit to Congress an annual report on the activities of the Center, as well as the research, conducted under this section. Each such report shall include a discussion of the Center’s compliance with subsection (c)(3)(B), including any reasons for lack of compliance with such subsection.
“(B) as preventing the Secretary from covering the routine costs of clinical care received by an individual entitled to, or enrolled for, benefits under title XVIII, XIX, or XXI of such individual is participating in a clinical trial and such costs would otherwise be covered under such title with respect to the beneficiary.

(2) Consultation—None of the reports submitted under this section or research findings disseminated by the Center or Commission shall be construed as mandating, for payment, coverage, or treatment.

(3) Protecting the physician-patient relationship—Nothing in this section shall be construed as authorizing a facility to dispose of or delete information described in such subparagraph after the effective date of the final regulations promulgated under paragraph (4)(A).

(4) Public availability of information—During the period described in paragraph (1)(A), a facility shall—

(A) make the information described in paragraph (3) available to the public upon request and update such information as may be necessary to reflect changes in such information and;

(B) post a notice of the availability of such information in the lobby of the facility in a prominent manner.

(5) Definitions.—For purposes of this subsection:

(A) IN GENERAL.—The following information is described in this paragraph:

(i) The information described in subsections (a) and (b), subject to subparagraph (C).

(ii) The identity of and information on—

(D) each, the governing body of the facility, including the name, title, and period of service of each such member;

(ii) each person or entity who is an officer, director, trustee, or managing employee of the facility, including the name, title, and date of start of service of each such person or entity; and

(III) each person who is an additional disclosable party of the facility.

(iii) A description of the organizational structure and the relationship of each person and entity described in subclasses (II) and (III) of clause (ii) to the facility and to one another;

(B) SPECIAL RULE WHERE INFORMATION IS ALREADY SUBMITTED OR OBTAINED.—To the extent that information reported by a facility to the Internal Revenue Service on Form 990, information submitted by a facility to the entities and Exchange Commission, or information otherwise submitted to the Secretary or any other Federal agency contains the information described in clauses (i), (ii), or (iii) of subparagraph (A), the Secretary may allow, to the extent practicable, such form or such information to meet the requirements of paragraph (1) and to be submitted in a manner specified by the Secretary.

(C) MANAGING EMPLOYER.—The term ‘managing employee’ means, with respect to a facility, any person or entity or any of the property or assets thereof.

(D) ORGANIZATIONAL STRUCTURE.—The term ‘organizational structure’ means, in these regulations, each of the following:

(i) a corporation, the officers, directors, and shareholders of the corporation who have an ownership interest in the corporation and who own 5 percent or more of the outstanding stock; and

(ii) a limited liability company, the members and managers of the limited liability company who own an ownership interest in the limited liability company;...
(iii) a general partnership, the partners of the general partnership;
(iv) a limited partnership, the general partners and any limited partners of the limited partnership who have an ownership interest in the limited partnership which is equal to or exceeds 10 percent;
(v) a trust, the trustees of the trust;
(vi) an individual, the individual; and
(vii) any other person or entity, such information as the Secretary determines appropriate.

(b) Public Availability of Information—Not later than the date that is 1 year after the date on which the final regulations promulgated under section 1240(c)(4)(A) of the Social Security Act, as added by subsection (a), are published in the Federal Register, the information reported in accordance with such final regulations shall be made available to the public in accordance with procedures established by the Secretary of Health and Human Services.

(c) Conforming Amendments.—(1) Skilled Nursing Facilities.—Section 1915(d)(1) of the Social Security Act (42 U.S.C. 1395i-3(d)(1)) is amended by striking subparagraph (C) and redesignating subparagraph (D) as subparagraph (C).

(2) Nursing Facilities.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)) is amended by adding at the end the following new subparagraph:

"(C) Compliance and Ethics Programs.—In this subparagraph, the term 'compliance and ethics program' means, with respect to a affiliated nursing facility, a program of the operating organization that—

(1) has been reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care; and

(2) includes at least the required components specified in clause (iv)."

(iv) Required Components of Program.—The required components of a compliance and ethics program of an organization are the following:

(I) The organization must have established compliance standards and procedures to be followed by its employees, contractors, and other agents that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under this Act.

(II) Specific individuals within high-level personnel of the organization must have been assigned overall responsibility to oversee compliance and procedures and have sufficient resources and authority to assure such compliance.

(III) The organization must have used due diligence, in good faith, to delegatively designate substantial discretionary authority to individuals whom the organization knew, or should have known through the exercise of due diligence, had a reasonable propensity to engage in criminal, civil, and administrative violations under this Act.

(IV) The organization must have taken reasonable steps to achieve compliance with its standards, such as by utilizing monitoring systems designed to detect criminal, civil, and administrative violations under this Act by its employees and other agents and by having in place a reporting system whereby employees and other agents could report violations by others within the organization without the fear of retribution.

(V) The organization must have established a compliance and ethics program of an organization are the following:

(1) has been reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations under this Act; and

(2) includes at least the required components specified in clause (iv).

(vi) Required Components of Program.—The required components of a compliance and ethics program of an organization are the following:

(1) The organization must have established compliance standards and procedures to be followed by its employees and other agents that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under this Act.

(2) Nursing Facilities.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)), as amended by section 1411(c)(2), is amended by adding at the end the following new subparagraph:

"(C) Compliance and Ethics Programs.—

(1) Requirement.—On or after the first day of the first calendar quarter beginning after the date that is 1 year after the date on which the final regulations promulgated under this subparagraph (C) are published in the Federal Register, a skilled nursing facility shall, with respect to the entity that operates or controls the facility under this subparagraph (C) (hereafter referred to as the 'operating organization' or 'organization'), have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care consistent with such regulations.

(2) Nursing Facilities.—

SEC. 1412. ACCOUNTABILITY REQUIREMENTS.

(a) Effective Compliance and Ethics Programs.—(1) Skilled Nursing Facilities.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)), as amended by section 1411(c)(2), is amended by adding at the end the following new subparagraph:

"(C) Compliance and Ethics Programs.—In this subparagraph, the term 'compliance and ethics program' means, with respect to a skilled nursing facility, a program of the operating organization that—

(1) has been reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care consistent with such regulations.

(2) Nursing Facilities.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396r(d)(1)), as amended by section 1411(c)(2), is amended by adding at the end the following new subparagraph:

"(C) Compliance and Ethics Programs.—

(1) Requirement.—On or after the first day of the first calendar quarter beginning after the date that is 1 year after the date on which the final regulations promulgated under this subparagraph (C) are published in the Federal Register, a skilled nursing facility shall, with respect to the entity that operates or controls the facility under this subparagraph (C) (hereafter referred to as the 'operating organization' or 'organization'), have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care consistent with such regulations.

(1) Requirement.—On or after the first day of the first calendar quarter beginning after the date that is 1 year after the date on which the final regulations promulgated under this subparagraph (C) are published in the Federal Register, a skilled nursing facility shall, with respect to the entity that operates or controls the facility under this subparagraph (C) (hereafter referred to as the 'operating organization' or 'organization'), have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care consistent with such regulations.

(1) Requirement.—On or after the first day of the first calendar quarter beginning after the date that is 1 year after the date on which the final regulations promulgated under this subparagraph (C) are published in the Federal Register, a skilled nursing facility shall, with respect to the entity that operates or controls the facility under this subparagraph (C) (hereafter referred to as the 'operating organization' or 'organization'), have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care consistent with such regulations.

(1) Requirement.—On or after the first day of the first calendar quarter beginning after the date that is 1 year after the date on which the final regulations promulgated under this subparagraph (C) are published in the Federal Register, a skilled nursing facility shall, with respect to the entity that operates or controls the facility under this subparagraph (C) (hereafter referred to as the 'operating organization' or 'organization'), have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care consistent with such regulations.

(1) Requirement.—On or after the first day of the first calendar quarter beginning after the date that is 1 year after the date on which the final regulations promulgated under this subparagraph (C) are published in the Federal Register, a skilled nursing facility shall, with respect to the entity that operates or controls the facility under this subparagraph (C) (hereafter referred to as the 'operating organization' or 'organization'), have in operation a compliance and ethics program that is effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care consistent with such regulations.
(III) The organization must have taken reasonable steps to achieve compliance with its standards through self-monitoring and auditing systems, including its policies and procedures to all employees and other agents and by having in place a reporting system whereby employees and other agents could report violations by others within the organization without fear of retribution.

(VI) The standards must be consistently enforced through appropriate disciplinary mechanisms, including, as appropriate, actions against individuals responsible for the failure to detect an offense.

(VII) After an offense has been detected, the organization must have taken all reasonable steps to prevent the recurrence of the offense and to prevent similar offenses, including repayment of any funds to which it was not entitled and any necessary modification to its program to prevent and detect such offenses.
(vi) Summary information on the number, type, severity, and outcome of substantiated complaints.

(vii) The number of adjudicated instances of criminal violations by employees of a nursing facility—

(1) that were committed inside the facility; and

(2) with respect to such instances of violations or crimes committed inside of the facility that were the violations or crimes of abuse, neglect, exploitation, criminal sexual conduct, or other violations or crimes that resulted in serious bodily injury; and

(viii) The number of civil monetary penalties assessed against the facility, employees, contractors, and other agents.

(ix) Any other information that the Secretary determines appropriate.

The facility shall not make available under clause (iv) identifying information on complainants or residents.

(B) Deadline for provision of information—

(1) In general.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on such website (or a successor website) not later than 1 year after the date of the enactment of this subsection.

(2) Exception.—The Secretary shall ensure that the information described in subparagraph (A)(i) and (A)(iii) is included on such website (or a successor website) not later than 1 year after the dates on which—

(A) the Secretary determined appropriate.

(3) Special focus facility program.—Section 1819(f) of such Act is amended by adding at the end the following new paragraph:

"(8) Special focus facility program.—(A) In general.—The Secretary shall conduct a special focus facility program for enforcement of requirements for skilled nursing facilities that the Secretary has identified and that substantially failed to meet applicable requirements of this Act.

(B) Program.—Under such program the Secretary shall conduct surveys of each facility in the program not less than once every 6 months.

(C) Review and modification of website.—(1) In general.—The Secretary shall establish a process—

(i) to review the accuracy, clarity of presentation, and comprehensiveness of information reported on such website as of the day before the date of the enactment of this subsection; and

(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

(2) Consultation.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

(A) State long-term care ombudsman programs;

(B) consumer advocacy groups;

(C) provider stakeholder groups; and

(D) any other representatives of programs or groups the Secretary determines appropriate.

(4) Timeliness of submission and certification information.—(A) In general.—Section 1919(g)(5) of the Social Security Act (42 U.S.C. 1395i-3(g)(5)) is amended by adding at the end the following new subparagraph:

"(E) Periodic surveys.—Under such program the Secretary shall conduct surveys of each facility in the program not less than once every 6 months.

(2) Review and modification of website.—(1) In general.—The Secretary shall establish a process—

(i) to review the accuracy, clarity of presentation, and comprehensiveness of information reported on such website as of the day before the date of the enactment of this subsection; and

(ii) not later than 1 year after the date of the enactment of this subsection, to modify or revamp such website in accordance with the review conducted under clause (i).

(B) Consultation.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

(A) State long-term care ombudsman programs;

(B) consumer advocacy groups;

(C) provider stakeholder groups; and

(D) any other representatives of programs or groups the Secretary determines appropriate.

(5) Timeliness of submission and certification information.—(A) In general.—Section 1919(g)(5) of the Social Security Act (42 U.S.C. 1396r(g)(5)) is amended by adding at the end the following new subparagraph:

"(E) Submission of survey and certification information to the Secretary.—In order to improve the timeliness of information made available to the public under paragraph (A) and provided on the Nursing Home Compare Medicare website under subsection (b)(8)(C), the Secretary shall submit information respecting any survey or certification recommendation made respecting a skilled nursing facility (including any enforcement actions taken by the State or any Federal enforcement action recommended by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.

(B) Effective date.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.

(6) Nursing home compare website.—(A) In general.—Section 1819(f) of such Act is amended by adding at the end the following new paragraph:

"(2) Review and modification of website.—(1) In general.—The Secretary shall ensure that the information described in subparagraph (A) and provided on the Nursing Home Compare Medicare website (or a successor website) not later than 1 year after the date of the enactment of this subsection.

(B) Consultation.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

(A) State long-term care ombudsman programs;

(B) consumer advocacy groups;

(C) provider stakeholder groups; and

(D) any other representatives of programs or groups the Secretary determines appropriate.

(2) Timeliness of submission and certification information.—(A) In general.—Section 1919(g)(5) of the Social Security Act (42 U.S.C. 1396r(g)(5)) is amended by adding at the end the following new subparagraph:

"(E) Submission of survey and certification information to the Secretary.—In order to improve the timeliness of information made available to the public under paragraph (A) and provided on the Nursing Home Compare Medicare website under subsection (b)(8)(C), the Secretary shall submit information respecting any survey or certification recommendation made respecting a skilled nursing facility (including any enforcement actions taken by the State or any Federal enforcement action recommended by the State) to the Secretary not later than the date on which the State sends such information to the facility. The Secretary shall use the information submitted under the preceding sentence to update the information provided on the Nursing Home Compare Medicare website as expeditiously as practicable but not less frequently than quarterly.

(B) Effective date.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.
INVESTIGATION REPORTS.—

(1) IN GENERAL.—The Secretary shall conduct a special focus facility program for enforcement of requirements for nursing facilities that the Secretary has identified as having a poor compliance history or that substantially fail to meet applicable requirements of this Act.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall take effect 1 year after the date of the enactment of this Act.

(3) SPECIAL FOCUS FACILITY PROGRAM.—Section 1910(f) of such Act is amended by adding at the end of the following new paragraph:

“(10) SPECIAL FOCUS FACILITY PROGRAM.—

(A) IN GENERAL.—The Secretary shall conduct a special focus facility program for enforcement of requirements for nursing facilities that the Secretary has identified as having a poor compliance history or that substantially fail to meet applicable requirements of this Act.

(B) PERIODIC SURVEYS.—Under such program the Secretary shall conduct surveys of each such facility not less often than once every 6 months.

(c) AVAILABILITY OF REPORTS ON SURVEYS, CERTIFICATIONS, AND COMPLAINT INVESTIGATIONS.—

(1) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1396t–3(d)(1)), as amended by sections 1411 and 1412, is amended by adding at the end the following new subparagraph:

“(D) post notice of the availability of such Form (or a successor form), complaint investigation reports, the facility’s plan of correction, and such other information that the State or the Secretary considers useful in assisting the public to assess the quality of care provided by such facility and the quality of care provided by individual facilities.”;

(2) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—The Secretary shall ensure that the facility or facility designee shall—

(i) have reports with respect to any surveys, certifications, and complaint investigations with respect to the facility during the 3 preceding years available for any individual to review upon request; and

(ii) post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

The facility shall not make available under clause (i) identifying information about complainants or residents.

(2) NURSING FACILITIES.—Section 1919(d)(1) of the Social Security Act (42 U.S.C. 1396t–3(d)(1)), as amended by sections 1411 and 1412, is amended by adding at the end the following new paragraph:

“(D) post notice of the availability of such Form (or a successor form), complaint investigation reports, the facility’s plan of correction, and such other information that the State or the Secretary considers useful in assisting the public to assess the quality of care provided by such facility and the quality of care provided by individual facilities.”;

(3) DEFINITIONS.—In this subsection:

(A) NURSING FACILITY.—The term “nursing facility” has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396t(a)).

(B) SECRETARY.—The term “Secretary” means the Secretary of Health and Human Services.

(C) SKILLED NURSING FACILITY.—The term “skilled nursing facility” has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396t(a)).

SEC. 1414. REPORTING OF EXPENDITURES.

Section 1888 of the Social Security Act (42 U.S.C. 1395y) is amended by adding at the end the following new subsection:

“(F) REPORTING OF DIRECT CARE EXPENDITURES.—

“(1) IN GENERAL.—For cost reports submitted under this title for cost reporting periods ending after the date that is no more than two years after the redesign of the report specified in subparagraph (2), skilled nursing facilities shall—

(A) separate the expenditures for wages and benefits for direct care staff (breaking out (at a minimum) registered nurses, licensed professional nurses, certified nurse assistants, and other medical and therapy staff); and

(B) take into account agency and contract staff in a manner to be determined by the Administrator.

“(2) MODIFICATION OF FORM.—The Secretary, in consultation with private sector accountants experienced with skilled nursing facility cost reporting, may—

(i) modify the form used to report such costs; and

(ii) modify or modify the form to the extent necessary to meet the requirement of paragraph (1) not later than 2 years after the date of the enactment of this subsection.

“(C) CATEGORIZATION BY FUNCTIONAL ACCOUNTS.—Beginning with cost reports submitted under paragraph (1), the Secretary, in consultation with the Medicare Payment Advisory Commission, the Inspector General of the Department of Health and Human Services, and other expert parters the Secretary determines appropriate, shall categorize expenditures reported by such reports to meet the requirement of paragraph (1) not later than 2 years after the date of the enactment of this subsection.

“(D) COMPLAINT PROCESSES AND WHISTLEBLOWER PROTECTION.—

“(A) COMPLAINT FORMS.—The State must make the standardized complaint form developed under subsection (b)(9) available upon request to—

(i) a resident of a skilled nursing facility;

(ii) any person acting on the resident’s behalf; and

(iii) any person who works at a skilled nursing facility or is a representative of such a worker.

“(B) COMPLAINT RESOLUTION PROCESS.—The State must establish a complaint resolution process in order to ensure that a resident, the legal representative of a resident of a skilled nursing facility, or other responsible party is not retaliated against if the resident, legal representative, or responsible party complained about the quality of care or other issues relating to the skilled nursing facility, that the legal representative or responsible party did not have access to such resident or otherwise retaliated against if such representative has complained, in good faith, about the quality of care provided by the facility or other issues relating to the facility, and that a person who works at a skilled nursing facility is not retaliated against if the worker has complained, in good faith, about quality of care or services an issue relating to the quality of care or services provided at the facility, whether the resident, legal representative, or other responsible party, or worker used the form developed under subsection (f)(9) or some other method for submitting the complaint. Such complaint resolution process shall include—

(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

(ii) procedures to determine the likely severity of a complaint and for the investigation of a complaint.

(iii) timelines for responding to a complaint and for notifying the complainant of the outcome of the investigation; and

(iv) procedures to protect the confidentiality of the complainant will be kept confidential.
(C) Whistleblower Protection.—

(1) Prohibition Against Retaliation.—No person who works at a skilled nursing facility may be penalized, discriminated, or retaliated against with respect to any aspect of employment, including discharge, promotion, compensation, terms, conditions, or privileges of employment, or have a contract for services terminated, because the person (or anyone acting at the person’s request) complained in good faith, about the quality of care or services provided by a skilled nursing facility or about other issues relating to quality of care or services, whether the form developed under subsection (f)(9) or some other method for submitting the complaint.

(2) Notice of Retaliation.

(ii) Retaliatory Reporting.—A skilled nursing facility may not file a complaint or a report (or anyone acting at the person’s request) complaining, in good faith, about the quality of care or services provided by a skilled nursing facility or about other issues relating to quality of care or services, whether the form developed under subsection (f)(9) or some other method for submitting the complaint.

(iii) Relief.—Any person aggrieved by a violation of clause (i) or clause (ii) may, in a civil action, obtain appropriate relief, including reinstatement, reimbursement of lost wages, compensation, and benefits, and exemplary damages where warranted, and such other relief as the court deems appropriate, as well as costs of suit and reasonable attorney and expert witness fees.

(iv) Limitations on Remedies.—The rights protected by this paragraph may not be diminished by contract or other agreement, and nothing in this paragraph shall be construed to diminish any greater or additional protection provided by Federal or State law or by contract or other agreement.

(v) Requirement to Post Notice of Employee Rights.—Each skilled nursing facility shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of persons under this paragraph and including a statement that an employee may file a complaint with the Secretary against a skilled nursing facility, or other responsible party, that the legal representative of a resident of a nursing facility, or other responsible party is not penalized, discriminated, or retaliated against if such representative party has complained, in good faith, about the quality of care or services or an issue relating to the quality of care or services provided by a skilled nursing facility, or other responsible party, that the legal representative, legal representative, other responsible party, or worker used the form developed under subsection (f)(9) or some other method for submitting the complaint. Such a complaint resolution process shall include—

(i) procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received;

(ii) procedures to determine the likely severity of a complaint and for the investigation of the complaint;

(iii) deadlines for responding to a complaint and for notifying the complainant of the outcome of the investigation; and

(iv) procedures to ensure that the identity of the complainant will be kept confidential.

(D) Rule of Construction.—Nothing in this paragraph shall be construed as preventing a resident of a skilled nursing facility (or a person acting on the resident’s behalf) from submitting a complaint in a manner other than by using the standardized complaint form developed under subsection (f)(9) or some other method for submitting the complaint.

5. ENSURING STAFFING ACCOUNTABILITY.

(a) Skilled Nursing Facilities.—Section 1819(b)(8) of the Social Security Act (42 U.S.C. 1395i–3(b)(8)) is amended by adding at the end the following new paragraph:

(3)(e) is amended by adding at the end the following new paragraph:

(B) Complaint Processes and Whistleblower Protection.—

(A) Complaint Forms.—The State must make the standardized complaint form developed under subsection (f)(11) available upon request to—

(i) a resident of a nursing facility;

(ii) any person acting on the resident’s behalf;

(iii) any person who works at a nursing facility; or a representative of such a worker;

(iv) a person to whom a complaint has been received;

(v) a State professional disciplinary agency or any other State professional disciplinary body that is a legal representative of a resident of a nursing facility, or other responsible party.

(B) Complaint Resolution Process.—The State must establish a complaint resolution process in order to ensure that a resident, the legal representative of a resident of a nursing facility, or other responsible party is not penalized, discriminated, or retaliated against if such representative party has complained, in good faith, about the quality of care or services provided by a skilled nursing facility, or other responsible party.

(C) Requirements for Submitting Complaints.—The Secretary shall post conspicuously in an appropriate location a sign (in a form specified by the Secretary) specifying the rights of persons under this paragraph and including a statement that an employee may file a complaint with the Secretary against a skilled nursing facility, or other responsible party, that the legal representative of a resident of a nursing facility, or other responsible party is not penalized, discriminated, or retaliated against if such representative party has complained, in good faith, about the quality of care or services provided by a skilled nursing facility, or other responsible party, that the legal representative of a resident of a nursing facility, or other responsible party, or worker used the form developed under subsection (f)(9) or some other method for submitting the complaint.

(D) Rule of Construction.—Nothing in this paragraph shall be construed as preventing a resident of a nursing facility (or a person acting on the resident’s behalf) from submitting a complaint in a manner other than by using the standardized complaint form developed under subsection (f)(9) or some other method for submitting the complaint.

(E) Good Faith Defined.—For purposes of this paragraph, an individual shall be deemed to be acting in good faith with respect to the filing of a complaint if the individual reasonably believes—

(i) the information reported or disclosed in the complaint is true; and

(ii) the violation of this title has occurred, or may occur in relation to such information.

(b) Nursing Facilities.

(i) Development by the Secretary.—Section 1919(f)(1) of the Social Security Act (42 U.S.C. 1395i–2(f)(1)), as amended by section 413(b), is amended by adding at the end the following new paragraph:

(11) Standardized Complaint Form.—The Secretary shall develop a standardized complaint form for use by a resident (or a person acting on the resident’s behalf) in filing a complaint with a State survey and certification agency and a State long-term care ombudsman program with respect to a nursing facility.

(ii) State Requirements.—Section 1919(e) of the Social Security Act (42 U.S.C. 1395i–3(e)) is amended by adding at the end the following new paragraph:

(ii) The Secretary in consultation with such programs, groups, and parties, shall require that the information submitted under this subparagraph, and after consulting with State long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties, shall require that the information submitted under this subparagraph, and after consulting with State long-term care ombudsman programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties that is 2 years after the date of enactment of this Act, is made available to the Secretary in a uniform format (accord-
staff shall be kept separate from information on employee staffing.

(b) Nursing Facilities.—Section 191(b)(8) of the Social Security Act (42 U.S.C. 1396n(c)(8)) by adding at the end the following new subparagraph:

“(C) Submission of Staffing Information Based on Payroll Data in a Uniform Format.—On and after the first day of the first calendar quarter beginning after the date that is 2 years after the date of enactment of this subparagraph, and after consulting with State long-term care ombudsmen programs, consumer advocacy groups, provider stakeholder groups, employees and their representatives, and other parties the Secretary deems appropriate, the Secretary shall require a nursing facility to electronically submit to the Secretary direct staffing information (including information with respect to agency and contract staffing) based on payroll and other verifiable and auditable data in a uniform format (according to specifications established by the Secretary in consultation with such program and groups, and parties). Such specifications shall require that the information submitted under the preceding sentence—

(1) be in a format that is easy to read and ensure the accuracy and completeness of information with respect to specific categories, such as nursing staff, before other categories of certified employees referenced in clause (1) per resident per day.

Nothing in this subparagraph shall be construed as preventing the Secretary from requiring agencies of such information with respect to specific categories, such as nursing staff, before other categories of certified employees. Information under this subparagraph (with respect to agency and contract staffing) shall be kept separate from information on employee staffing.

SEC. 1417. Nationwide Program for National Criminal History Background Checks on Direct Patient Access Employees of Long-Term Care Facilities and Providers

(a) In General.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”), shall establish a program to conduct background checks on prospective direct patient access employees on a nationwide basis (in this subsection, such program shall be referred to as the “nationwide program”). The Secretary shall carry out the nationwide program under conditions and as the pilot program under section 307 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2257), including the prohibition on hiring abusive workers and the authorization of the imposition of penalties by a participating State under subsections (b)(5)(A) and (b)(6), respectively, of such section 307. The program under this subsection shall contain the following modifications to such pilot program:

(1) Amendments.—

(A) newly participating states.—The Secretary shall enter into agreements with each State—

(i) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(ii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

Under such an agreement a State may agree to cover and reimburse each long-term care facility or provider for all costs attributable to conducting background checks and screening described in this subsection that were otherwise required to be conducted by such State or by such facility or provider before the enactment of this subsection, except that Federal funding with respect to such reimbursement shall be limited to the amount made available to the State from funds under subsection (b)(1).

(B) Certain Previously Participating States.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has entered into an agreement with under subsection (c)(1);

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

Sec. 1418. State Requirements

(4) State Requirements.—An agreement entered into under paragraph (1) shall require that a participating State—

(A) be responsible for monitoring compliance with the requirements of the nationwide program;

(B) have procedures in place to—

(i) conduct screening and criminal or other background checks under the nationwide program in accordance with the requirements of this section;

(ii) monitor compliance by long-term care facilities and providers with the procedures and requirements of the nationwide program; and

(iii) as appropriate, provide for a provider’s period of employment by a long-term care facility or provider of a direct patient access employee, not to exceed 60 days, pending completion of the required criminal history background check; and, in the case where the employee has appealed the results of such background check, pending completion of the appeals process, during which the employee shall be subject to direct on-site supervision (in accordance with procedures established by the State to ensure that a long-term care facility or provider furnishes such direct supervision on a consistent basis).

(C) provide for the designation of a single State agency as responsible for—

(i) overseeing the coordination of any State and national criminal history background checks requested by a long-term care facility or provider (or the designated agent of the long-term care facility or provider) utilizing a search of State and Federal criminal history records, including a fingerprint check of such records;

(ii) overseeing the design of appropriate privacy and security safeguards for use in the design and delivery of the requirements of the nationwide or national criminal history background checks conducted regarding a prospective direct patient access employee to determine whether the employee has a prior conviction for a relevant crime;

(iii) immediately reporting to the long-term care facility or provider that requested the criminal history background check the results of such review; and

(iv) in the case of an employee with a conviction for a relevant crime that is subject to reporting under section 1129E of the Social Security Act (42 U.S.C. 1320a–7e), reporting the existence of such conviction to the data base established under such section;

(v) determine which individuals are direct patient access employees (as defined in paragraph (6)(B) for purposes of the nationwide program;

(vii) as appropriate, specify offenses, including convictions for violent crimes, for purposes of the nationwide program; and

(viii) describe and test methods that reduce duplicative fingerprinting, including providing for the development of “rap back” capability such that, if a direct patient access employee of a long-term care facility or provider is convicted of a crime following the initial criminal history background check conducted with respect to such employee, the Secretary shall match the prints on file with the State law enforcement department; the department shall immediately inform the State and the State will immediately inform the long-term care facility or provider which employs the direct patient access employee of such conviction.

(D) provide for appeals for direct patient access employees (as defined in paragraph (6)(B) of this section); and

(E) override an agreement under paragraph (1) if the Secretary determines that the requirement of an agreement under paragraph (1) is not being satisfied.

(B) require States to describe and test procedures that reduce duplicative fingerprinting, including providing for the development of “rap back” capability such that, if a direct patient access employee of a long-term care facility or provider is convicted of a crime following the initial criminal history background check conducted with respect to such employee (whether or not the employee is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nurse aide, registered therapist, or other medical personnel);

(iv) require a nursing facility to electronically submit to the Secretary direct staffing information (including information with respect to agency and contract staffing) based on payroll and other verifiable and auditable data in a uniform format (according to specifications established by the Secretary in consultation with such program and groups, and parties). Such specifications shall require that the information submitted under the preceding sentence—

(1) be in a format that is easy to read and ensure the accuracy and completeness of information with respect to specific categories, such as nursing staff, before other categories of certified employees referenced in clause (1) per resident per day.

Nothing in this subparagraph shall be construed as preventing the Secretary from requiring agencies of such information with respect to specific categories, such as nursing staff, before other categories of certified employees. Information under this subparagraph (with respect to agency and contract staffing) shall be kept separate from information on employee staffing.

SEC. 1418. STATE REQUIREMENTS

(a) In General.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”), shall establish a program to conduct background checks on prospective direct patient access employees on a nationwide basis (in this subsection, such program shall be referred to as the “nationwide program”). The Secretary shall carry out the nationwide program under conditions and as the pilot program under section 307 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2257), including the prohibition on hiring abusive workers and the authorization of the imposition of penalties by a participating State under subsections (b)(5)(A) and (b)(6), respectively, of such section 307. The program under this subsection shall contain the following modifications to such pilot program:

(1) Amendments.—

(A) New Participating States.—The Secretary shall enter into agreements with each State—

(i) that has not entered into an agreement with under subsection (c)(1) of such section 307;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

Under such an agreement a State may agree to cover and reimburse each long-term care facility or provider for all costs attributable to conducting background checks and screening described in this subsection that were otherwise required to be conducted by such State or by such facility or provider before the enactment of this subsection, except that Federal funding with respect to such reimbursement shall be limited to the amount made available to the State from funds under subsection (b)(1).

(B) Certain Previously Participating States.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has entered into an agreement with under subsection (c)(1);

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

Sec. 1417. Nationwide Program for National Criminal History Background Checks on Direct Patient Access Employees of Long-Term Care Facilities and Providers

(a) In General.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”), shall establish a program to conduct background checks on prospective direct patient access employees on a nationwide basis (in this subsection, such program shall be referred to as the “nationwide program”). The Secretary shall carry out the nationwide program under conditions and as the pilot program under section 307 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2257), including the prohibition on hiring abusive workers and the authorization of the imposition of penalties by a participating State under subsections (b)(5)(A) and (b)(6), respectively, of such section 307. The program under this subsection shall contain the following modifications to such pilot program:

(1) Amendments.—

(A) New Participating States.—The Secretary shall enter into agreements with each State—

(i) that has not entered into an agreement with under subsection (c)(1) of such section 307;

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.

Under such an agreement a State may agree to cover and reimburse each long-term care facility or provider for all costs attributable to conducting background checks and screening described in this subsection that were otherwise required to be conducted by such State or by such facility or provider before the enactment of this subsection, except that Federal funding with respect to such reimbursement shall be limited to the amount made available to the State from funds under subsection (b)(1).

(B) Certain Previously Participating States.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has entered into an agreement with under subsection (c)(1);

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis; and

(iii) that submits an application to the Secretary containing such information and at such time as the Secretary may specify.
(I) the department will immediately inform the State agency designated under clause (v) and such agency will immediately inform the facility or provider which employs the direct patient access employee of any such conviction; and

(II) the State will provide, or will require the facility to provide, to the employee a copy of the criminal history background check conducted with respect to the employee at no charge in the case where the individual requests such a copy.

Background checks and screenings under this subsection shall be valid for a period of no longer than 2 years, as determined by the State and approved by the Secretary.

(6) PAYMENTS.—

(A) NEWLY PARTICIPATING STATES.—

(i) IN GENERAL.—As part of the application submitted under paragraph (1)(A)(i), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) a particular amount of non-Federal contributions, as a condition of receiving the Federal match under clause (i).

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(A) shall be an amount that the Secretary determines appropriate by the Secretary.

(B) PREVIOUSLY PARTICIPATING STATES.—

(i) IN GENERAL.—As part of the application submitted by a State under paragraph (1)(B)(iii), the State shall guarantee, with respect to the costs to be incurred by the State in carrying out the nationwide program, that the State will make available (directly or through donations from public or private entities) the remainder of the non-Federal contributions, as a condition of receiving the Federal match under clause (i).

(ii) FEDERAL MATCH.—The payment amount to each State that the Secretary enters into an agreement with under paragraph (1)(B) shall be 3 times the amount that the State guarantees to make available under clause (i).

(6) DEFINITIONS.—Under the nationwide program:

(A) LONG-TERM CARE FACILITY OR PROVIDER.—The term ‘long-term care facility or provider’ means the following facilities or providers which receive payment for services under title XVIII or XIX of the Social Security Act:

(i) A skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1396r(a))).

(ii) A nursing facility (as defined in section 1919(a) of such Act (42 U.S.C. 1396r(a))).

(iii) A home health agency.

(iv) A provider of hospice care (as defined in section 1861(dd)(1) of such Act (42 U.S.C. 1395ww(d)(1))).

(v) A long-term care hospital (as described in section 1395ww(d)(3)(B)(v)).

(vi) A provider of personal care services.

(vii) A provider of adult day care.

(viii) A residential care provider that arranges for, or directly provides, long-term care services, including an assisted living facility that provides a nursing home level of care services, including an assisted living facility that provides a nursing home level of care services.

(ix) Any other facility or provider of long-term care services under such titles as the participating State determines appropriate.

(B) DIRECT PATIENT ACCESS EMPLOYEE.—The term ‘direct patient access employee’ means any individual who has access to a patient or resident of a long-term care facility or provider through employment or through a contract with such facility or provider and has duties that involve (or may involve) one-on-one contact with a patient or resident of the facility or provider, as determined by the State for purposes of the nationwide program. Such term does not include a volunteer who performs duties that are equivalent to the duties of a direct patient access employee and those duties involve (or may involve) one-on-one contact with a patient or resident of the long-term care facility or provider.

(7) EVALUATION AND REPORTS.—

(A) EVALUATION.—The Inspector General of the Department of Health and Human Services shall conduct an evaluation of the nationwide program. Such evaluation shall include—

(i) a review of the various procedures implemented by participating States for long-term care facilities or providers, including staffing agencies, to conduct background checks of direct patient access employees and identify the most efficient, effective, and economical procedures for conducting such background checks;

(ii) an assessment of the costs of conducting such background checks (including start-up and administrative costs);

(iii) a determination of the extent to which conducting such background checks leads to any unintended consequences, including a reduction in the available workforce for such facilities or providers;

(iv) an assessment of the impact of the program on reducing the number of incidents of neglect, abuse, and mistreatment of residents and patients of such facilities or providers;

(v) an evaluation of other aspects of the program, as determined appropriate by the Secretary.

(B) REPORT.—Not later than 180 days after the completion of the nationwide program, the Inspector General of the Department of Health and Human Services shall submit a report to Congress containing the results of the evaluation conducted under subparagraph (A).

(a) FUNDING.—

(1) NOTIFICATION.—The Secretary of Health and Human Services shall notify the Secretary of the amount necessary to carry out the nationwide program under this section, including costs for the Department of Health and Human Services to administer the program, for the period of fiscal years 2010 through 2012.

(2) ALLOCATION OF FUNDS.—Out of any funds in the Treasury not otherwise appropriated, the Secretary of the Treasury shall provide for the transfer to the Secretary of Health and Human Services of the amount specified as necessary to carry out the nationwide program under paragraph (1). Such amount shall remain available until expended.

(b) REPORT.—

(1) IN GENERAL.—Section 1819(h)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1396d-3(h)(2)(B)(ii)) is amended to read as follows:

‘‘(ii) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—

‘‘(I) AMOUNT.—The Secretary may impose a civil money penalty in the applicable per instance or per day amount (as defined in subclause (II) and (III) for each day or instance, to the extent not more than the amount specified as necessary to carry out the nationwide program under paragraph (1). Such amount shall remain available until expended.

‘‘(II) APPLICABLE PER INSTANCE AMOUNT.—In this clause, the term ‘applicable per instance amount’ means:

‘‘(aa) in the case where the facility is cited for actual harm or immediate jeopardy, an amount not less than $3,050 and not more than $25,000; and

‘‘(bb) in each case of any other deficiency, an amount not less than $250 and not to exceed $3,050.

(IV) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclauses (V) and (VI), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under this clause not later than 10 calendar days after the date of such imposition, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

‘‘(V) PROHIBITION ON REDUCTION FOR CERTAIN DEFICIENCIES.—The Secretary may not reduce under subclause (IV) the amount of a penalty if the deficiency is a repeat deficiency.

‘‘(bb) CERTAIN OTHER DEFICIENCIES.—The Secretary may not reduce under subclause (IV) the amount of a penalty if the penalty is imposed for a deficiency described in subclause (II)(aa) or (II)(aa) and the actual harm or widespread harm immediately jeopardizes the health or safety of a resident or patient of the facility, or the deficiency is imposed for a deficiency described in subclause (II)(bb).

(VI) LIMITATION ON AGGREGATE REDUCTIONS.—The aggregate reduction in a penalty under subclause (IV) may not exceed 35 percent on the basis of self-reporting, on the basis of a waiver of an appeal (as provided for under regulations under section 488.436 of title 42, Code of Federal Regulations), or on the basis of both.

(7) CONSTRUCTION.—In the case of a civil money penalty imposed under this clause, the Secretary—

(aa) subject to item (cc), shall, not later than 30 days after the imposition of the penalty, provide the opportunity for the facility to participate in an independent informal dispute resolution process, established by the State survey agency, which generates a written record prior to the collection of such penalty, but such opportunity shall not affect the responsibility of the survey agency for its final recommendations for such penalties;

(bb) in the case where the penalty is imposed for each day of noncompliance, shall not exceed the penalty for any day during the period beginning on the initial day of the imposition of the penalty and ending on the day on which the informal dispute resolution process under item (aa) is completed;

(cc) may provide for the collection of such civil money penalty and the placement of such amounts collected in an escrow account under the direction of the Secretary on the earlier of the date on which the informal dispute resolution process under item (aa) is completed or the date that is 90 days after the date of the imposition of the penalty;

(dd) may provide that such amounts collected are kept in such account pending the resolution of any subsequent appeals; and

(ee) in the case where the facility successfully appeals the penalty, may provide for...
the return of such amounts collected (plus interest) to the facility; and

“(f)(i) in the case where all such appeals are unsuccessful, may provide that some portion of such funds collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities under quality assurance programs, the appointment of temporary management, and other activities approved by the Secretary).”

“(I) REPEAT DEFICIENCIES.—The State may not reduce under clause (iv) the amount of a penalty if the State had reduced a penalty imposed on the facility in the preceding year under such clause with respect to a repeat deficiency.

“(II) CERTAIN OTHER DEFICIENCIES.—The State may not reduce under clause (iv) the amount of a penalty if any such penalty imposed for a deficiency described in clause (ii)(I) or (ii)(II) and the actual harm or wide-spread harm that immediately jeopardizes the health and safety of a resident of the facility, or if the penalty is imposed for a deficiency described in clause (ii)(I).

“(III) LIMITATION ON AGGREGATE REDUCTIONS.—The aggregate reduction in a penalty under clause (ii) shall not exceed $3,050 and not more than $25,000; and

“(IV) may provide that such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities under quality assurance programs, the appointment of temporary management, and other activities approved by the Secretary).”

“(f)(ii) in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under subclause (III), the penalty imposed on the facility in the preceding year under such clause with respect to a repeat deficiency.

“(g) CIVIL MONEY PENALTIES.—

“(I) AMOUNT.—Subject to subclause (II), the amount of a penalty may impose a civil money penalty in an amount not to exceed $10,000 for each day or each instance of noncompliance (as determined appropriate by the Secretary).

“(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed on the facility in the preceding year under such clause with respect to a repeat deficiency.

“(III) LIMITATION ON AGGREGATE REDUCTIONS.—The aggregate reduction in a civil money penalty under subparagraph (A)(ii), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed on the facility in the preceding year under such clause with respect to a repeat deficiency.

“(I) TIME.'.$.

“IN GENERAL.—Section 1919(h)(2) of the Social Security Act (42 U.S.C. 1395i–3(h)(2)) is amended by inserting ‘‘(ii),’’ after ‘‘(i),’’.

“(B) NURSING FACILITIES.—

“(A) IN GENERAL.—Section 1919(h)(2)(B) of the Social Security Act (42 U.S.C. 1395i–3(h)(2)(B)) is amended by inserting ‘‘(ii),’’ after ‘‘(i)’’.

“(B) IN GENERAL.—The State may assess a civil money penalty under subparagraph (A)(ii) in the applicable per instance or per day amount (as defined in subparagraph (G)) and may assess a civil money penalty for an instance, respectively, of noncompliance (as determined appropriate by the Secretary).

“(C) APPLICABLE PER INSTANCE AMOUNT.—In this subparagraph, the term ‘applicable per instance amount’ means—

“(I) in the case where the deficiency is found to be a direct proximate cause of death of a resident of the facility, an amount not to exceed $100,000;

“(II) in each case of a deficiency where the facility is cited for actual harm or immediate jeopardy, an amount not less than $3,050 and not more than $25,000; and

“(III) in each case of any other deficiency, an amount not less than $500 and not to exceed $3,050.

“(D) APPLICABLE PER DAY AMOUNT.—In this subparagraph, the term ‘applicable per day amount’ means—

“(I) in the case where the facility is cited for actual harm or immediate jeopardy, an amount not less than $3,050 and not more than $25,000 and

“(II) in each case of any other deficiency, an amount not less than $250 and not to exceed $3,050.

“(E) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to clauses (v) and (vi), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed under subparagraph (A)(ii) not later than 10 calendar days after the date of such imposition, the State may reduce the amount of the penalty imposed by not more than 50 percent.

“(V) PROHIBITION ON REDUCTION FOR CERTAIN DEFICIENCIES.—

“(I) REPEAT DEFICIENCIES.—The State may not reduce under clause (iv) the amount of a penalty if the State had reduced a penalty imposed on the facility in the preceding year under such clause with respect to a repeat deficiency.

“(II) CERTAIN OTHER DEFICIENCIES.—The State may not reduce under clause (iv) the amount of a penalty if any such penalty imposed for a deficiency described in clause (ii)(I) or (ii)(II) and the actual harm or widespread harm that immediately jeopardizes the health and safety of a resident of the facility, or if the penalty is imposed for a deficiency described in clause (ii)(I).

“(III) LIMITATION ON AGGREGATE REDUCTIONS.—The aggregate reduction in a civil money penalty under subparagraph (A)(ii) shall not exceed $3,050 and not more than $25,000; and

“(IV) may provide that some portion of such amounts collected may be used to support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility), projects that support resident and family councils and other consumer involvement in assuring quality care in facilities, and facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities under quality assurance programs, the appointment of temporary management, and other activities approved by the Secretary).”

“(f)(ii) in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed on the facility in the preceding year under such clause with respect to a repeat deficiency.

“(g) CIVIL MONEY PENALTIES.—

“(I) AMOUNT.—Subject to subclause (II), the amount of a penalty may impose a civil money penalty in an amount not to exceed $10,000 for each day or each instance of noncompliance (as determined appropriate by the Secretary).

“(II) REDUCTION OF CIVIL MONEY PENALTIES IN CERTAIN CIRCUMSTANCES.—Subject to subclause (III), in the case where a facility self-reports and promptly corrects a deficiency for which a penalty was imposed on the facility in the preceding year under such clause with respect to a repeat deficiency.
man as such provisions apply to a penalty or proceeding under section 1128(a)."

(b) CONFORMING AMENDMENT.—Section 1916(h)(8) of the Social Security Act (42 U.S.C. 1396(h)(8)) is amended by inserting "and in paragraph (3)(C)(ii)" after "paragraph (2)(A)".

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 1422. NATIONAL INDEPENDENT MONITOR PILOT PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish a pilot program (in this section referred to as the "pilot program") to develop, test, and implement use of an independent monitor to oversee interstate and large intrastate chains of skilled nursing facilities and nursing facilities.

(2) SELECTION.—The Secretary shall select chains of skilled nursing facilities and nursing facilities described in paragraph (1) to participate in the pilot program from among those chains that submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(3) DURATION.—The Secretary shall conduct the pilot program for a two-year period.

(4) IMPLEMENTATION.—The Secretary shall implement the pilot program not later than one year after the date of the enactment of this Act.

(b) REQUIREMENTS.—The Secretary shall evaluate chains selected to participate in the pilot program on criteria selected by the Secretary, including where evidence suggests that one or more facilities of the chain are experiencing serious safety and quality of care criteria, and to evaluate a chain that includes one or more facilities participating in the "Special Focus Facility" program (or a successor program) or one or more facilities with a record of repeated serious safety and quality care deficiencies.

(c) RESPONSIBILITIES OF THE INDEPENDENT MONITOR.—An independent monitor that enters into a contract with the Secretary to participate in the conduct of such program shall—

(1) conduct periodic reviews and prepare root-cause analysis and quality and deficiency analyses of a chain to assess if facilities of the chain are in compliance with State and Federal laws and regulations applicable to the facilities;

(2) undertake sustained oversight of the chain, whether publicly or privately held, to involve the owners of the chain and the principal business partners of such owners in facilitating compliance by facilities of the chain with State and Federal laws and regulations applicable to the facilities;

(3) analyze the management structure, distribution of revenues, and nurse staffing levels of facilities of the chain in relation to resident census, staff turnover rates, and tenure;

(4) report findings and recommendations with respect to such reviews, analyses, and oversight to the chain and facilities of the chain, to the Secretary and to relevant State agencies;

(5) publish the results of such reviews, analyses, and oversight.

(d) IMPLEMENTATION OF RECOMMENDATIONS.—

(1) RECEIPT OF FINDINGS BY CHAIN.—Not later than 10 days after receipt of a finding of an independent monitor under subsection (c)(4), a chain in the pilot program shall submit to the independent monitor a report—

(A) outlining corrective actions the chain will take to implement the recommendations in such report; or

(B) indicating that the chain will not implement the recommendations and why it will not do so.

(2) RECEIPT OF REPORT BY INDEPENDENT MONITOR.—Not later than 10 days after the date of a report submitted by a chain under paragraph (1), an independent monitor shall finalize its recommendations and submit a report to the chain and facilities of the chain and, the Secretary (in an amount and in accordance with procedures established by the Secretary).

(i) WAIVER AUTHORITY.—The Secretary may waive such procedures and recommendations, and contain such final recommendations.

(c) COST OF APPOINTMENT.—A chain shall be responsible for the costs associated with the appointment of independent monitors under the pilot program. The chain shall pay an amount and in accordance with procedures established by the Secretary.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

(h) DEFINITIONS.—In this section:

(1) FACILITY.—The term "facility" means a skilled nursing facility or a nursing facility.

(2) NURSING FACILITY.—The term "nursing facility" has the meaning given such term in section 1919(a) of the Social Security Act (42 U.S.C. 1396r(c)).

(3) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services, acting through the Assistant Secretary for Planning and Evaluation.

(4) SKILLED NURSING FACILITY.—The term "skilled nursing facility" has the meaning given such term in section 1128B(a) of the Social Security Act (42 U.S.C. 1395v(c)).

(i) EVALUATION AND REPORT.—The Inspector General of the Department of Health and Human Services shall evaluate the pilot program. Such evaluation shall—

(A) determine whether the independent monitor program should be established on a permanent basis; and

(B) if the Inspector General determines that the independent monitor program should be established on a permanent basis, recommend appropriate procedures and mechanisms for such establishment.

(2) REPORT.—Not later than 180 days after the date of such closure, the Inspector General shall submit to Congress and the Secretary a report containing the results of the evaluation conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Inspector General determines appropriate.

SEC. 1423. NOTIFICATION OF FACILITY CLOSURE.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919(c) of the Social Security Act (42 U.S.C. 1395i–3(c)) is amended—

(A) by striking "subsection (c)(2)" and inserting "paragraphs (2) and (7) of subsection (c)";

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919(c) of the Social Security Act (42 U.S.C. 1395i–3(c)) is amended—

(A) by adding at the end the following new paragraph:

(7) NOTIFICATION OF FACILITY CLOSURE.—

"(A) IN GENERAL.—Any individual who is an administrator of a nursing facility must—

"(i) submit to the Secretary, the State long-term care ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure—

"(I) subject to subsection (C), not later than the close of the calendar month that is 30 days prior to the date of such closure; and

"(II) in the case of a facility where the Secretary terminates the facility’s participation under this title, not later than the date that the Secretary determines appropriate;

"(ii) ensure that the facility does not admit any new residents on or after the date of such closure; and

"(iii) include in the notice a plan for the transfer and adequate relocation of the residents of the facility to another facility or other setting in terms of quality, services, and location, taking into consideration the needs and best interests of each resident.

"(B) RELATIONSHIP.—

"(i) IN GENERAL.—The State shall ensure that, before a facility closes, all residents of the facility have been successfully relocated to another facility or an alternative home and community-based setting.

"(ii) CONTINUATION OF PAYMENTS UNTIL RESIDENTS RELOCATED.—The Secretary may—

"(A) in the first sentence, by striking "the Secretary shall terminate" and inserting the "Secretary, subject to subsection (c)(7), shall terminate"; and

"(B) in the second sentence, by striking "subsection (c)(2)" and inserting "paragraphs (2) and (7) of subsection (c)");

"(c) CONFORMING AMENDMENTS.—Section 1919(c)(4) of the Social Security Act (42 U.S.C. 1395i–3(c)(4)) is amended—

(A) by striking "the Secretary, subject to subsection (c)(7), shall terminate" and inserting the "Secretary, subject to subsection (c)(7), shall terminate"; and

(B) by striking "subsection (c)(2)" and inserting "paragraphs (2) and (7) of subsection (c)".

(2) EFFECTIVE DATE.—The amendments made by this section shall take effect not later than the date that the Secretary determines appropriate;
has submitted a notification under subparagraph (A) during the period beginning on the date such notification is submitted and ending on the date on which the resident is successful in obtaining the initial request for coverage, if appropriate; and
(c) Effective Date.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

PART 3—IMPROVING STAFF TRAINING

SEC. 1431. DEMENTIA AND ABUSE PREVENTION TRAINING

(a) SKILLED NURSING FACILITIES.—Section 1819(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1395i–2(f)(2)(A)(i)(I)) is amended by inserting ‘‘including, in the case of initial training and, if the Secretary determines appropriate, in the case of ongoing training, dementia management training and resident abuse prevention training’’ after ‘‘curriculum’’.

(b) NURSING FACILITIES.—Section 1919(f)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1396r(f)(2)(A)(i)(I)) is amended by inserting ‘‘after the date that is 180 days after the date of enactment of this Act, require more than 12 hours per year’’ after ‘‘in this paragraph’’.

(c) Effect of Date.—The amendments made by this section shall take effect 1 year after the date of enactment of this Act.

SEC. 1432. STUDY AND REPORT ON TRAINING REQUIRED FOR CERTIFIED NURSE AIDES AND SUPERVISORY STAFF.

(a) Study.—

(1) In general.—The Secretary shall conduct a study on the content of training for certified nurse aides and supervisory staff of skilled nursing facilities and nursing facilities.

(2) Content of Study.—The study shall include an analysis of the following:

(A) Whether the number of initial training hours for certified nurse aides required under subsections 1819(f)(2)(A)(i)(I) and 1919(f)(2)(A)(i)(II) of the Social Security Act (42 U.S.C. 1395i–2(f)(2)(A)(i)(I) and 1396r(f)(2)(A)(i)(II)) should be increased from 75 and, if so, what the required number of initial training hours should be, including any recommendations for the content of such training (including training related to dementia).

(B) Whether requirements for ongoing training under such sections 1819(f)(2)(A)(i)(I) and 1919(f)(2)(A)(i)(II) should be increased from 12 hours per year, including any recommendations for the content of such training.

(c) Effective Date.—In conducting the analysis under paragraph (1)(A), the Secretary shall consult with States that, as of the date of the enactment of this Act, require more than 75 hours of training for certified nurse aides.

(b) Definitions.—In this section:

(A) NURSING FACILITY.—The term ‘‘nursing facility’’ has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–2(a)).

(B) SKILLED NURSING FACILITY.—The term ‘‘skilled nursing facility’’ has the meaning given such term in section 1819(a) of the Social Security Act (42 U.S.C. 1395i–2(a)).

(b) Report.—Not later than 2 years after the date of enactment of this Act, the Secretary shall submit to Congress a report containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

SEC. 1433. QUALIFICATION OF DIRECTOR OF FOOD SERVICES OF A SKILLED NURSING FACILITY OR NURSING FACILITY

(a) Medicare.—Section 1819(b)(4)(A) of the Social Security Act (42 U.S.C. 1395i– 2(b)(4)(A)) is amended by adding at the end the following:

(1) contribute to a large burden of disease, including those that address the health care and care transitions for patients across providers and health care settings, including end of life care;

(2) have the potential for rapid improvement due to existing evidence, standards of care or other reasons.

(4) DEFINITIONS.—In this part:

(A) CONSENSUS-BASED ENTITY.—The term ‘‘consensus-based entity’’ means an entity with a contract with the Secretary under section 1890.

(B) QUALITY MEASURE.—The term ‘‘quality measure’’ means a national consensus standard for measuring the performance and improvement of population health, or of institutional providers of services, physicians, and other health care practitioners in the delivery of health care services.

(c) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in such proportion as the Secretary determines appropriate), of $2,000,000, for the activities under this section for each of the fiscal years 2010 through 2014.

(2) Authorization of Appropriations.—For purposes of carrying out the provisions of this section, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services $2,000,000 for each of the fiscal years 2010 through 2014.

SEC. 1442. DEVELOPMENT OF NEW QUALITY MEASURES; GAO EVALUATION OF DATA COLLECTION PROCESS FOR QUALITY MEASUREMENT.

(a) AGREEMENTS WITH QUALIFIED ENTITIES.—

(1) IN GENERAL.—The Secretary shall enter into agreements with qualified entities to develop quality measures for the delivery of health care services in the United States.

(b) FORM OF AGREEMENTS.—The Secretary may carry out paragraph (1) by contract, grant, or otherwise.

(c) RECOMMENDATIONS OF CONSENSUS-BASED ENTITY.—In carrying out this section, the Secretary shall—

(1) seek public input; and

(2) take into consideration recommendations from the consensus-based entity with a contract with the Secretary under section 1890(a).

(b) DETERMINATION OF AREAS WHERE QUALITY MEASURES ARE REQUIRED.—Consistent with the national priorities established under this part and with the programs administered by the Centers for Medicare & Medicaid Services and in consultation with other relevant Federal agencies, the Secretary shall determine areas in which quality measures for assessing health care services in the United States are needed.

(c) DEVELOPMENT OF QUALITY MEASURES.—

(1) PATIENT-CENTERED AND POPULATION-BASED MEASURES.—In entering into agreements under subsection (a), the Secretary shall—

(2) address health disparities across groups and areas; and
(E) health disparities including those associated with individual race, ethnicity, age, gender, place of residence or language; and
(F) the efficiency and resource use in the provision of care.
(2) Use of funds.—An entity that enters into an agreement under subsection (a) shall develop quality measures that, to the extent possible, have the ability to be collected through the use of health information technologies supporting better delivery of health care services; and
(3) Availability of funds.—The Secretary of Health and Human Services shall make available to users of such measures.
(3) Availability of measures.—The Secretary shall make quality measures developed under this section available to the public.
(4) Testing of proposed measures.—The Secretary may use amounts made available under subsection (f) to fund the testing of proposed quality measures by qualified entities. Testing funded under this paragraph shall include testing of the feasibility and usability of proposed measures.
(5) Updating of endorsed measures.—The Secretary may use amounts made available under subsection (f) to fund the testing, and if applicable, the consensus-based entities of quality measures that have previously been endorsed by such an entity as not developed, in a manner consistent with section 1890(b)(3).
(e) Application for grant.—A grant may be made under this section only if an application for the grant, as a whole, submitted to the Secretary and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this section.
(f) Funding.—In general.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under subsection (a) of such amount as the Secretary determines appropriate, of $25,000,000, to the Secretary for purposes of carrying out this section for each of the fiscal years 2010 through 2014.
(2) Authorization of appropriations.—For purposes of carrying out the provisions of this section, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services $1,000,000 for each of the fiscal years 2010 through 2014.
SEC. 1193. GAO EVALUATION OF DATA COLLECTION PROCESS FOR QUALITY MEASURES.
(a) GAO evaluations.—The Comptroller General of the United States shall conduct periodic evaluations of the implementation of the processes for quality measures used by the Secretary.
(b) Considerations.—In carrying out the evaluation required under subsection (a), the Comptroller General shall determine—
(1) whether the system for the collection of data for quality measures provides for validation of data as relevant and scientifically credible;
(2) whether data collection efforts under the system use the most efficient and cost-effective manner that minimizes administrative burden on persons required to collect data and that adequately protects the privacy of patients’ personal health information and provides data security;
(3) whether standards under the system provide for an appropriate opportunity for physicians and other clinicians and institutional providers of services to review and request additional information and for the Secretary to provide additional information and for the Secretary to provide additional information;
(4) to the extent to which quality measures are consistent with section 1192(c)(1) or result in direct or indirect costs to users of such measures.
(b) Report.—The Comptroller General shall submit to the Committee on Education and Labor containing a description of the findings and conclusions of the results of each such evaluation.
SEC. 1443. MULTI-STAKEHOLDER PRE-RULEMAKING INPUT INTO SELECTION OF QUALITY MEASURES.
Section 1808 of the Social Security Act (42 U.S.C. 1395ww(b)(2)) is amended by adding at the end the following new subsection:
(1) LIST OF MEASURES.—Not later than December 1 before each year, the Secretary shall make public a list of measures being considered for selection for quality measurement by the Secretary in rulemaking with respect to payment systems under this title beginning in the payment year beginning in such year and for payment systems beginning in the following year, as the case may be.
(2) CONSULTATION ON SELECTION OF ENDORED QUALITY MEASURES.—Within a reasonable time after the Secretary determines to be necessary to carry out this section, the Secretary shall consult with other entities of quality measures that have been previously endorsed by such an entity and the Secretary shall consult with the Secretary, as determined appropriate by the Secretary, including such measure.
(3) MULTI-STAKEHOLDER INPUT.—Not later than February 1 of each year (beginning with 2011), the consensus-based entity described in paragraph (2) shall transmit to the Secretary the recommendations of multi-stakeholder groups provided under paragraph (2). Such recommendations shall be included in the transmissions the consensus-based entity makes to the Secretary under the contract provided for under section 1890.
(4) REQUIREMENT FOR TRANSPARENCY IN PROCESSING.—The Secretary shall require for purposes of this section, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services $1,000,000 for each of the fiscal years 2010 through 2014.
SEC. 1194. APPLICATION OF QUALITY MEASURES.
(a) INPATIENT HOSPITAL SERVICES.—Section 1886(r)(3)(B) of such Act (42 U.S.C. 1395ww(r)(3)(B)) is amended by adding at the end the following new subparagraph:
(4) USE OF ENDORSED QUALITY MEASURES.—With respect to the selection of quality measures for covered OPD services under this paragraph, the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization, as defined in paragraph (2), or a consensus organization that the Secretary deems appropriate, of $1,000,000, to the Secretary for purposes of carrying out this subsection for each of the fiscal years 2010 through 2014.
(b) OUTPATIENT HOSPITAL SERVICES.—Section 1833(c)(17) of such Act (42 U.S.C. 1395w(c)(17)) is amended by adding at the end the following new subparagraph:
(F) USE OF ENDORSED QUALITY MEASURES.—The provisions of clause (x) of section 1866(b)(3)(C) shall apply to quality measures for covered OPD services under this paragraph in the same manner as such provisions apply to inpatient quality measures for inpatient hospital services.
(c) PHYSICIANS’ SERVICES.—Section 1848(l)(2)(C)(i)(II) of such Act (42 U.S.C. 1395w-4(c)(2)(C)(i)(II)) is amended by adding at the end the following new subparagraph:
(4) The Secretary shall make publicly available a list of measures that are consistent with section 1192(c)(1) or result in direct or indirect costs to users of such measures,
If the entity does not endorse a measure, for payment years beginning with 2012 or fiscal year 2013, the amendments made by this section (a).

SEC. 1445. CONSENSUS-BASED ENTITY FUNDING.

(42 U.S.C. 1395aaa(d)) is amended by striking "(1) IN GENERAL.—Except as provided in paragraph (3) or (4)," and inserting "(1) IN GENERAL.—Except as provided in paragraphs (3) or (4),"

SEC. 1446. QUALITY INDICATORS FOR CARE OF PEOPLE WITH ALZHEIMER'S DISEASE.

(a) QUALITY INDICATORS.—The Secretary of Health and Human Services shall develop quality indicators for the provision of medical services to people with Alzheimer's disease and other dementias and a plan for implementing the indicators to measure the quality of care provided for people with these conditions by physicians, hospitals, and other appropriate providers of services and suppliers.

(b) REPORT.—The Secretary shall submit a report to the Committees on Energy and Commerce and Ways and Means of the United States Senate and the Committees on Finance and Health, Education, Labor, and Pensions of the United States Senate not later than 24 months after the date of the enactment of this Act setting forth the status of its efforts to implement the requirements of subsection (a).

Subtitle D—Physician Payments Sunshine Provision

SEC. 1451. REPORTS ON FINANCIAL RELATIONSHIPS BETWEEN MANUFACTURERS AND DISTRIBUTORS OF COVERED DRUGS, DEVICES, BIOLOGICALS, OR MEDICAL SUPPLIES UNDER MEDICARE, MEDICAID, OR CHAMPUS AND OTHER HEALTH CARE ENTITIES.

(a) In General.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by section 1631(a), is further amended by inserting after section 11280 the following new section:

"SEC. 11280. FINANCIAL REPORTS ON PHYSICIAN'S FINANCIAL RELATIONSHIPS WITH MANUFACTURERS AND DISTRIBUTORS OF COVERED DRUGS, DEVICES, BIOLOGICALS, OR MEDICAL SUPPLIES UNDER MEDICARE, MEDICAID, OR CHAMPUS AND WITH OTHER HEALTH CARE ENTITIES.

"(a) Reporting of Payments or Other Transfers of Value.—

"(1) IN GENERAL.—Except as provided in this subsection, not later than March 31, 2011, and annually thereafter, each applicable manufacturer or distributor that provides a payment or other transfer of value to a covered recipient, or to an entity or individual at the request or designation of a covered recipient, shall submit to the Secretary, in such electronic form as the Secretary shall require, the following information with respect to the preceding calendar year:

"(A) With respect to the covered recipient, the recipient's name, business address, physician specialty, and national provider identifier;

"(B) With respect to the payment or other transfer of value, other than a drug sample—

"(i) its value and date;

"(ii) the name, if any, of the related drug, device, or supply, if available, to the level of specificity available; and

"(iii) a description of its form, indicated (as appropriate) as—

"(I) cash or a cash equivalent;

"(II) in-kind items or services;

"(III) stock, a stock option, or any other ownership interest, dividend, profit, or other return on investment; or

"(IV) any other form (as defined by the Secretary).

"(C) With respect to a drug sample, the name, number, date, and dosage units of the sample.

"(2) AGGREGATE REPORTING.—Information submitted by an applicable manufacturer or distributor under paragraph (1) shall include the aggregate amount of all payments or other transfers of value made in the reporting period (or an immediate family member of such individual at the request of or designated on behalf of a covered recipient) during the year involved, including all payments and transfers of value regardless of whether such payments or transfer of value were individually disclosed.

"(b) REPORTING OF OWNERSHIP INTEREST BY APPLICABLE MANUFACTURER OR DISTRIBUTOR.—In the case where an applicable manufacturer or distributor provides a payment or other transfer of value to an entity or individual at the request of or designated on behalf of a covered recipient, the manufacturer or distributor shall disclose that payment or other transfer of value under the name of the covered recipient.

"(4) DELAYED REPORTING FOR PAYMENTS MADE PURSUANT TO PRODUCT DEVELOPMENT AGREEMENT.—"(A) With respect to a covered recipient, the recipient's name, business address, physician specialty, and national provider identifier;

"(B) With respect to the payment or other transfer of value, other than a drug sample—

"(i) its value and date;

"(ii) the name of the related drug, device, or supply, if available, to the level of specificity available; and

"(iii) a description of its form, indicated (as appropriate) as—

"(I) cash or a cash equivalent;

"(II) in-kind items or services;

"(III) stock, a stock option, or any other ownership interest, dividend, profit, or other return on investment; or

"(IV) any other form (as defined by the Secretary).

"(C) With respect to a drug sample, the name, number, date, and dosage units of the sample.

"(a)(1)(B), and information described in subsection (f)(8)(A) and (f)(8)(B).

"(c) With respect to an applicable group purchasing organization, applicable distributor shall submit to the Secretary, in such electronic form as the Secretary shall require, the following in addition to the requirements under subsection (a)(1), any applicable manufacturer, applicable group purchasing organization, or applicable distributor shall submit to the Secretary in such electronic form as the Secretary shall require, the following information regarding any ownership or investment interest (other than ownership or investment interest the Secretary determines appropriate.

"(d) Any other information regarding the ownership or investment interest the Secretary determines appropriate.
providing advanced diagnostic imaging and radiation oncology services to Medicare beneficiaries under title XVIII. The study shall be completed and submitted to Congress by April 1, 2010.

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(c) PUBLIC AVAILABILITY.—

(1) IN GENERAL.—The Secretary shall establish procedures to ensure that not later than September 30, 2011, and on June 30 of each year thereafter, the information submitted under subsections (a) and (b), other than regard drug samples, with respect to the preceding calendar year is made available through an Internet website that—

(A) is searchable and is in a format that is clear and understandable;

(B) contains information that is presented in the same manner as funding for clinical research, and designates such separately listed information as funding for clinical research;

(C) contains information that is able to be easily downloaded;

(D) contains a description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (a) during the preceding year;

(E) contains background information on industry-physician relationships;

(F) in the case of information submitted with respect to the preceding calendar year, includes a description of any penalty imposed under section (a)(1)(B)(ii), the nature of the payment or other transfer of value, indicated (as appropriate) under subsection (a)(1)(B)(iii), and the name of the covered drug, device, biological, or medical supply, as applicable;

(G) contains any other information the Secretary determines would be helpful to the public;

(H) provides the covered recipient an opportunity to submit corrections to the information made available to the public with respect to itself;

(2) ACCURACY OF REPORTING.—The accuracy of the information that is submitted under subsections (a) and (b) and made available under subsection (c)(1)(B) shall be the responsibility of the reporting entity reporting under subsection (a) or (b), as applicable. The Secretary shall establish procedures to ensure that the covered recipient is provided with an opportunity to submit corrections to the applicable reporting entity with regard to information made public with respect to the covered recipient and, under such procedures, the corrections shall be transmitted to the Secretary.

(3) PENALTY FOR FALSE CLAIMS.—Information relating to drug samples provided under subsection (a) shall not be made available to the public by the Secretary but may be made available outside the Department of Health and Human Services by the Secretary for research or legitimate business purposes pursuant to data use agreements.

(4) PRIVACY OF NATIONAL PROVIDER IDENTIFIERS.—Information relating to national provider identifiers provided under subsection (a) shall not be made available to the public by the Secretary but may be made available outside the Department of Health and Human Services by the Secretary for research or legitimate business purposes pursuant to data use agreements.

(5) PENALTIES FOR NONCOMPLIANCE.—

(A) IN GENERAL.—Subject to subparagraph (B), except as provided in paragraph (2), any reporting entity that fails to submit information required under subsection (a) or (b), as applicable, in timely manner, or in accordance with regulations promulgated to carry out such applicable subsection shall be subject to a civil money penalty of not less than $1,000, but not more than $10,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed in the same manner as civil money penalties under subsection (a) of section 1128A, are imposed and collected under that section.

(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A) with respect to each annual submission of information under subsection (a) by a reporting entity, shall not exceed $150,000.

(2) KNOWING FAILURE TO REPORT.—

(A) IN GENERAL.—Subject to subparagraph (B), any reporting entity that knowingly fails to submit information required under subsection (a) or (b), as applicable, in timely manner, or in accordance with regulations promulgated to carry out such applicable subsection shall be subject to a civil money penalty of not less than $10,000, but not more than $100,000, for each payment or other transfer of value or ownership or investment interest not reported as required under such subsection. Such penalty shall be imposed in the same manner as civil money penalties under section (a) of section 1128A, are imposed and collected under that section.

(B) LIMITATION.—The total amount of civil money penalties imposed under subparagraph (A), with respect to each annual submission of information under subsection (a) by a reporting entity, shall not exceed $1,000,000.

(3) USE OF FUNDS.—Funds collected by the Secretary as a result of the imposition of a civil money penalty under this subsection shall be used to carry out this section.

(4) ENFORCEMENT THROUGH STATE ATTORNEYS GENERAL.—The attorney general of a State, after providing notice to the Secretary declining such opportunity, may proceed to bring an action under this subsection and the Secretary shall be liable to civil money penalties as provided in subsection (b), as applicable, in a timely manner in accordance with regulations promulgated to carry out such applicable subsection.

(5) ANNUAL REPORT TO CONGRESS.—Not later than April 1 of each year beginning with 2011, the Secretary shall submit to Congress a report that includes the following:

(A) The information submitted under this section during the preceding year, aggregated for each applicable reporting entity that submitted such information during such year.

(B) A description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (d), during the preceding year.

(6) ANNUAL REPORT TO CONGRESS.—Not later than April 1 of each year beginning with 2011, the Secretary shall submit to Congress a report that includes the following:

(A) The information submitted under this section during the preceding year, aggregated for each applicable reporting entity that submitted such information during such year.

(B) A description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (d), during the preceding year.

(f) DEFINITIONS.—In this section:

(1) APPLICABLE DISTRIBUTOR.—The term ‘applicable distributor’ means—

(A) any entity, other than an applicable group purchasing organization, that buys and resells, or receives a commission or other payment from, or engages in another transaction with, another seller, for selling or arranging for the sale of a covered drug, device, biological, or medical supply;

(B) any entity under common ownership with such an entity described in subparagraph (A) and which provides assistance or support to such entity so described with respect to the production, preparation, propagation, conversion, processing, marketing, or distribution of a covered drug, device, biological, or medical supply.

Such term does not include a wholesale pharmaceutical distributor.

(2) APPLICABLE MANUFACTURER.—The term ‘applicable manufacturer’ means any entity engaged in the production, preparation, propagation, conversion, processing, marketing, or manufacture of a covered drug, device, biological, or medical supply.

(3) USE OF FUNDS.—Funds collected by the Secretary as a result of the imposition of a civil money penalty under this subsection shall be used to carry out this section.

(4) ENFORCEMENT THROUGH STATE ATTORNEYS GENERAL.—The attorney general of a State, after providing notice to the Secretary declining such opportunity, may proceed to bring an action under this subsection and the Secretary shall be liable to civil money penalties as provided in subsection (b), as applicable, in a timely manner in accordance with regulations promulgated to carry out such applicable subsection.

(5) ANNUAL REPORT TO CONGRESS.—Not later than April 1 of each year beginning with 2011, the Secretary shall submit to Congress a report that includes the following:

(A) The information submitted under this section during the preceding year, aggregated for each applicable reporting entity that submitted such information during such year.

(B) A description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (d), during the preceding year.

(ii) Travel or trip.

(iii) Honoraria.

(iv) Research funding or grant.

(v) Payments to another provider.

(vi) Consulting fees.

(vii) Ownership or investment interest and royalties or license fee.

(viii) Ownership or investment interest in a company engaged in the production, preparation, propagation, conversion, processing, marketing, or distribution of a covered drug, device, biological, or medical supply.

(2) APPLICABLE MANUFACTURER.—The term ‘applicable manufacturer’ means any entity engaged in the production, preparation, propagation, conversion, processing, marketing, or manufacture of a covered drug, device, biological, or medical supply.

Such term does not include a wholesale pharmaceutical distributor.

(3) USE OF FUNDS.—Funds collected by the Secretary as a result of the imposition of a civil money penalty under this subsection shall be used to carry out this section.

(4) ENFORCEMENT THROUGH STATE ATTORNEYS GENERAL.—The attorney general of a State, after providing notice to the Secretary declining such opportunity, may proceed to bring an action under this subsection and the Secretary shall be liable to civil money penalties as provided in subsection (b), as applicable, in a timely manner in accordance with regulations promulgated to carry out such applicable subsection.

(5) ANNUAL REPORT TO CONGRESS.—Not later than April 1 of each year beginning with 2011, the Secretary shall submit to Congress a report that includes the following:

(A) The information submitted under this section during the preceding year, aggregated for each applicable reporting entity that submitted such information during such year.

(B) A description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (d), during the preceding year.

(i) Gift, food, or entertainment.

(ii) Travel or trip.

(iii) Honoraria.

(iv) Research funding or grant.

(v) Payments to another provider.

(vi) Consulting fees.

(vii) Ownership or investment interest and royalties or license fee.

(viii) Ownership or investment interest in a company engaged in the production, preparation, propagation, conversion, processing, marketing, or distribution of a covered drug, device, biological, or medical supply.

(2) APPLICABLE MANUFACTURER.—The term ‘applicable manufacturer’ means any entity engaged in the production, preparation, propagation, conversion, processing, marketing, or manufacture of a covered drug, device, biological, or medical supply.

Such term does not include a wholesale pharmaceutical distributor.

(3) USE OF FUNDS.—Funds collected by the Secretary as a result of the imposition of a civil money penalty under this subsection shall be used to carry out this section.

(4) ENFORCEMENT THROUGH STATE ATTORNEYS GENERAL.—The attorney general of a State, after providing notice to the Secretary declining such opportunity, may proceed to bring an action under this subsection and the Secretary shall be liable to civil money penalties as provided in subsection (b), as applicable, in a timely manner in accordance with regulations promulgated to carry out such applicable subsection.

(5) ANNUAL REPORT TO CONGRESS.—Not later than April 1 of each year beginning with 2011, the Secretary shall submit to Congress a report that includes the following:

(A) The information submitted under this section during the preceding year, aggregated for each applicable reporting entity that submitted such information during such year.

(B) A description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (d), during the preceding year.

(i) Gift, food, or entertainment.

(ii) Travel or trip.

(iii) Honoraria.

(iv) Research funding or grant.

(v) Payments to another provider.

(vi) Consulting fees.

(vii) Ownership or investment interest and royalties or license fee.

(viii) Ownership or investment interest in a company engaged in the production, preparation, propagation, conversion, processing, marketing, or distribution of a covered drug, device, biological, or medical supply.
with respect to covered recipients or other hospitals and entities in the State.

‘(b) Relation to State Laws.—

‘(1) IN GENERAL.—Effective on January 1, 2011, subject to paragraph (2), the provisions of this section shall preempt any law or regulation of a State or political subdivision of a State that requires an applicable manufacturer or applicable distributor (as such terms are defined in subsection (f)) to disclose or report, in any format, the type of information described in subsection (a) regarding a payment or other transfer of value provided by the manufacturer to a covered recipient (as so defined).

‘(2) No Preemption of Additional Requirements.—Paragraph (1) shall not preempt any statute or regulation of a State or political subdivision of a State that requires any of the following:

‘(A) The disclosure or reporting of information not of the type required to be disclosed or reported under this section.

‘(B) The disclosure or reporting, in any format, of information described in subsection (f)(8)(C), except in the case of information described in clause (i) of subsection (f)(8)(C).

‘(C) The disclosure or reporting, in any format, of information required to be disclosed or reported under this section to a Federal, State, or local governmental agency for public health surveillance, investigation, or other public health purposes or health care oversight purposes.

‘(D) The disclosure or reporting, in any format, required to be reported under any law or regulation of a State or of a political subdivision of a State or of a political subdivision of a State that is 6 months after the date such surveys are collected and shall be made publicly available on an Internet website of the Department of Health and Human Services.

‘(e) Access to Information.—The Secretary, through the Director of the Centers for Disease Control and Prevention, shall promulgate regulations to carry out this section.

‘(1) in which the applicable manufacturer is unaware of the identity of the covered recipient and is not using such activity or service to limit the discovery or admissibility of information described in this paragraph in a criminal, civil, or administrative proceeding.

‘(b) Availability of Information From the Disclosure of Financial Relationship Report (DFRR).—The Secretary of Health and Human Services shall submit to Congress a report on the full results of the Disclosure of Physician Financial Relationships surveys required under section 1128H of the Social Security Act is amended by inserting after subsection (c) the following:

‘(3) IMPLEMENTATION.—Not later than 1 year after the date of enactment of this section, the Secretary, through the Director of the Office of the National Coordinator for Health Information Technology, shall ensure that the transmission of information under this subsection is facilitated by systems established under the HITrHEC Act, where appropriate.

‘(4) Procedures to Ensure the Validity of Information.—The Secretary shall establish procedures regarding the validity of the information submitted under this subsection in order to ensure that such information is appropriately compared across hospitals and centers. Such procedures shall address failure to report as well as errors in reporting.

‘(5) Coordination With HIT.—The Secretary, through the Director of the CDC and the Office of the National Coordinator for Health Information Technology, shall ensure that the transmission of information under this subsection is facilitated by systems established under the HITRHEC Act, where appropriate.

‘(b) Public Posting of Information.—The Secretary shall promptly post, on the official public Internet site of the Department of Health and Human Services, the information reported under subsection (a). Such information shall be set forth in a manner that allows for the comparison of information on health care-associated infections—

‘(1) among hospitals and ambulatory surgical centers; and

‘(2) by demographic information.

‘(c) Annual Report to Congress.—On an annual basis the Secretary shall submit to Congress a report that summarizes each of the following:

‘(1) The number and types of health care-associated infections reported under subsection (a) in hospitals and ambulatory surgical centers during such year;

‘(2) Factors that contribute to the occurrence of such infections, including health care worker immunization rates.

‘(d) Disclosure of Information.—Nothing in this section or any other provision of law shall be construed to require any manufacturer, distributor, or hospital to disclose to any State any of the information described in this section or to limit any manufacturer, distributor, or hospital from disclosing the information described in this section to any other person.

‘(e) Subpoenas.—Nothing in this section shall be construed to prohibit any State or political subdivision of a State from enforcing any State or political subdivision of a State law or regulation.

‘(f) Periodic Survey.—Not later than May 1 of each year beginning in 2011, the Secretary shall submit to Congress a report that includes a summary of the information submitted under subsections (a), (b), and (d) during the preceding year.
"(4) The total increases or decreases in health care costs that resulted from increases or decreases in the rates of occurrence of each such type of infection during such year.

"(5) Recommendations, in coordination with the Center for Quality Improvement established under section 931 of the Public Health Service Act, for best practices to eliminate the rates of occurrence of each such type of infection in hospitals and ambulatory surgical centers.

"(d) Care Workforce of State Laws.—Nothing in this section shall be construed as preempting or otherwise affecting any provision of State law relating to the disclosure of information concerning the association of disease events or patient safety procedures for a hospital or ambulatory surgical center.

"(e) Health Care-associated Infection.—For purposes of this section:

"(1) In general.—The term 'health care-associated infection' means an infection that develops in a patient who has received care in any institutional setting where health care is delivered and is related to receiving health care.

"(2) Related to receiving health care.—The term 'related to receiving health care', with respect to an infection, means that the infection was not incubating or present at admission or prior to the onset of the infection.

"(3) In paragraph (7)(E), by inserting 'and paragraph (8)' after 'this paragraph'; and

"(4) by adding at the end the following new paragraph:

"(8) REDISTRIBUTION OF UNUSED RESIDENCY POSITIONS.—

"(A) REDUCTIONS IN LIMIT BASED ON UNUSED RESIDENCY POSITIONS.—

"(i) Programs subject to reduction.—If a hospital's reference resident level (specified in clause (i)) is less than the otherwise applicable resident limit (as defined in such paragraph), a hospital is entitled to use for portions of cost reporting periods occurring on or after July 1, 2011, the otherwise applicable resident limit that is 90 percent of the difference between such otherwise applicable resident limit and such reference resident level.

"(ii) Reference resident level.—

"(I) In general.—Except as otherwise provided in a subsequent subclause, the reference resident level specified in this clause for a hospital is the highest resident level for any of the 3 most recent cost reporting periods (ending before the date of the enactment of this paragraph of the hospital for which a resident has been actively applying (subject to audit), as determined by the Secretary.

"(II) Use of most recent accounting period to recognize expansion of existing programs.—If a hospital submits a timely request to increase its resident level due to an expansion, or planned expansion, of an existing program, the reference resident level for such hospital is not reflected on the most recent settled or submittted cost report, after audit and subject to the discretion of the Secretary, subject to the limitation described in clause (iv), the reference resident level for such hospital is the resident level that includes the additional residents attributable to the expansion, as determined by the Secretary.

"(III) Special provider agreement.—In the case of a hospital described in paragraph (4)(H)(v), the reference resident level specified in this clause for a hospital that submitted to the Secretary a timely request, before the start of the 2009–2010 academic year, for an increase in its reference resident level due to a planned expansion.

"(IV) Prior Reset.—The reference resident level specified in this clause for a hospital that the Secretary determines required to take into account an increase in resident positions made available to the hospital under paragraph (7)(B) that are not otherwise taken into account under a previous subclause.

"(III) Considerations in redistribution.—In determining for which qualifying hospitals the increase in the otherwise applicable resident limit is provided under this subparagraph, the Secretary shall give preference to hospitals insofar as they have in effect formal arrangements (as determined by the Secretary) for the provision of additional positions for primary care residents.

"(IV) Prior for certain hospitals.—In determining for which qualifying hospitals the increase in the otherwise applicable resident limit is provided under this subparagraph, the Secretary shall give preference to hospitals with a number of positions (as of July 1, 2011) in excess of the otherwise applicable resident limit for such period.

"(V) The Secretary shall give preference to hospitals with a number of positions (as of July 1, 2009) in excess of the otherwise applicable resident limit for such period.

"(V) The Secretary shall give preference to hospitals in States that have lower resident-to-population ratios (including a greater preference for those States with lower resident-to-population ratios).
**SEC. 1502. INCREASING TRAINING IN NONPROVIDER SETTINGS.**

(a) DIRECT GME.—Section 1886(h)(4)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(E)) is amended—

(1) by designating the first sentence as a clause (I) with the heading “IN GENERAL.—” and appropriate indentation;

(2) by striking “shall be counted and that all the time” and inserting “shall be counted and that all the time”;

(3) by inserting after clause (I), as so inserted, the following:

(II) effective for cost reporting periods beginning before January 1, 2009, all the time;

(III) in subparagraph (B) of paragraph (2)(D) for that hospital, the hospital's resident limit; and

(IV) in subparagraph (B) of paragraph (2)(D), the hospital's resident limit.

(b) NONPROVIDER SETTING THAT IS PRIMARILY ENGAGED IN FURNISHING PATIENT CARE.—The term ‘nonprovider setting that is primarily engaged in furnishing patient care’ means a nonprovider setting in which the primary activity is the care and treatment of patients, as defined by the Secretary, that develops and operates an accredited training program for medical resident positions that is primarily engaged in furnishing patient care.

SEC. 1503. RULES FOR COUNTING RESIDENT TIME FOR DIDACTIC AND SCHOLARLY ACTIVITIES AND OTHER ACTIVITIES.

(a) DIRECT GME.—Section 1886(h)(4)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(E)) is amended—

(1) in paragraph (4)(E), as amended by section 1502(a)—

(A) in clause (i), by striking “such rules” and inserting “subject to clause (ii), such rules”;

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

(II) effective for the cost reporting periods beginning before July 1, 2011, insofar as an additional payment for resident positions distributed to a hospital under subsection (h)(8)(B), the hospital's resident limit; and

(III) effective for cost reporting periods beginning after July 1, 2011, insofar as an additional payment for resident positions distributed to a hospital under subsection (h)(8)(B), the hospital's resident limit.

(b) IME.—Section 1886(d)(5)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(v)) is amended—

(1) by striking “(vi)” Effective for discharges occurring on or after October 1, 1997 and inserting “(v)(i)” Effective for discharges occurring on or after October 1, 1997, and before July 1, 2009;

(2) by adding after clause (I), as inserted in paragraph (1), the following new clause:

(II) Effective for discharges occurring on or after July 1, 2009, all the time spent by an intern or resident in patient care activities at an entity in a nonprovider setting shall be counted towards the determination of full-time equivalency if the hospital incurs the costs of the stipends and fringe benefits of the intern or resident during the time the intern or resident spends in that setting.”;

(c) OIG STUDY ON IMPACT ON TRAINING.—The Inspector General of the Department of Health and Human Services shall analyze the data collected by the Secretary of Health and Human Services from the records made available to the Secretary under section 1886(d)(4)(E) of the Social Security Act, as amended by subsection (a), in order to assess the extent to which there is an increase in time spent by medical residents in training in nonprovider settings as a result of the amendments made by this section. Not later than 4 years after the date of the enactment of this Act, the Inspector General shall submit a report to Congress on such analysis and assessment.

(d) DEMONSTRATION PROJECT FOR APPROVED TEACHING HOSPITALS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration project under which an approved teaching hospital that develops and operates an improved teaching hospital setting in nonpatient care activities, such as didactic conferences and seminars, as such time and activities are defined by the Secretary, shall be counted toward the determination of full-time equivalency;

(2) DEMONSTRATION PROJECT FOR PROFESSIONAL ORGANIZATIONS.—In determining the hospital's number of full-time equivalent residents for purposes of this subsection, all the time that is spent by a professional organization in an approved medical residency training program in a nonprovider setting that is primarily engaged in furnishing patient care shall be counted toward the determination of full-time equivalency.

(e) IME DETERMINATIONS.—Section 1886(d)(5)(B)(v) of such Act (42 U.S.C. 1395ww(d)(5)(B)(v)), as amended by section 1501(b), is amended by adding at the end the following new clause:

(II) the base level of primary care resident positions for purposes of this subsection, to maintain records, and periodically report to the Secretary, on the number of primary care residents in its residency training programs and

(II) the number of such additional positions.

SEC. 1504. APPROPRIATIONS FOR THE MEDICAID PROGRAM.

(a) FUNDING FOR MEDICAID.—The amount appropriated for the fiscal year 2011 for the Medicaid program in title XIX of the Social Security Act is $881,818,000,000,000, which includes $251,224,000,000,000 for state matching payments.

(b) MEDICAID EXPANSION.—The amount appropriated for the fiscal year 2011 for the Medicaid expansion program established under section 1902(w) of the Social Security Act is $281,206,000,000,000,000,000,000.

(c) MEDICAID STRENGTHENING.—The amount appropriated for the fiscal year 2011 for the Medicaid strengthening program established under section 1902(x) of the Social Security Act is $281,206,000,000,000,000,000,000.

(d) MEDICAID FUNDING FOR ALASKA.—The amount appropriated for the fiscal year 2011 for the Medicaid program in Alaska is $281,206,000,000,000,000,000,000.
hospital shall be counted toward the determination of full-time equivalency if the hospital—

(‘‘aa’’ is recognized as a subsection (d) hospital;

(b) is recognized as a subsection (d) hospital;

(cc) is reimbursed under a reimbursement system used under section 1844(b)(5); or

(dd) is a provider-based hospital outpatient department.

‘‘III’’ in determining the hospital’s number of full-time equivalent residents for purposes of this subparagraph, all the time spent by an intern or resident in an approved medical residency training program in research activities associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall not be counted toward the determination of full-time equivalency.

(c) EFFECTIVE DATES; APPLICATION.—

(1) IN GENERAL.—Except as otherwise provided, the Secretary of Health and Human Services shall implement the amendments made by this section in a manner so as to apply to cost reporting periods beginning on or after October 1, 2001.

(2) DIRECT GME.—Section 1886(h)(4)(E)(II) of the Social Security Act, as added by subsection (a)(1)(B), shall apply to cost reporting periods beginning on or after July 1, 2001.

(3) IME.—Section 1886(d)(5)(B)(x)(III) of the Social Security Act, as added by subsection (b), shall apply to cost reporting periods beginning on or after July 1, 2001.

(4) THE AMENDMENTS MADE BY THIS SECTION.—The amendments made by this section shall not affect any temporary affiliation described in section 413.79(h) of title 42, Code of Federal Regulations (as in effect on the date of enactment of this Act) and shall not affect the application of section 1886(h)(4)(H)(vi) of the Social Security Act.

(c) CONFORMING AMENDMENTS.—

(1) Section 422(b)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173), as amended by section 1501(c), is amended by striking ‘‘(7)’’ and inserting ‘‘(4)(H)(vi), (7),’’ and

(2) Section 1886(h)(7)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(7)(E)) is amended by inserting ‘‘or paragraph (7)(E),’’ after ‘‘(F),’’.

SEC. 1505. IMPROVING ACCOUNTABILITY FOR APPROVED MEDICAL RESIDENCY TRAINING.

(a) SPECIFICATION OF GOALS FOR APPROVED MEDICAL RESIDENCY TRAINING PROGRAMS.—Section 1886(h)(1) of the Social Security Act (42 U.S.C. 1395ww(h)(1)) is amended—

(1) by designating the matter beginning with ‘‘(I) IN GENERAL.—The Secretary shall, by’’ as subparagraph (A) with the heading ‘‘(I) IN GENERAL.—’’ and with appropriate indentation; and

(2) by adding at the end the following new subparagraph:

‘‘(ii) By inserting ‘‘and Accountability for Approved Medical Residency Training Programs’’ and (B) Goals and Accountability for Approved Medical Residency Training Programs’’ as a subparagraph (A) with the heading ‘‘(II) GOALS AND ACCOUNTABILITY FOR APPROVED MEDICAL RESIDENCY TRAINING PROGRAMS.—The goals of medical residency training programs are to foster a physician workforce so that physicians are trained to be able to do the following:

(1) Work effectively in various health care delivery settings, such as nonprovider settings.

(2) Coordinate patient care within and across settings relevant to their specialties.

(3) Understand the relevant cost and value of various diagnostic and treatment options.

(4) Work in inter-professional teams and multi-disciplinary team-based models in provider and nonprovider settings to enhance safety and improve quality of patient care.

(5) Be knowledgeable in methods of identifying systematic errors in health care delivery and in implementing systemic solutions in terms of such errors, including experiences and participation in continuous quality improvement projects to improve health outcomes of the population the physicians serve.

(6) Be meaningful EHR users (as determined under section 1408(o)(2)) in the delivery of care and in improving the quality of the health of the community and the individuals that the hospital serves.

(b) GAO STUDY ON EVALUATION OF TRAINING PROGRAMS.

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study to evaluate the extent to which medical residency training programs—

(A) are meeting the goals described in section 1886(h)(1) of the Social Security Act, as added by subsection (a), in a range of residency programs, including primary care and other specialties; and

(B) have appropriate faculty expertise to teach the topics required to achieve such goals.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on such study and shall include in such report any recommendations as to how medical residency training programs could be further encouraged to meet such goals through means such as—

(i) development of curriculum requirements; and

(ii) assessment of the accreditation processes of the Accreditation Council for Graduate Medical Education and the American Osteopathic Association and effectiveness of those processes in accrediting medical residency programs that meet the goals referred to in paragraph (1)(A).

TITLE VI—PROGRAM INTEGRITY

Subtitle A—Increased Funding to Fight Waste, Fraud, and Abuse

SEC. 1601. INCREASED FUNDING AND FLEXIBILITY TO FIGHT FRAUD AND ABUSE.

(a) IN GENERAL.—Section 1871(k) of the Social Security Act (42 U.S.C. 1395l(k)) is amended—

(1) by adding at the end the following new paragraph:

(‘‘A’’) By inserting ‘‘and Accountability for Approved Medical Residency Training Programs’’ as a subparagraph (A) with the heading ‘‘(II) GOALS AND ACCOUNTABILITY FOR APPROVED MEDICAL RESIDENCY TRAINING PROGRAMS.—The goals of medical residency training programs are to foster a physician workforce so that physicians are trained to be able to do the following:

(1) Work effectively in various health care delivery settings, such as nonprovider settings.

(2) Coordinate patient care within and across settings relevant to their specialties.

(3) Understand the relevant cost and value of various diagnostic and treatment options.

(4) Work in inter-professional teams and multi-disciplinary team-based models in provider and nonprovider settings to enhance safety and improve quality of patient care.

(5) Be knowledgeable in methods of identifying systematic errors in health care delivery and in implementing systemic solutions in terms of such errors, including experiences and participation in continuous quality improvement projects to improve health outcomes of the population the physicians serve.

(6) Be meaningful EHR users (as determined under section 1408(o)(2)) in the delivery of care and in improving the quality of the health of the community and the individuals that the hospital serves.

(b) GAO STUDY ON EVALUATION OF TRAINING PROGRAMS.

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study to evaluate the extent to which medical residency training programs—

(A) are meeting the goals described in section 1886(h)(1) of the Social Security Act, as added by subsection (a), in a range of residency programs, including primary care and other specialties; and

(B) have appropriate faculty expertise to teach the topics required to achieve such goals.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on such study and shall include in such report any recommendations as to how medical residency training programs could be further encouraged to meet such goals through means such as—

(i) development of curriculum requirements; and

(ii) assessment of the accreditation processes of the Accreditation Council for Graduate Medical Education and the American Osteopathic Association and effectiveness of those processes in accrediting medical residency programs that meet the goals referred to in paragraph (1)(A).

Subtitle B—Enhanced Penalties for Fraud and Abuse

SEC. 1611. ENHANCED PENALTIES FOR FALSE STATEMENTS ON PROVIDER OR SUPPLIER ENROLLMENT APPLICATIONS.

(a) IN GENERAL.—Section 1128a(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)) is amended—

(1) in paragraph (1)(D), by striking all that follows ‘‘in which the person was excluded’’ and inserting ‘‘under Federal law from the Federal health care program under which the claim was made, or’’;

(2) by striking ‘‘or’’ at the end of paragraph (6);

(3) in paragraph (7), by inserting at the end ‘‘or’’;

(4) by inserting after paragraph (7) the following new paragraph:

(‘‘B’’) knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, agreement, bid, or contract to participate or enroll as a provider of services or supplier under a Federal health care program, including managed care organizations under title XIX, Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans—

(5) in the matter following paragraph (8), as inserted by paragraph (4), by striking ‘‘or’’;
in cases under paragraph (7), $50,000 for each such act)" and inserting "(a) in cases under paragraph (7), $50,000 for each such act, or in cases under paragraph (6), $50,000 for each false statement, omission, or misrepresentation of a material fact)"; and (b) in the second sentence, by striking "for a lawful purpose)" and inserting "for a lawful purpose, or in cases under paragraph (7), an assessment of not more than 3 times the amount claimed as the result of the false statement, omission, or misrepresentation of material fact claimed by a provider of services or supplier whose application to participate contained such false statement, omission, or misrepresentation)".

The amendments made by subsection (a) shall apply to acts committed on or after January 1, 2010.

SEC. 1614. ENHANCED HOSPICE CARE PROGRAM SAFE-GUARDS.

(a) MEDICARE.—Part A of title XVIII of the Social Security Act is amended by inserting after section 1128A(a) the following new section:

"SEC. 1819A. ASSURING QUALITY OF CARE IN HOSPICE CARE.

"(a) IN GENERAL.—If the Secretary determines that a hospice program that is certified for participation under this title is not in compliance with such requirements but, as of a previous period, was in compliance with such requirements, the Secretary shall terminate the certification of the program.

"(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to acts committed on or after January 1, 2010.

SEC. 1615. ENHANCED PENALTIES FOR DELAYING INSPECTIONS.

(a) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by sections 1611 and 1612, is further amended—

(1) in paragraph (7), by striking "or" at the end;

(2) in paragraph (8), by inserting "or" at the end of paragraph (8);

(3) by inserting after paragraph (9), the following new paragraph:

"(9) knowingly makes, uses, or causes to be made a false record or statement material fact to a false or fraudulent claim for payment for items and services furnished under a Federal health care program;"; and

(4) in the matter following paragraph (9), as inserted by paragraph (3)—

(A) by striking "or in cases under paragraph (8)" and inserting "or in cases under paragraph (8)"; and

(B) by striking "a material fact, in cases under paragraph (9), $50,000 for each false record or statement)";

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to acts committed on or after January 1, 2010.

SEC. 1613. ENHANCED PENALTIES FOR DELAYING INSPECTIONS.

(a) IN GENERAL.—Section 1128A(a) of the Social Security Act (42 U.S.C. 1320a–7a(a)), as amended by sections 1611 and 1612, is further amended—

(1) in paragraph (8), by striking "or" at the end;

(2) in paragraph (9), by inserting "or" at the end of paragraph (9); and

(3) by inserting after paragraph (9) the following new paragraph:

"(9) fails to grant timely access, upon reasonable request (as defined by the Secretary in regulations), to the Inspector General of the Department of Health and Human Services, for the purpose of audits, investigations, evaluations, or other statutory functions of the Inspector General of the Department of Health and Human Services;"; and

(4) in the matter following paragraph (10), as inserted by paragraph (3), by inserting "; and in cases under paragraph (10), $15,000 for each day of the failure described in such paragraph after "false record or statement);"

(b) ENSURING TIMELY INSPECTIONS RELATING TO CONTRACTS WITH MA ORGANIZATIONS.—Section 1857(d)(2)(B) of such Act (42 U.S.C. 1395w–27(d)(2)) is amended—

(1) in subparagraph (A), by inserting "timely" before "inspect"; and

(2) in subparagraph (B), by inserting "timely" before "audit and inspect".

The amendments made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1614. ENHANCED HOSPICE CARE PROGRAM SAFE-GUARDS.

(a) MEDICARE.—Part A of title XVIII of the Social Security Act is amended by inserting after section 1128A(a) the following new section:

"SEC. 1819A. ASSURING QUALITY OF CARE IN HOSPICE CARE.

"(a) IN GENERAL.—If the Secretary determines that a hospice program that is certified for participation under this title has demonstrated a substandard quality of care and fails to meet such requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services by the agency or organization involved and determines—

"(1) that the deficiencies included immediately jeopardize the health and safety of the individuals to whom the program furnishes items and services, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subsection (b)(2)(A)(iii) or terminate the certification of the program, and may, in addition, for 1 or more of the other remedies described in subsection (A),

"(2) that the deficiencies involved do not immediately jeopardize the health and safety of the individuals to whom the program furnishes items and services, the Secretary may—

"(A) impose intermediate sanctions developed pursuant to subsection (b), in lieu of terminating the certification of the program; and

"(B) if, after such a period of intermediate sanctions, the program is still not in compliance with such requirements, the Secretary shall terminate the certification of the program.

If the Secretary determines that a hospice program that is certified for participation under this title is in compliance with such requirements but, as of a previous period, was not in compliance with such requirements, the Secretary may provide for a civil money penalty under subsection (b)(2)(A)(i) for the days in which it finds that the program was not in compliance with such requirements.

"(b) INTERMEDIATE SANCTIONS.—

"(1) DEVELOPMENT AND IMPLEMENTATION.—The Secretary shall develop and implement, by not later than July 1, 2011, specific procedures under paragraph (1) is to be applied, including the amount of any fines and the severity of each of these sanctions. Such procedures shall be designed so as to minimize the time between identification of deficiencies and imposition of these sanctions and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies.

"(2) SPECIFIED SANCTIONS.—(A) IN GENERAL.—Intermediate sanctions developed under paragraph (1) may include—

"(i) civil money penalties in an amount not to exceed $25,000 for each day of noncompliance or, in the case of a per instance penalty applied by the Secretary, not to exceed $25,000.

"(ii) denial of all or part of the payments to which a hospice program would otherwise be entitled under this title with respect to items and services furnished by a hospice program on or after the date on which the Secretary determines that intermediate sanctions should be imposed pursuant to subsection (a)(2),

"(iii) the appointment of temporary management to oversee the operation of the hospice program and to protect and assure the health and safety of the individuals under the care of the program while improvements are made.

"(iv) corrective action plans, and

"(v) in-service training for staff.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceedings under subparagraph (B). The temporary management under clause (iii) shall not be terminated until the Secretary has determined that the program has the management capability to continue compliance with all requirements referred to in that clause.

"(B) CLARIFICATION.—The sanctions specified in subparagraph (A)(ii) are in addition to sanctions otherwise available under State or Federal law and shall not be construed as limiting other remedies, including any remedies available to an individual at common law.

"(C) COMMENCEMENT OF PAYMENT.—A denial of payment under subparagraph (A)(ii) shall terminate when the Secretary determines that the hospice program no longer demonstrates a substandard quality of care and meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are provided care and services by the agency or organization involved.

"(D) SECURITIZATION.—The Secretary shall develop and implement, by not later than July 1, 2011, specific procedures under paragraph (1) is to be applied, including the amount of any fines and the severity of each of these sanctions. Such procedures shall be designed so as to minimize the time between identification of deficiencies and imposition of these sanctions and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies.

"(c) APPLICATION TO CHIP.—Title XXI of the Social Security Act is amended by inserting after the following new paragraph:

"(1) in paragraph (a), by striking "or" at the end of paragraph (9);

"(2) in paragraph (11), by striking paragraph (9), (a), and (b) and inserting the following new paragraph:

"(1) orders or prescribes an item or service affecting the delivery of health care, diagnostic and clinical laboratory tests, prescription drugs, durable medical equipment, ambulance services, physical or occupational therapy, home health care, dental care, and supplies necessary for emergency medical care, during a period when the person has been excluded from participation in a Federal health care program, and the person knows or should know that a claim for such item or service will be presented to such a program;

"(2) denies or reduces payment for items and services furnished by a hospice program under this title on the basis of information available to the Secretary at the time of submission of claims, and the person knows or should know that a claim for such item or service will be presented to such a program.

The amendments made by subsection (a) shall apply to acts committed on or after January 1, 2010.
(4) in the matter following paragraph (1), as inserted by paragraph (2), by striking “$15,000 for each day of the failure described in such paragraph” and inserting “$15,000 for each day such failure described in such paragraph, or in cases under paragraph (1), $50,000 for each order or prescription for an item or service by an excluded individual or entity”;

SEC. 1616. ENHANCED PENALTIES FOR PROVIDERS AND SUPPLIERS TO REPORT FALSE INFORMATION BY MEDICARE ADVANTAGE AND PART D PLANS.

(a) In General.—Section 1857(g)(2)(A) of the Social Security Act (42 U.S.C. 1395w–27(g)(2)(A)) is amended by inserting “except with respect to a determination under subparagraph (E), an assessment of not more than 3 times the amount claimed by such plan or plan sponsor based upon the misrepresentation or falsified information involved,” after “for each such determination,”;

(b) Effective Date.—The amendment made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1617. ENHANCED PENALTIES FOR MEDICARE ADVANTAGE AND PART D PLANS.

(a) In General.—Section 1857(g)(1) of the Social Security Act (42 U.S.C. 1395w–27(g)(1)), as amended by section 1221(b), is amended—

(1) in subparagraph (G), by striking “or” at the end;

(2) by inserting after subparagraph (H) the following new subparagraph:

“‘(I) except as provided under subparagraph (C), an item or service has been furnished by an excluded individual or entity to an individual or entity furnishing the items or services.”;

(b) Effective Date.—The amendment made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1618. ENHANCED PENALTIES FOR OBSTRUCTION OF PROGRAM AUDITS.

(a) In General.—Section 1128(b)(2) of the Social Security Act (42 U.S.C. 1320a-7(b)(2)) is amended—

(1) in the heading, by inserting “OR AUDIT” after “INVESTIGATION”;

(2) by striking “intragovernmental investigation into” and all that follows through the period and inserting “investigation or audit related to—”;

(3) in clause (i), by striking “any” and inserting “an”;

(4) in clause (ii), by striking “of” and inserting “on”;

(b) Effective Date.—The amendments made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1619. EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) In General.—Section 1128(c)(6) of the Social Security Act, as previously amended by this division, is further amended—

(1) in the heading, by striking “AND PERIOD” and inserting “PERIOD, AND EFFECT”;

(2) by adding at the end the following new paragraph:

“(d)(A) For purposes of this Act, subject to subparagraph (C), the effect of exclusion is that no person may participate in any Federal health care program (as defined in section 1128B(f)) with respect to any item or service furnished—

(i) by an excluded individual or entity; or

(ii) at the medical direction or on the prescription of a physician or other authorized individual when the person authorizing a claim for such item or service knew or had reason to know of the exclusion of such individual.

(B) For purposes of this section and sections 1128A and 1128B, subject to subparagraph (C), an item or service has been furnished by an individual or entity if the individual or entity directly or indirectly participated in such item or service furnished by an individual or entity; or

(C) the types of violations reported under section 1877 of the Social Security Act (42 U.S.C. 1320j-1) pursuant to a self-referral disclosure protocol, or to whom such payment was made.

(c) Effective Date.—The amendments made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1620. OIG AUTHORITY TO EXCLUDE FROM FEDERAL HEALTH CARE PROGRAMS OFFICERS AND OWNERS OF ENTITIES CONVICTED OF FRAUD.

(a) In General.—Section 1128(b)(15)(A) of the Social Security Act (42 U.S.C. 1320a-7(b)(15)(A)) is amended—

(1) in clause (i)—

(A) by striking “has” and inserting “had”;

(B) by striking “sanctioned entity and who knows or should know (as defined in section 1128A(i)(6)(B))” and inserting “sanctioned entity or who knows or should know (as defined in section 1128A(i)(6)(C))”;

(2) in clause (ii)—

(A) by striking “is an officer” and inserting “was an officer”;

(B) by inserting before the period the following:

“at the time of, and who knew or should have known (as defined in section 1128A(i)(6)(C))”;

(3) by inserting “and”; and

(4) by striking “sanctioned entity and who knows or should know” after “by an individual or entity that submitted the claim” and inserting “or entity furnishing the items or services”.

(b) Effective Date.—The amendment made by subsection (a) shall apply to violations committed on or after January 1, 2010.

SEC. 1621. SELF-REFERRAL DISCLOSURE PROTOCOL.

(a) Development of Self-Referral Disclosure Protocol.—

(1) In General.—The Secretary of Health and Human Services, in cooperation with the Inspector General of the Department of Health and Human Services, shall establish, not later than 6 months after the date of the enactment of this Act, a protocol to enable health care providers of services and suppliers to disclose an actual or potential violation of section 1877 of the Social Security Act (42 U.S.C. 1320j-1) pursuant to a self-referral disclosure protocol (in this section referred to as an “SRDP”). The SRDP shall include direction to health care providers of services and suppliers on—

(A) a specific person, official, or office to whom such disclosures shall be made; and

(B) instruction on the implication of the SRDP on corporate integrity agreements and corporate compliance agreements.

(2) Publication on Internet Website of SRDP Information.—The Secretary shall post information on the public Internet website of the Centers for Medicare & Medicaid Services to inform relevant stakeholders of how to disclose actual or potential violations pursuant to an SRDP.

(3) Relation to Advisory Opinions.—The SRDP shall be separate from the advisory opinion process set forth in regulations implementing section 1877(g) of the Social Security Act.

(b) Reduction in Amounts Owed.—The Secretary is authorized to reduce the amount due and owing for all violations under section 1877 of the Social Security Act to an amount less than that specified in subsection (g) of such section. In establishing such a reduction for a violation, the Secretary may consider the following factors:

(1) The nature and extent of the improper or inadequate practice;

(2) The timely submission of a self-disclosure;

(3) The cooperation in providing additional information related to the disclosure.

Such factors as the Secretary considers appropriate.

(c) Report.—Not later than 18 months after the date on which the SRDP protocol is established under subsection (a) the Secretary shall submit to Congress a report on the implementation of this section. Such report shall include—

(1) the number of health care providers of services and suppliers making disclosures pursuant to an SRDP;

(2) the amounts collected pursuant to the SRDP;

(3) the types of violations reported under the SRDP; and

cover the improperly paid amount from the contractor.”.

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(4) such other information as may be necessary to evaluate the impact of this section.

(d) RELATION TO OTHER LAW AND REGULATION.—Nothing in this section shall affect the application of section 1126G(c) of the Social Security Act, as added by section 1641, except, in the case of a health care provider of services or supplier who is a person (as defined in section 1126G(c)) who discloses an overpayment (as defined in such paragraph) to the Secretary of Health and Human Services pursuant to a SRDP established under this section, the 60-day period described in paragraph (2) of such section 1126G(c) shall be extended with respect to the return of an overpayment to the extent required for site visits or prepayment review, enhanced review of claims, and any other actions as specified by the Secretary in the programs under titles XVIII, XIX, and XXI.

Under such procedures, the Secretary may extend such period for more than 365 days if the Secretary determines that such period is necessary and requisite to evaluate the impact of this section.

(4) MORATORIUM ON ENROLLMENT OF PROVIDERS.—If the Secretary determines that such previous affiliation or affiliation within a geographic area, under title XVIII, XIX, or XXI, the Secretary may impose any of the following requirements with respect to a provider of services or a supplier (whether such provider or supplier is initially enrolling in the program or is renewing such enrollment):

(a) to enforce any determination made by the Secretary with respect to a category of provider or supplier poses a serious risk of fraud, waste, or abuse, the Secretary shall deny the application of such provider or supplier described in such subsection (b), as the Secretary determines necessary under such subsection.

(b) CONFORMING AMENDMENTS.—

(1) MEDICAID.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by adding at the end such section the following new paragraph:

‘‘(j) DISCLOSURE.—A provider of services or supplier enrolling or participating in the program under title XVIII, XIX, or XXI shall disclose (in a form and manner determined by the Secretary) any current affiliation or affiliation within the previous 10-year period with a provider of services or supplier that is in default or with a person or entity that has been suspended or excluded under such program, subject to a payment suspension, or has had its billing privileges revoked.

(2) CHIP.—Section 2105 of such Act (42 U.S.C. 1525) is amended by adding at the end such section the following new paragraph:

‘‘(k) DISCLOSURE.—A provider of services or supplier enrolling or participating in the program under title XVIII, XIX, or XXI shall disclose (in a form and manner determined by the Secretary) any current affiliation or affiliation within the previous 10-year period with a provider of services or supplier that is in default or with a person or entity that has been suspended or excluded under such program, subject to a payment suspension, or has had its billing privileges revoked.

(3) MEDICARE.—Section 1866(j) of such Act (42 U.S.C. 1395ww(j)) is amended by adding at the end of such section the following new paragraph:

‘‘(l) DISCLOSURE.—A provider of services or supplier enrolling or participating in the program under title XVIII, XIX, or XXI shall disclose (in a form and manner determined by the Secretary) any current affiliation or affiliation within the previous 10-year period with a provider of services or supplier that is in default or with a person or entity that has been suspended or excluded under such program, subject to a payment suspension, or has had its billing privileges revoked.

(4) CONFORMING AMENDMENTS.—

(a) Applicability of provisions of section 1126G(a) apply to enrollments and renewals of enrollments of providers of services and suppliers under this title.

(b) CONFORMING AMENDMENTS.—

(1) MEDICAID.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended—

(4) such other information as may be necessary to evaluate the impact of this section.

(b) CONFORMING AMENDMENTS.—

(1) MEDICAID.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by adding at the end such section the following new paragraph:

‘‘(j) DISCLOSURE.—A provider of services or supplier enrolling or participating in the program under title XVIII, XIX, or XXI shall disclose (in a form and manner determined by the Secretary) any current affiliation or affiliation within the previous 10-year period with a provider of services or supplier that is in default or with a person or entity that has been suspended or excluded under such program, subject to a payment suspension, or has had its billing privileges revoked.

(2) CHIP.—Section 2102 of such Act (42 U.S.C. 1522) is amended by adding at the end such section the following new paragraph:

‘‘(k) DISCLOSURE.—A provider of services or supplier enrolling or participating in the program under title XVIII, XIX, or XXI shall disclose (in a form and manner determined by the Secretary) any current affiliation or affiliation within the previous 10-year period with a provider of services or supplier that is in default or with a person or entity that has been suspended or excluded under such program, subject to a payment suspension, or has had its billing privileges revoked.
SEC. 1633. REQUIRED INCLUSION OF PAYMENT MODIFIER FOR CERTAIN EVALUATION AND MANAGEMENT SERVICES.

Section 1866(j) of the Social Security Act (42 U.S.C. 1395w–4), as amended by section 401 of theHITECH Act (Public Law 111–5), is amended by adding at the end the following new subsection:

"(p) PAYMENT MODIFIER FOR CERTAIN EVALUATION AND MANAGEMENT SERVICES.—The Secretary shall establish a payment modifier under this section for evaluation and management services (as specified in section 1842(b)(16)(B)(iii)) that result in the ordering of additional services (such as prescription drugs, the furnishing or ordering of durable medical equipment in order to enable better monitoring of claims for payment for such additional services under this title, or the ordering, furnishing, or prescribing of other items and services determined by the Secretary to pose a high risk of waste, fraud, and abuse. The Secretary may require providers of services or suppliers to report such modifier in claims submitted for payment.".

SEC. 1634. EVALUATIONS AND REPORTS REQUIRED UNDER MEDICARE INTEGRITY PROGRAM.

(a) In General.—Section 1899(c) of the Social Security Act (42 U.S.C. 1395dd(c)), is amended—

(1) in paragraph (3), by striking at the end "and"

(2) by redesignating paragraph (4) as paragraph (5); and

(3) by inserting after paragraph (3) the following new paragraph:

"(4) for the contract year beginning in 2011 and each subsequent contract year, the entity provides assurances to the satisfaction of the Secretary that the entity will conduct periodic evaluations of the effectiveness of the activities carried out by such entity under the Program and will submit to the Secretary an annual report on such activities; and"

(b) Reference to Medicaid Integrity Program.—For a similar provision with respect to the Medicaid Integrity Program, see section 1752.

SEC. 1635. REQUIRE PROVIDERS AND SUPPLIERS TO ADOPT PROGRAMS TO REDUCE FRAUD, WASTE, AND ABUSE.

(a) In General.—Section 1866(j) of the Social Security Act (42 U.S.C. 1395w–4), as amended by section 1833(c), is further amended by adding at the end the following new paragraph:

"(4) COMPLIANCE PROGRAMS FOR PROVIDERS OF SERVICES AND SUPPLIERS.—

"(A) The Secretary may not enroll (or renew the enrollment of) a provider of services or a supplier (other than a physician or a skilled nursing facility) under this title if such provider of services or supplier fails to, subject to subparagraph (E), establish a compliance program that contains the core elements established under subparagraph (A) and is administered by the Secretary, that the provider or supplier has established such a program.

"(B) ESTABLISHMENT OF CORE ELEMENTS.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish core elements for a compliance program under paragraph (A) (which include written policies, peer review, standards of conduct, a compliance officer and a compliance committee, effective training and education to fraud prevention and abuse for the organization's employees, and contractors; a confidential or anonymous mechanism, such as a hotline, to receive and report questions and reports of fraud, waste, or abuse; disciplinary guidelines for enforcement of standards; internal monitoring and auditing procedures, including monitoring and auditing of contractors; procedures for ensuring prompt responses to detected offends and development of corrective actions in response to potential offenses; and procedures to return all identified overpayments to the programs under this title, title XIX, and title XXI.)

"(C) TIMELINE FOR IMPLEMENTATION.—The Secretary shall determine a timeline for the establishment of the core elements under subparagraph (A) (including the required program for providers of services and suppliers (other than physicians and skilled nursing facilities) shall be required to have established such a program for payment for such items and services under the fee schedule under this section for which such services are furnished and for which the physician is employed, under contract, or affiliated if such compliance is required by such provider or entity.

"(D) PILOT PROGRAM.—The Secretary may conduct a pilot program on the application of this subsection with respect to a category of services or items (other than physicians and skilled nursing facilities) that the Secretary determines to be a category which is at high risk for waste, fraud, and abuse in the provision of services under contract with, in partnership with, or affiliated with such organization or sponsor to ensure that, with respect to items and services furnished by such provider to an enrolee of such organization, written request, signed by such enrolee, except in cases in which the Secretary finds it impracticable for the enrolee to do so, is filed for payment for such items and services in such form, in such manner, and by such persons as may by regulation prescribe, no later than the closer of the 1 calendar year period after such items and services are furnished. In applying the provisions of this subsection, the Secretary may specify exceptions to the 1 calendar year period specified."

(c) Effective Date.—The amendments made by this section shall be effective for services furnished on or after January 1, 2011.

SEC. 1636. PHYSICIANS WHO ORDER DURABLE MEDICAL EQUIPMENT OR HOME HEALTH SERVICES REQUIRED TO BE ENROLLED MEDICARE PHYSICIANS OR ELIGIBLE PROFESSIONALS.

(a) DME.—Section 1834(a)(11)(B) of the Social Security Act (42 U.S.C. 1395(a)(11)(B)) is amended by striking "physician" and inserting "physician enrolled under section 1866(j) or other professional, as determined by the Secretary.".

(b) Home Health Services.—

(1) Part A.—Section 1834(a)(2) of such Act (42 U.S.C. 1395(a)(2)) is amended in the matter preceding subparagraph (A) by inserting "in the case of services described in subparagraph (C), a physician enrolled under section 1866(j) or other professional, as determined by the Secretary," before "or, in the case of services".

(2) Part B.—Section 1835(a)(2) of such Act (42 U.S.C. 1395a(a)(2)) is amended in the matter preceding subparagraph (A) by inserting "or, in the case of services described in subparagraph (A), a physician enrolled under section 1866(j) or other professional, as determined by the Secretary," after "a physician".

(c) Discretion to Expand Application.—The Secretary may extend the requirement applied by the amendments made by subsections (a) and (b) to durable medical equipment and home health services (relating to requiring certifications and written orders to be obtained by enrolled professionals (other than provider) to other categories of items or services under title XVIII of the Social Security Act, see section 1753.

SEC. 1637. MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS REDUCED TO NOT MORE THAN 12 MONTHS.

(a) Purpose.—In general, the 36-month period currently allowed for claims filing under parts A, B, and, D of title XVIII of the Social Security Act presents opportunities for waste, fraud, and abuse before implementing the regulations. In applying the provisions of this subsection with respect to a category of services or items (other than physicians and skilled nursing facilities) that the Secretary determines to be a category which is at high risk for waste, fraud, and abuse in the provision of services under contract with, in partnership with, or affiliated with such organization or sponsor to ensure that, with respect to items and services furnished by such provider to an enrolee of such organization, written request, signed by such enrolee, except in cases in which the Secretary finds it impracticable for the enrolee to do so, is filed for payment for such items and services in such form, in such manner, and by such persons as may by regulation prescribe, no later than the closer of the 1 calendar year period after such items and services are furnished. In applying the provisions of this subsection, the Secretary may specify exceptions to the 1 calendar year period specified.

(b) Effective Date.—The amendments made by this section shall apply to written orders and certifications made on or after July 1, 2010.

SEC. 1638. REQUIREMENT FOR PHYSICIANS TO PROVIDE DOCUMENTATION ON REFERRALS TO PROGRAMS AT HIGH RISK OF WASTE AND ABUSE.

(a) Physicians and Other Suppliers.—Section 1842(h) of the Social Security Act is amended by adding at the end the following new paragraph:

"(E) In applying paragraph (3), a physician enrolled under section 1866(j) or other professional, as determined by the Secretary, may require physicians or other professionals to provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, and for other items or services written or ordered by such physician or supplier under this title, as specified by the Secretary.".

(b) Home Health Services.—Section 1866(a)(1) of such Act (42 U.S.C. 1395c), is amended—
SEC. 1639. FACE-TO-FACE ENCOUNTER WITH PATIENT REQUIRED BEFORE ELIGIBILITY CERTIFICATIONS FOR HOME HEALTH SERVICES OR DURABLE MEDICAL EQUIPMENT.
(a) Condition of Payment for Home Health Services.
(1) Part A.—Section 1814(a)(2)(C) of such Act is amended—
(A) by striking ‘‘and such services’’ and inserting ‘‘such services and’’; and
(B) by inserting after ‘‘care of a physician’’ the following: ‘‘and, in the case of a certification or recertification made by a provider after January 1, 2010, prior to making such certification the physician must document that the physician has had a face-to-face encounter (including through use of telehealth and or request for services that are incident to services involved) with the individual during the 6-month period preceding such certification, or other reasonable timeframe as determined by the Secretary’’.
(2) Part B.—Section 1833(a)(2)(A) of the Social Security Act is amended—
(A) by striking ‘‘and before ‘‘(iii)’’; and
(B) by inserting after ‘‘care of a physician’’ the following: ‘‘and, and in the case of a certification or recertification made by a provider beginning on or after January 1, 2012, prior to making such certification the physician must document that the physician has had a face-to-face encounter (including through use of telehealth and or request for services that are incident to services involved) with the individual during the 6-month period preceding such certification, or other reasonable timeframe as determined by the Secretary’’.
(b) Condition of Payment for Durable Medical Equipment.
Section 1851(a)(11)(B) of the Social Security Act (42 U.S.C. 1395m(a)(11)(B)) is amended by adding after the period at the end the following new provisions: ‘‘and shall be written order requirements for payment under this subsection be written only pursuant to the eligible health care professional authorized to make such written order documentation that such professional has had a face-to-face encounter (including through use of telehealth and other than with respect to encounters that are incident to services involved) with the individual during the 6-month period preceding such certification, or other reasonable timeframe as determined by the Secretary’’.
(c) The Secretary may apply a face-to-face encounter requirement similar to the requirement described in the amendments made in subsection (a) and (b) of this section to items and services for which payment is provided under title XVIII of the Social Security Act based upon a finding that such a decision would reduce the risk of waste, fraud, or abuse.
(d) Application to Medicaid and CHIP.
The face-to-face encounter requirements described in the amendments made by subsections (a) and (b) and any expanded application pursuant to subsection (c) shall apply with respect to a certification or recertification for home health services under title XIX or XXI of the Social Security Act, a written order for durable medical equipment under such title, and any other applicable item or service identified pursuant to subsection (c) for which such requirements apply, respectively, in the same manner and to the same extent as such requirements apply in the case of a certification or recertification, written order, or other applicable item or service so identified, respectively, under title XVIII of such Act.
SEC. 1640. EXTENSION OF TESTIMONIAL SUBPOENA AUTHORITY TO PROGRAM EXCLUSION INVESTIGATIONS.
(a) In General.—Section 1128G of the Social Security Act (42 U.S.C. 1320a–7(g)) is amended by adding at the end the following new paragraph:
‘‘(4) The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section to the same extent as they are applicable with respect to title II. The Secretary may extend the applicable timeframe granted by section 205(d) (as made applicable to this section) to the Inspector General of the Department of Health and Human Services or the Administrator of the Centers for Medicare & Medicaid Services for purposes of any investigation under this section.’’.
(b) Effective Date.—The amendments made by subsection (a) shall apply to investigations beginning on or after January 1, 2010.
SEC. 1641. REQUIRED REPAYMENTS OF MEDICAID AND MEDICARE OVERPAYMENTS.
Section 1129G of the Social Security Act, as inserted by section 1631 and amended by section 1632, is further amended by adding at the end the following new subsection:
‘‘(a) Medicare.—Section 1128B(f) of such Act (42 U.S.C. 1395w(b)(7)) is amended by adding at the end the following new subsection:
‘‘(4) The provisions of subsections (d) and (e) of section 205 shall apply with respect to this section to the same extent as they are applicable with respect to title II. The Secretary may extend the applicable timeframe granted by section 205(d) (as made applicable to this section) to the Inspector General of the Department of Health and Human Services or the Administrator of the Centers for Medicare & Medicaid Services for purposes of any investigation under this section.’’.
(c) Enforcement.—The Secretary, shall provide to the Secretary access to information relating to any ownership or compensation arrangement between such facility and the medical director of such facility or between such facility and any physician.
SEC. 1642. ACCESS TO CERTAIN INFORMATION ON MEDICAL DIALYSIS FACILITIES.
Section 1881(b) of the Social Security Act (42 U.S.C. 1395rr(b)) is amended by adding at the end the following new paragraph:
‘‘(D) Billing agents, clearinghouses, or other alternate entities required to register under Medicare.
(a) Medicare.—Section 1866(a)(13) of the Social Security Act (42 U.S.C. 1395cc(a)(13)) is amended by adding at the end the following new subparagraph:
‘‘(D) BILLING AGENTS AND CLEARINGHOUSES.
(1) Scope of requirement.
(2) The Secretary is required to establish requirements for the registration of billing agents, clearinghouses, or other alternate entities that are used to submit claims for payment to Medicare.
(3) The Secretary shall promulgate such regulations as are necessary to implement the requirements established under this subsection.
(4) Effective date.
SEC. 1643. ACCESS TO CERTAIN INFORMATION ON MEDICAL DIALYSIS FACILITIES.
Section 1129A of the Social Security Act, as amended by sections 1611, 1612, 1613, and 1615, is further amended—
(1) in subsection (a)—
(A) in paragraph (1), by striking ‘‘to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1));’’;
(B) in paragraph (4)—
(i) in the matter preceding subparagraph (A), by striking ‘‘participating in a program under title XVIII or a State health care program’’ and inserting ‘‘participating in a Federal health care program (as defined in section 1128B(f)(7)(Q));’’ and
(ii) in subparagraph (A), by striking ‘‘title XVIII or a State health care program’’ and
‘‘(A) KNOWS.—The term ‘knows’ has the meaning given the terms ‘knowing’ and ‘knowingly’ in section 3729(b) of title 31 of the United States Code.’’.
‘‘(B) OVERPAYMENT.—The term ‘overpayment’ means any funds that a person receives or retains under title XVIII, or a State health care program, as a result of an inapplicable reconciliation (pursuant to the applicable existing process under the respective title), is not entitled under such title.’’.
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SEC. 1644. ACCESS TO CERTAIN INFORMATION ON MEDICAL DIALYSIS FACILITIES.
The face-to-face encounter requirements described in section 1128G of the Social Security Act, as inserted by section 1631 and amended by section 1632, is further amended by adding at the end the following new subsection:
‘‘(C) Access to certain information on medical dialysis facilities.
(1) In General.
(2) The Secretary shall promulgate such regulations as are necessary to implement the requirements established under this subsection.
(3) Effective date.
SEC. 1645. COMFORMING CIVIL MONETARY PENALTIES TO FALSE CLAIMS ACT AMENDMENTS.
Section 1128A of the Social Security Act, as amended by sections 1611, 1612, 1613, and 1615, is further amended—
(1) in subsection (a)—
(A) in paragraph (1), by striking ‘‘to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1));’’;
(B) in paragraph (4)—
(i) in the matter preceding subparagraph (A), by striking ‘‘participating in a program under title XVIII or a State health care program’’ and inserting ‘‘participating in a Federal health care program (as defined in section 1128B(f)(7)(Q));’’ and
(ii) in subparagraph (A), by striking ‘‘title XVIII or a State health care program’’ and
‘‘(4) DEFINITIONS.—In this subsection:
(5) RESPONSIBILITY.—The term ‘‘responsible official’’ means an individual who can reasonably be expected to have knowledge of the facts that are the basis for a civil monetary penalty as described in paragraph (1) and whose conduct is the basis for such penalty.
(6) EXCEPTIONS.—Nothing in this subsection shall be construed to create a duty of the Secretary to monitor or investigate the actions of such providers.
(7) Repeal.—The amendments made by this section are effective as if they had been made by section 1631 of the Affordable Care Act.
SEC. 1647. CONFORMING CIVIL MONETARY PENALTIES TO FALSE CLAIMS ACT AMENDMENTS.
SEC. 1648. CONFORMING CIVIL MONETARY PENALTIES TO FALSE CLAIMS ACT AMENDMENTS.
SEC. 1649. CONFORMING CIVIL MONETARY PENALTIES TO FALSE CLAIMS ACT AMENDMENTS.
SEC. 1650. CONFORMING CIVIL MONETARY PENALTIES TO FALSE CLAIMS ACT AMENDMENTS.
SEC. 1651. CONFORMING CIVIL MONETARY PENALTIES TO FALSE CLAIMS ACT AMENDMENTS.
SEC. 1652. CONFORMING CIVIL MONETARY PENALTIES TO FALSE CLAIMS ACT AMENDMENTS.
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SEC. 1654. CONFORMING CIVIL MONETARY PENALTIES TO FALSE CLAIMS ACT AMENDMENTS.
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SEC. 1656. CONFORMING CIVIL MONETARY PENALTIES TO FALSE CLAIMS ACT AMENDMENTS.
SEC. 1657. CONFORMING CIVIL MONETARY PENALTIES TO FALSE CLAIMS ACT AMENDMENTS.
inserting “a Federal health care program (as defined in section 1128B(f))’’;
(C) by striking “or” at the end of para-
graph (10);
(D) by inserting after paragraph (11) the following new paragraphs:
“(12) conspires to commit a violation of this section; or
“(13) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to a Federal health care program, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to a Federal health care program;”;
and
(E) in paragraph following paragraph (13), as amended by subparagraph (D),
(i) by striking “or” before “in cases under paragraph (11)”;
and
(ii) by inserting “, in cases under paragraph (12), $50,000 for any violation described in this section committed in furtherance of the conspiracy involved; or in cases under paragraph (13), $50,000 for each false record or statement, or concealment, avoidance, or decease after ‘by an excluded individual’;” and
(F) in the second sentence, by striking “such false statement, omission, or misrepresentation”) and inserting “such false statement or misrepresentation, in cases under paragraph (12), an assessment of not more than 3 times the total amount that would otherwise apply for any violation described in this section committed in furtherance of the conspiracy involved, or in cases under paragraph (13), an assessment of not more than 3 times the total amount of the obligation to which the false record or statement was material or that was avoided or decreased after ‘by an excluded individual’;” and

SEC. 1646. PROVIDING FOR AUDITS AND INVESTIGATIONS.

(a) In general.—Subchapter IV of chapter 7 of title 5, United States Code, is amended by striking “the Office of Inspector General of the Health Choices Administration shall have the authority to conduct audits, evaluations, and investigations relating to the public health insurance coverage obtained under section 1301 of the Affordable Health Care for America Act, including matters relating to fraud, abuse, and misconduct in connection with the admission and continued participation of any health benefit plan participating in the Health Insurance Exchange established under section 301 of such Act;” and
(b) Effective date.—The provisions of this section shall take effect on the date of the enactment of this Act.

Subtitle D—Access to Information Needed to Prevent Fraud, Waste, and Abuse

SEC. 1651. ACCESS TO INFORMATION NECESSARY TO IDENTIFY FRAUD, WASTE, AND ABUSE.

(a) GAO ACCESS.—Subchapter II of chapter 7 of title 31, United States Code, is amended by adding at the end the following:
“(721. Access to certain information
‘‘No provision of the Social Security Act shall be construed to limit, amend, or supersede the authority of the Comptroller General to obtain any information, to inspect any record, or to interview any officer or employee under section 7201, including with respect to any information disclosed to or obtained by the Secretary of Health and Human Services under part C or D of title XVIII of the Act.’’
(b) ACCESS TO MEDICARE PART D DATA PROGRAM INTEGRITY PURPOSES.—
be accessible through the NPDB, and other activities necessary to eliminate duplication between the two data banks. Upon the completion of such process, notwithstanding any other provision of law, the Secretary shall cease the operation of the HIPDB and shall collect information required to be reported under the preceding provisions of this section in the NPDB. Wherever provided in this subsection, the provisions of subsections (a) through (g) shall continue to apply with respect to the reporting of (or failure to report) or the treatment of the information specified in this section.

(b) ELIMINATION OF THE RESPONSIBILITY OF THE HIS OFFICE OF THE INSPECTOR GENERAL.—Section 1128C(a)(1) of the Social Security Act (42 U.S.C. 1320a-7c(a)(1)) is amended—

(1) in subparagraph (C), by adding at the end “and”;

(2) in subparagraph (D), by striking at the end “,” and inserting inserting a period; and

(3) by striking subparagraph (E).

(c) SPECIAL PROVISION FOR ACCESS TO THE NATIONAL PRACTITIONER DATA BANK BY THE DEPARTMENT OF VETERANS AFFAIRS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, during the one-year period that begins on the date that is specified in subsection (e)(1), the information described in paragraph (2) shall be available from the National Practitioner Data Bank (described in section 1921 of the Social Security Act) to the Secretary of Veterans Affairs without charge.

(2) INFORMATION DESCRIBED.—For purposes of paragraph (1), the information described in this paragraph is the information that would, but for the amendments made by this section, have been available to the Secretary of Veterans Affairs under section 1128E of the Social Security Act.
with 2015 with respect to amounts described in subsection (y); and

(b) by adding at the end the following new subsection:

"(y) INCREASED FMAP FOR CERTAIN TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS.—(A) IN GENERAL.—The FMAP for purposes of section 1905(y) of such Act (42 U.S.C. 1396d(y)), as added by subsection (a)(2)(B), is amended by inserting "or (IX)" after "or (VIII)."

(B) ENHANCED FMAP.—Section 1905(b)(4) of such Act is amended by inserting "1902(a)(10)(A)(i)(XI), 1902(a)(10)(A)(i)(XII), or" after "on the basis of section 1903(f)(4)

(4) CONSTRUCTION.—Nothing in this subsection shall be construed as not providing for coverage under subparagraph (A)(i)(VII) or (E)(v) of section 1902(a)(10) of the Social Security Act, as added by paragraphs (1) and (2), or any paragraph under the amendments made by paragraph (3), for an individual who has been provided medical assistance under title XIX of the Act under a demonstration waiver approved under section 1115 of such Act or with State funds.

(5) CONFORMING AMENDMENTS.—(A) Section 1902(b)(4) of the Social Security Act (42 U.S.C. 1396b(v)(4)) is amended—


(ii) by inserting "1902(a)(10)(E)(v)," before "1905(b)(4)";

(B) Section 1905(a) of such Act (42 U.S.C. 1396d(a)), as amended by sections 171A(a)(4) and 1731(c), is further amended, in the matter preceding paragraph (1)—

(i) by striking "or" at the end of clause (xv);

(ii) by adding "or" at the end of clause (xv); and

(iii) by inserting after clause (xv) the following:

(xvi) individuals described in section 1902(a)(10)(A)(i)(VIII);

(b) ELIGIBILITY FOR TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS WITH INCOME NOT EXCEEDING 150 PERCENT OF THE FEDERAL POVERTY LEVEL.—(1) IN GENERAL.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396b(a)(10)(A)(i)), as amended by subsection (a), is amended—

(A) by striking "or" at the end of subclause (VII); and

(B) by adding at the end the following new subclauses:

"(IX) who are over 18, and under 65 years of age, who would be eligible for medical assistance under the State plan under subclause (I) or (II) on the income standards, methodologies, and procedures in effect as of June 16, 2009 but for income, who are in families whose income does not exceed 150 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; or

"(X) beginning with 2014, who are under 19 years of age, who would be eligible for medical assistance under the State plan under subclause (I), (IV) (insofar as it relates to subsection (1)(B)), (VI), or (VIII) (based on the income standards, methodologies, and procedures in effect as of June 16, 2009) but for income, who are in families whose income does not exceed 150 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved; or

"(XI) beginning with 2014, who are under 19 years of age, who are not described in subsection (X), and who would be eligible for child health assistance under a State child health plan insofar as such plan provides benefits under this title (as described in section 5210(a)(x)(ii)) based on such plan as in effect as of June 16, 2009; or".

(2) INCREASED FMAP FOR CERTAIN TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS.—(A) IN GENERAL.—The FMAP for purposes of section 1905(y) of such Act (42 U.S.C. 1396d(y)), as added by subsection (a)(2)(B), is amended by inserting "or (IX)" after "or (VIII)."

(B) ENHANCED FMAP.—Section 1905(b)(4) of such Act is amended by inserting "1902(a)(10)(A)(i)(XI), 1902(a)(10)(A)(i)(XII), or" after "on the basis of section 1903(f)(4)

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as not providing for coverage under subparagraph (A)(i)(VII) or (E)(v) of section 1902(a)(10) of the Social Security Act, as added by paragraph (1), or an increased or enhanced FMAP under the amendments made by paragraph (2), for an individual who has been provided medical assistance under title XIX of the Act under a demonstration waiver approved under section 1115 of such Act or with State funds.


(5) INCREASED FMAP FOR CERTAIN TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS.—For purposes of section 1903(f)(4) of such Act, as added by subsection (a)(4), section shall be construed as not providing for increased FMAP for certain traditional Medicaid eligible individual. The State shall not do any redeterminations of eligibility for such individuals unless the periodicity of such redeterminations is consistent with the periodicity for redeterminations by the Commissioner of eligibility for affordability credits under subtitle C of title II of division A of the Affordable Health Care for America Act, as specified under such memorandum.

(6) ELIGIBILITY FOR TRADITIONAL MEDICAID ELIGIBLE INDIVIDUALS.—Pursuant to such memorandum, the State shall accept without further determination the enrollment under this title of an individual determined by the Commissioner to be a traditional Medicaid eligible individual. The State may do redeterminations of eligibility of such individual consistent with such section and the memorandum.

(7) DETERMINATIONS OF ELIGIBILITY FOR AFFORDABILITY CREDITS.—If the Commissioner determines that a State Medicaid agency has the capacity to make determinations of eligibility for affordability credits under subtitle C of title II of division A of the Affordable Health Care for America Act, under such memorandum.

"(A) the State Medicaid agency shall conduct such determinations for any Exchange-eligible individual who requests such a determination;

"(B) in the case that a State Medicaid agency determines that an Exchange-eligible individual is not eligible for affordability credits, the agency shall forward the information on the basis of which such determination was made to the Commissioner; and

"(C) the Commissioner shall reimburse the State Medicaid agency for the costs of conducting such determinations.

(8) REFERRALS UNDER MEMORANDUM.—Pursuant to such memorandum, if an individual applies to the State for assistance in obtaining health coverage and the State determines that the individual is not eligible for medical assistance under this title and is not authorized under such memorandum to make an determination with respect to eligibility for affordability credits through the Health Insurance Exchange, the State shall refer the individual to the Commissioner. The Commissioner may determine eligibility and, with the individual's authorization, provide to the Commissioner information obtained by the State as part of the application process.

(9) ADDITIONAL TERMS.—Such memorandum shall include such additional provisions as are necessary to implement effectively the provisions of this section and title II of division A of the Affordable Health Care for America Act.

"(B) TREATMENT OF CERTAIN NEWBORNS.—(1) IN GENERAL.—The child who is deemed under section 305(d) of the Affordable Health Care for America Act to be a Medicaid eligible individual and enrolled under this title pursuant to such section, the State shall provide for a determination, by not later than the end of the period referred to in paragraph (2) of such section, of the child's eligibility for medical assistance under this title.

"(2) EXTENDED TREATMENT AS TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—In accord-
the child obtains such coverage or the State otherwise makes a determination of the child’s eligibility for medical assistance under its plan under this title pursuant to paragraph (2).”

“2. LIMITATION.—Paragraph (1) shall not be construed as preventing a State from imposing a limitation described in section 2110(b)(6)(A)(i)(II) for a fiscal year in order to ensure that the child obtains such coverage or the State applies any asset or resource test described in subparagraph (A) are hereby waived.

“3. REFERENCES.—Any reference to a provision described in a provision in subparagraph (A) shall be deemed to be a reference to such provision as modified through the application of subparagraphs (A) and (B).”

“B. OVERIDING CONTRARY PROVISIONS.—

“1. CHIP and Medicaid MAINTENANCE OF ELIGIBILITY.—

“2. TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—The term ‘traditional Medicaid eligible individual’ means an individual who is eligible for medical assistance under Medicaid.

“3. NON-TRADITIONAL MEDICAID ELIGIBLE INDIVIDUAL.—The term ‘non-traditional Medicaid eligible individual’ means a Medicaid eligible individual who is not a traditional Medicaid eligible individual.

“4. MEMORANDUM.—The term ‘memorandum’ means a Medicaid memorandum of understanding under section 306(e)(2) of the Affordable Health Care for America Act.

“5. Y1.—The term ‘Y1’ has the meaning given such term in section 100(c) of the Affordable Health Care for America Act.

“b. CONFORMING AMENDMENTS TO ERROR RATES.

“(1) Section 1903(u)(1)(D) of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end the following new clause:

“(vi) In determining the amount of erroneous overpayments, there shall not be included any payments made under such an average State child health plan that are attributable to an error in an eligibility determination under subtitle C of title II of division A of the Affordable Health Care for America Act.”

“(2) Section 2105(c)(11) of such Act (42 U.S.C. 1396u(c)(11)) is amended by adding at the end the following new sentence:

“(b) MEDICAID MAINTENANCE OF EFFORT; SIMPLIFYING AND COORDINATING ELIGIBILITY RULES BETWEEN EXCHANGE AND MEDICAID.—

“1. IN GENERAL.—

“(1) MAINTENANCE OF EFFORT.—

“(a)CHIP MAINTENANCE OF ELIGIBILITY.—

“(i) Subject to subparagraph (B), a State is not eligible for payment under this subsection for the fiscal year beginning 2015, any benchmark benefit package described in section 1115 in reducing the health care reforms effect with community-based health care networks serving low-income beneficiaries.

“(ii) The Secretary shall consult with community-based health care networks serving low-income beneficiaries. (ii) the distribution of Medicaid DSH among the States, taking into account the ratio of the amount of DSH funds allocated to the number of uninsured individuals in each State.

“(B) SPECIFICATION OF DSH HEALTH REFORM METHODOLOGY.—The DSH Health Reform methodology described in subsection (b) of purposes of implementing the requirements of such subsection.

“(2) REDUCTION IN MEDICAID DSH.

“(a) REPORT.

“(1) IN GENERAL.—Not later than January 1, 2014, the Secretary shall submit to Congress a report concerning the extent to which, based upon the impact of the health care reforms carried out under division A in reducing the number of uninsured individuals, there is a continued role for Medicaid DSH in providing the minimum benefits and cost-sharing standards of a basic plan offered through the Health Insurance Exchange.

“(2) M ATTERS TO BE INCLUDED .—The report shall include the following:

“(O) STANDARDS FOR BENCHMARK PACKAGES.—Section 1396a(b)(1) of such Act (42 U.S.C. 1396a(b)(1)) is amended—

“(1) in each of paragraphs (1) and (2), by inserting ‘‘subject to subparagraphs (A), (B), and (C),’’ after subparagraph (A); and

“(C) STANDARDS FOR BENCHMARK PACKAGES.—Section 1397ee(c)(11) is amended by adding at the end the following new paragraph:

“(d) EFERENCE BETWEEN EXCHANGE AND MEDICAID.—

“(1) IN GENERAL.—

“(2) MAINTENANCE OF EFFORT.—

“(a) IN GENERAL.—

“(i) Subject to subparagraph (B), a State is not eligible for payment under this subsection for the fiscal year beginning after the date of the enactment of this subsection and any benchmark benefit package described in section 1115 in reducing the health care reforms effect with community-based health care networks serving low-income beneficiaries.

“(ii) The Secretary shall consult with community-based health care networks serving low-income beneficiaries. (ii) the distribution of Medicaid DSH among the States, taking into account the ratio of the amount of DSH funds allocated to the number of uninsured individuals in each State.

“(B) SPECIFICATION OF DSH HEALTH REFORM METHODOLOGY.—The DSH Health Reform methodology described in subsection (b) of purposes of implementing the requirements of such subsection.

“(ii) The Secretary shall consult with community-based health care networks serving low-income beneficiaries. (ii) the distribution of Medicaid DSH among the States, taking into account the ratio of the amount of DSH funds allocated to the number of uninsured individuals in each State.

“(B) SPECIFICATION OF DSH HEALTH REFORM METHODOLOGY.—The DSH Health Reform methodology described in subsection (b) of purposes of implementing the requirements of such subsection.

“(O) STANDARDS FOR BENCHMARK PACKAGES.—Section 1397ee(c)(11) is amended by adding at the end the following new paragraph:

“(d) EFERENCE BETWEEN EXCHANGE AND MEDICAID.—

“(1) IN GENERAL.—

“(2) MAINTENANCE OF EFFORT.—

“(a) IN GENERAL.—

“(i) Subject to subparagraph (B), a State is not eligible for payment under this subsection for the fiscal year beginning after the date of the enactment of this subsection and any benchmark benefit package described in section 1115 in reducing the health care reforms effect with community-based health care networks serving low-income beneficiaries. (ii) the distribution of Medicaid DSH among the States, taking into account the ratio of the amount of DSH funds allocated to the number of uninsured individuals in each State.

“(B) SPECIFICATION OF DSH HEALTH REFORM METHODOLOGY.—The DSH Health Reform methodology described in subsection (b) of purposes of implementing the requirements of such subsection.

“(ii) The Secretary shall consult with community-based health care networks serving low-income beneficiaries. (ii) the distribution of Medicaid DSH among the States, taking into account the ratio of the amount of DSH funds allocated to the number of uninsured individuals in each State.

“(B) SPECIFICATION OF DSH HEALTH REFORM METHODOLOGY.—The DSH Health Reform methodology described in subsection (b) of purposes of implementing the requirements of such subsection.

“(O) STANDARDS FOR BENCHMARK PACKAGES.—Section 1397ee(c)(11) is amended by adding at the end the following new paragraph:

“(d) EFERENCE BETWEEN EXCHANGE AND MEDICAID.—

“(1) IN GENERAL.—

“(2) MAINTENANCE OF EFFORT.—

“(a) IN GENERAL.—

“(i) Subject to subparagraph (B), a State is not eligible for payment under this subsection for the fiscal year beginning after the date of the enactment of this subsection and any benchmark benefit package described in section 1115 in reducing the health care reforms effect with community-based health care networks serving low-income beneficiaries.

“(ii) The Secretary shall consult with community-based health care networks serving low-income beneficiaries. (ii) the distribution of Medicaid DSH among the States, taking into account the ratio of the amount of DSH funds allocated to the number of uninsured individuals in each State.

“(B) SPECIFICATION OF DSH HEALTH REFORM METHODOLOGY.—The DSH Health Reform methodology described in subsection (b) of purposes of implementing the requirements of such subsection.

“(O) STANDARDS FOR BENCHMARK PACKAGES.—Section 1397ee(c)(11) is amended by adding at the end the following new paragraph:

“(d) EFERENCE BETWEEN EXCHANGE AND MEDICAID.—

“(1) IN GENERAL.—

“(2) MAINTENANCE OF EFFORT.—

“(a) IN GENERAL.—

“(i) Subject to subparagraph (B), a State is not eligible for payment under this subsection for the fiscal year beginning after the date of the enactment of this subsection and any benchmark benefit package described in section 1115 in reducing the health care reforms effect with community-based health care networks serving low-income beneficiaries. (ii) the distribution of Medicaid DSH among the States, taking into account the ratio of the amount of DSH funds allocated to the number of uninsured individuals in each State.

“(B) SPECIFICATION OF DSH HEALTH REFORM METHODOLOGY.—The DSH Health Reform methodology described in subsection (b) of purposes of implementing the requirements of such subsection.
(3) COORDINATION WITH MEDICARE DSH REDUCTIONS.—The Secretary shall coordinate the report under this subsection with the report on Medicare DSH under section 1112.

(4) (A) In this section, the term “Medicaid DSH” means adjustments in payments under section 1923 of the Social Security Act for inpatient hospital services furnished by disproportionate share hospitals.

(b) MEDICAID DSH REDUCTIONS.—

(1) IN GENERAL.—For each of fiscal years 2017 through 2019 the Secretary shall effect the following reductions:

(i) REVISIONS OF ALLOTMENTS.—The Secretary shall reduce DSH allotments to States in the amount specified under the DSH health reform methodology under paragraph (2) for the State for the fiscal year.

(ii) REDUCTIONS IN PAYMENTS.—The Secretary shall reduce payments to States under section 1923(a) of the Social Security Act (42 U.S.C. 1396r–4(a)) for each calendar quarter in the fiscal year, in the manner specified in subparagraph (C), in an amount equal to ¼ of the DSH allotment reduction under clause (i) for the State for the fiscal year.

(B) AGGREGATE REDUCTIONS.—The aggregate reductions in DSH allotments for all States under subparagraph (A)(i) shall be equal to:

(A) $1,500,000,000 for fiscal year 2017;

(B) $2,500,000,000 for fiscal year 2018; and

(C) $6,000,000,000 for fiscal year 2019.

The Secretary shall distribute such aggregate reduction among States in accordance with paragraph (2).

(C) MANNER OF PAYMENT REDUCTION.—The amount of the payment reduction under subparagraph (A)(ii) for a State for a quarter shall be equal to an amount determined by the Secretary to be an appropriate amount for that State not to exceed the amount specified in this subsection to the extent that the amount specified in this subsection is—

(i) in excess of the amount determined to be an appropriate amount for that State under subparagraph (A)(i) and

(ii) such an amount determined to be an appropriate amount for that State under subparagraph (A)(i) plus such amount as the Secretary determines is necessary to ensure that the manner of distribution of the aggregate reduction among States is in accordance with paragraph (2).

(2) DSH HEALTH REFORM METHODOLOGY.—

The Secretary shall carry out paragraph (1) through use of a DSH Health Reform methodology described in paragraph (2).

(A) IN GENERAL.—For each of fiscal years 2017 through 2019 the Secretary shall carry out paragraph (1) for the State for the fiscal year.

(B) AGGREGATE REDUCTIONS.—The aggregate reductions in DSH allotments for all States under subparagraph (A)(i) shall be equal to:

(A) $1,500,000,000 for fiscal year 2017;

(B) $2,500,000,000 for fiscal year 2018; and

(C) $6,000,000,000 for fiscal year 2019.

The Secretary shall distribute such aggregate reduction among States in accordance with paragraph (2).

(C) MANNER OF PAYMENT REDUCTION.—The amount of the payment reduction under subparagraph (A)(ii) for a State for a quarter shall be equal to an amount determined by the Secretary to be an appropriate amount for that State not to exceed the amount specified in this subsection to the extent that the amount specified in this subsection is—

(i) in excess of the amount determined to be an appropriate amount for that State under subparagraph (A)(i) and

(ii) such an amount determined to be an appropriate amount for that State under subparagraph (A)(i) plus such amount as the Secretary determines is necessary to ensure that the manner of distribution of the aggregate reduction among States is in accordance with paragraph (2).

(D) DEFINITIONS.—In this section:

(i) STATE.—The term “State” means the 50 States and the District of Columbia.

(ii) THE TERM “DSH ALLOTMENT” MEANS, WITH RESPECT TO A STATE FOR A FISCAL YEAR, THE ALLOTMENT MADE UNDER SECTION 1923(b) OF THE SOCIAL SECURITY ACT (42 U.S.C. 1396r–4(b)–1) FOR THE STATE FOR THE FISCAL YEAR.

(iii) DSH HEALTH REFORM METHODOLOGY.—The Secretary shall, for each of fiscal years 2017 through 2019, carry out paragraph (1) through use of a DSH Health Reform methodology described in paragraph (2).

(A) IN GENERAL.—Not later than the publication deadline specified in subparagraph (B), the Secretary shall publish in the Federal Register a notice specifying the DSH allotment to each State under section 1923(f) of the Social Security Act for the respective fiscal year specified in such subparagraph, consistent with the description of the DSH Health Reform methodology described in paragraph (2).

(B) PUBLICATION DEADLINE.—The publication deadline specified in this subparagraph is—

(i) January 1, 2016, with respect to DSH allotments described in subparagraph (A) for fiscal year 2017;

(ii) January 1, 2017, with respect to DSH allotments described in subparagraph (A) for fiscal year 2018;

(iii) January 1, 2018, with respect to DSH allotments described in subparagraph (A) for fiscal year 2019.

(C) CONFORMING AMENDMENTS.—

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

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6) the following new paragraph:

“(7) SPECIAL RULE FOR FISCAL YEARS 2017, 2018, AND 2019.—For each of fiscal years 2017, 2018, and 2019, the DSH allotments under this subsection are subject to reduction under section 1706(b) of the Affordable Health Care for America Act.

(2) The second sentence of section 1923(b)(4) of such Act (42 U.S.C. 1396r–4(b)(4)) is amended by inserting before the period the following:

“or to effect the reductions described in subsection (b) of section 1706 of the Affordable Health Care for America Act.”

(D) DISPROPORTIONATE SHARE HOSPITALS (DSH) AND ESSENTIAL ACCESS HOSPITALS (EAH) NON-DISABILITY DETERMINATION DEADLINES.—

(1) IN GENERAL.—Section 1923(d) of the Social Security Act (42 U.S.C. 1396r–4) is amended by adding at the end the following new paragraph:

“(d) DISPROPORTIONATE SHARE HOSPITALS (DSH) AND ESSENTIAL ACCESS HOSPITALS (EAH) NON-DISABILITY DETERMINATION DEADLINES.—

(1) IN GENERAL.—Section 1923(d) of the Social Security Act (42 U.S.C. 1396r–4) is amended by adding at the end the following new paragraph:

“(1) in subsection (a)(4)—

(A) by striking “and” before “(C);” and

(B) by inserting before the semicolon at the end the following: “; and (D) preventive services described in subsection (c)(6);” and

(2) by adding at the end the following new subsection:

“(e) PREVENTIVE SERVICES.—The preventive services described in subsection (c) are services not otherwise described in subsection (a) or (r) that the Secretary determines are—

(E) appropriated for individuals entitled to medical assistance under this title.”.

(2) ELIMINATION OF COST-SHARING.—

(1) Subsections (a)(2)(D) and (b)(2)(D) of section 1916(b) of such Act (42 U.S.C. 1396o) are each amended by inserting “preventive services described in section 1905(z),” after “emergency services (as defined by the Secretary),”.

(2) Section 1916(z)(1) of such Act (42 U.S.C. 1396o–1(a)(1)(A)) is amended by inserting “, preventive services described in section 1905(z),” after “subsection (c).”.

(E) CONFORMING AMENDMENT.—Section 1932 of such Act (42 U.S.C. 1396l) is amended—

(1) in subsection (c)(2)(B)(i), by striking “the advisory committee referred to in subsection (e)” and inserting “the Director of the Centers for Disease Control and Prevention”;

(2) in subsection (e), by striking “Advisory Committee” and all that follows and inserting “the Director of the Centers for Disease Control and Prevention”;

(3) by striking subsection (g).

(3) EFFECTIVE DATE.—Except as provided in section 1706, the amendments made by this section shall apply to services furnished on or after July 1, 2010, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 1712. TOBACCO CESSATION.

(a) DROPPIPING TOBACCO CESSATION EXCLUSIONS FROM COVERAGE FOR OUTPATIENT DRUGS.—

Section 2127(d)(2) of the Social Security Act (42 U.S.C. 1396r–8(d)(2)) is amended—

(1) by striking subparagraph (E);

(2) in subparagraph (G), by inserting before the period the following:

“(F) makes provisions for, and accepts, reimbursement under this title for services provided to eligible beneficiaries under this title;”;

(3) EFFECTIVE DATE.—The amendments made by this section shall apply to drugs and services furnished on or after January 1, 2010.

SEC. 1713. OPTIONAL COVERAGE OF NURSE HOME VISITATION SERVICES.

(a) IN GENERAL.—Section 1902(a)(55) of the Social Security Act (42 U.S.C. 1396a(a)(55)) is amended by striking “under subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(V), or (a)(10)(A)(i)(VI)” and inserting “(including receipt and processing of applications of individuals for affordability credits under subtitle C of title II of division A of the Affordable Health Care for America Act pursuant to a Medicaid memorandum of understanding under section 1943(a)(1))”;

(b) EFFECTIVE DATE.—Except as provided in section 1759, the amendment made by this section shall apply to services furnished on or after July 1, 2010, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date.

Subtitle B—Prevention

SECTION 1711. REQUIRED COVERAGE OF PREVENTIVE SERVICES.

(a) COVERAGE.—Section 1905(b)(1) of the Social Security Act (42 U.S.C. 1396d) is amended, as amended by section 1701(a)(3)(B), to include—

(1) in subsection (a)(4)—

(A) by striking “and” before “(C);” and

(B) by inserting before the semicolon at the end the following: “; and (D) preventive services described in subsection (c)(6);” and

(2) by adding at the end the following new paragraph:

“(28) nurse home visitation services (as defined in subsection (aa)); and;

(3) by redesignating subparagraph (F) as subparagraph (G); and

(c) by inserting after paragraph 27 the following new paragraph:

“(28) nurse home visitation services (as defined in subsection (aa)); and;

(2) by adding at the end the following new paragraph:

“(aa) The term ‘nurse home visitation services’ means home visits by trained
nurses to families with a first-time pregnant woman, or a child (under 2 years of age), who is eligible for medical assistance under this title, but only, to the extent determined by the Secretary in recognition of evidence that such services are effective in one or more of the following:

(1) Improving maternal or child health and pregnancy outcomes or increasing birth intervals between pregnancies.

(2) Reducing the incidence of child abuse, neglect, and abuse and improving family stability (including reduction in the incidence of intimate partner violence), or reducing maternal and child involvement in the criminal justice system.

(3) Increasing economic self-sufficiency, employment advancement, school-readiness, and educational achievement, or reducing dependence on public assistance.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2010.

(c) CONSTRUCTION.—Nothing in the amendments made by this section shall be construed as affecting the ability of a State under title XIX or XXI of the Social Security Act to provide home visitation services as part of another class of items and services falling within the definition of medical assistance or other health assistance under the respective title, or as an administrative expenditure for which payment is made under title XIX or XXI of such Act, respectively, on or after the date of the enactment of this Act.

SEC. 1714. STATE ELIGIBILITY OPTION FOR FAMILY PLANNING SERVICES.

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(A) in subclause (XVIII), by striking "or" at the end; and

(B) in subclause (XIX), by adding "or" at the end; and

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

"(XX) who are described in subsection (hh) (relating to individuals who meet certain income standards);"

(2) REMOVED.—Section 1902 of such Act (42 U.S.C. 1396a), as amended by section 1703, is amended by adding at the end the following new subsection:

"(hh) Individuals described in this subsection are individuals—

"(A) whose income does not exceed an income eligibility level established by the State that is not less than the highest income eligibility level established under the State plan under this title (or under its State child health plan under title XXI for pregnant women); and

"(B) who are not pregnant.

(b) IN GENERAL.—Subject to subparagraph (B), the term "qualified entity" means any entity that—

(1) is eligible for payments under a State plan approved under this section; and

(2) is determined by the State agency to be capable of providing services described in section 1115 of such Act, respectively, on or after the date of the enactment of this Act and shall apply to an individual described in subsection (a) that is presumptively eligible for medical assistance under a State plan.

(b) PREVIOUSLY DETERMINED ELIGIBILITY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall determine the eligibility of an individual described in subsection (a) to receive medical care under this title on the basis of an application by the individual, a demonstration project waiver granted under section 1115, or any other standard recognized by the Secretary.

(2) LIMITATION ON BENEFITS.—Section 1902(a)(13) of such Act (42 U.S.C. 1396a(a)(13)) is amended in the matter following subparagraph (G) of such section by—

(A) by striking "and" (XIV)" and inserting "(XIV)"; and

(B) by inserting "; and (XV) the medical assistance made available to an individual described in subsection (hh) shall be limited to family planning services and supplies described in section 1105(a)(4)(C) including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting after "cervical cancer";"

(3) CONFORMING AMENDMENTS.—Section 1906(a) of such Act (42 U.S.C. 1396a(a), as amended by section 1731(c), is amended in the matter preceding paragraph (1) by—

(A) in clause (xii), by striking "or" at the end; and

(B) in clause (xiv), by adding "or" at the end; and

(C) by inserting after clause (xiv) the following:

"(xv) individuals described in section 1902(hh).".

(b) PRESUMPTIVE ELIGIBILITY.—

(1) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1920B the following:

"SEC. 1920C. (a) STATE OPTION.—State plan approved under this section may provide for making medical assistance available to an individual described in section 1902(hh) (relating to individuals who meet certain income eligibility levels) during a presumptive eligibility period. In the case of an individual described in section 1902(hh), such medical assistance shall be limited to family planning services and supplies described in 1906(a)(4)(C) and, at the State's option, medical diagnosis and treatment services that are provided in conjunction with a family planning service in a family planning setting.

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

"(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The term 'presumptive eligibility period' means, with respect to an individual described in subsection (a), the period that:

"(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(hh); and

"(B) ends with (and includes) the earlier of—

"(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

"(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

"(2) QUALIFIED ENTITY.—

"(A) IN GENERAL.—Subject to subparagraph (B), the term 'qualified entity' means any entity that—

"(i) is eligible for payments under a State plan approved under this title; and

"(ii) is determined by the State agency to be capable of providing services described in section 1105(a)(4)(C), medical assistance that—

"(i) is furnished to an individual described in subsection (a); and

"(ii) is determined by the State agency to be capable of providing family planning services and supplies.

"(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities to be presumptively eligible in order to prevent fraud and abuse.

(c) ADMINISTRATION.—

(1) IN GENERAL.—The State agency shall provide qualified entities with—

"(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

"(B) information on how to assist such individuals in completing and filing such forms.

(d) NOTIFICATION REQUIREMENTS.—A qualified entity that determines eligibility under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall—

"(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

"(B) inform such individual at the time the determination is made that an application for medical assistance under a State plan, if made by not later than the last day of the month following the month during which the determination is made.

(e) APPLICATION FOR MEDICAL ASSISTANCE.—In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance by not later than the last day of the month following the month during which the determination is made.

(f) PAYMENT.—Notwithstanding any other provision of law, medical assistance that—

"(1) is furnished to an individual described in subsection (a); and

"(2) during a presumptive eligibility period; and

"(3) is furnished by a entity that is eligible for payments under the State plan; and

"(4) is included in the care and services covered by the State plan,

shall be treated as medical assistance provided by such entity under section 1902(hh) (relating to individuals who meet certain income standards) as amended by section 1703(c), is amended in—

(1) by striking "and" at the end of subparapraph (A); and

(2) by striking "or" and inserting "for".

(g) EFFECTIVE DATE.—The amendments made by this section take effect on the date of the enactment of this Act and shall apply to an individual described in subsection (a) that is presumptively eligible for medical assistance under this title on the basis of an application by the individual.
(iii) by adding at the end the following new subparagraph:

‘‘(C) payment for primary care services (as defined in subsection (kk)(1)) furnished by physicians, practitioners, or professionals and services furnished by other health care professionals that would be primary care services under such section if furnished by a physician) at a rate not less than 80 percent of the rate that would be applicable if the adjustment described in subsection (kk)(2) were to apply to such services and physicians or professionals (as the case may be) is consistent with the payment rates described in section 1848 for services furnished in 2010, 90 percent of such adjusted payment rate for services and physicians (or professionals) furnished in 2011, 100 percent payment rate for services and physicians (or professionals) furnished in 2012 and each subsequent year’’; and

(B) by adding at the end the following new subsection:

‘‘(kk) INCREASED PAYMENT FOR PRIMARY CARE SERVICES.—For purposes of subsection (a)(13):

‘‘(1) PRIMARY CARE SERVICES DEFINED.—The term ‘primary care services’ means evaluation and management services, without regard to the specialty of the physician furnishing the services, that are procedure codes (for services covered under title XVIII) for services in the category designated Evaluation and Management in the Health Common Procedure Coding System (established by the Secretary under section 1844(c)(5) as of December 31, 2009, and as subsequently modified by the Secretary).

‘‘(2) ADJUSTMENT.—The adjustment described in this paragraph is the substitution of 1.25 percent for the update otherwise provided for medical services and physicians (or professionals) furnished in 2010, 1.25 percent for the update otherwise provided for medical services and physicians (or professionals) furnished in 2011, 1.25 percent for the update otherwise provided for medical services and physicians (or professionals) furnished in 2012 and each subsequent year.’’

(2) in subsection (a), by striking ‘‘and services furnished on or after January 1, 2010.‘‘

(3) in subsection (b), by striking ‘‘and services furnished on or after January 1, 2010.‘‘

(4) in subsection (c), by striking ‘‘and services furnished on or after January 1, 2010.‘‘

(5) in subsection (d), by striking ‘‘and services furnished on or after January 1, 2010.‘‘

SEC. 1724. OPTIONAL COVERAGE FOR FREE-STANDING BIRTH CENTER SERVICES.

(a) In General.—Section 1905 of the Social Security Act (42 U.S.C. 1396a), as amended by section 1713(a), is amended—

(1) in subsection (a)—

(A) by redesignating paragraph (29) as paragraph (30); (B) in paragraph (28), by striking at the end ‘‘and’’; and

(C) by inserting after paragraph (28) the following new paragraph:

‘‘(29) freestanding birth center services (as defined in subsection (l)(3)(A) and other ambulatory services that are otherwise free-standing birth center (as defined in subsection (l)(3)(B)) and that are otherwise included in the plan; and’’;

and

(2) in subsection (b)(1), by adding at the end the following new paragraph:

‘‘(C) ‘The term ‘freestanding birth center’ services means a health facility—

‘‘(i) that is not a hospital; and

‘‘(ii) that is planned to occur away from the pregnant woman’s residence.’’

(3) in subsection (b)(2), by striking ‘‘or a rural health clinic’’ and inserting ‘‘or a rural health clinic’’;

(4) in subsection (b)(3), by striking ‘‘or a public health clinic’’ and inserting ‘‘or a public health clinic’’.

SEC. 1725. INCLUSION OF PUBLIC HEALTH CLINICS UNDER THE VACCINES FOR CHILDREN ACT.


(1) by striking ‘‘or a public health clinic’’;

(2) by inserting ‘‘or a public health clinic’’.

SEC. 1728. INCLUSION OF COVERED SERVICES OF PODIATRISTS.

(a) in General.—Section 1905(a)(5)(A) of the Social Security Act (42 U.S.C. 1396a(a)(5)(A)) is amended—

(1) by striking ‘‘or a public health clinic’’; and

(2) by striking ‘‘or a public health clinic’’;

(3) by striking ‘‘or a rural health clinic’’; and

(4) by striking ‘‘or a public health clinic’’.

(b) EFFECTIVE DATE.—Except as provided in section 1726, the amendment made by subsection (a) shall apply to services furnished on or after January 1, 2010.

SEC. 1729A. REQUIREMENT OF COVERAGE OF SERVICES OF OPTOMETRISTS.

(a) in General.—Section 1905(a)(5) of the Social Security Act (42 U.S.C. 1396a(a)(5)) is amended—

(1) by striking ‘‘and’’ before ‘‘(B)’’; and

(2) by inserting before the semicolon the following: ‘‘; and (C) medical and other health services (as defined in section 1905(a)(5) of the Social Security Act) furnished by an optometrist (described in section 1861(r)(4)) to the extent such services may be performed under State law.’’

(b) EFFECTIVE DATE.—Except as provided in section 1790, the amendments made by subsection (a) shall take effect 90 days after the enactment of this Act.
Nothing in this title shall prevent or limit a State from covering therapeutic foster care for eligible children in out-of-home placements under sections 1905(a)(28)(A) of the Social Security Act (42 U.S.C. 1396a(a)).

For purposes of this section, the term "therapeutic foster care" means a foster care program that provides:

(1) to the child—
(A) structured daily activities that develop, reinforce, and reinforce and appropriate social, communications, and behavioral skills;
(B) crisis intervention and crisis support services;
(C) medication monitoring;
(D) counseling; and
(E) case management services; and
(2) established for the purpose of providing health care and consultation with the foster parent on the management of children with mental illnesses and related health and development services;

SEC. 1728. ASSURING ADEQUATE PAYMENT LEVELS FOR SERVICES.

(a) In General.—Title XIX of the Social Security Act is amended by inserting after section 1921 the following new section:

"ASSURING ADEQUATE PAYMENT LEVELS FOR SERVICES

"Sec. 1921. (a) IN GENERAL.—A State plan under this title shall not be considered to meet the requirement of section 1902(a)(30)(A) for a year (beginning with 2011) unless, by not later than April 1 before the beginning of such year, the State submits to the Secretary an amendment to the plan that specifies the payment rates to be used for such services under the plan in such year and includes in such submission such additional data as will assist the Secretary in evaluating the State’s compliance with such requirement, including data relating to how rates are established for payment to other managed care organizations under sections 1903(m) and 1922 take into account such payment rates.

"(b) SECRETARIAL REVIEW.—The Secretary, by not later than 90 days after the date of submission of a plan amendment under subsection (a), shall—

(1) review each such amendment for compliance with the requirement of section 1902(a)(30)(A); and
(2) approve or disapprove each such amendment.

If the Secretary disapproves such an amendment, the State shall immediately submit a revised amendment that meets such requirement.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 1729. MEDICAID COVERAGE FOR YOUNGS UPON RELEASE FROM PUBLIC INSTITUTIONS.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a), as amended by section 1631(b) and 1703(a), is amended—

(1) by striking "and" at the end of paragraph (74); and
(2) by striking the period at the end of paragraph (75) and inserting "; and"

(3) by inserting after paragraph (75) the following new paragraph:

"(76) provide that in the case of any youth who is 18 years of age or younger, was enrolled for medical assistance under the State plan for such youth beginning of such year, the State submits to the Secretary an amendment to the plan immediately before becoming an inmate of a public institution, is 18 years of age or younger upon release from such institution, and is eligible for such medical assistance under the State plan at the time of release from such institution—

(A) during the period such youth is incarcerated in public institutions, the State shall not terminate eligibility for medical assistance under the State plan for such youth;
(B) during the period such youth is incarcerated in a public institution, the State shall establish a process that ensures—
(i) that the State does not claim federal financial participation for services that are provided to such youth and that are excluded under subsection 1905(a)(28)(A); and
(ii) that the youth receives medical assistance for which federal participation is available under this title;
(C) on or before the date such youth is released from such institution, the State shall ensure that such youth is enrolled for medical assistance under this title, unless and until there is a determination that the individual is no longer eligible to be so enrolled; and
(D) the State shall ensure that enrollment of such youth is processed under this title immediately upon leaving the institution.

"SEC. 1730. QUALITY MEASURES FOR MATERNITY AND ADULT HEALTH SERVICES UNDER MEDICAID AND CHIP.

Title XI of the Social Security Act (42 U.S.C. 1391 et seq.) is amended by inserting after section 1130A the following new section:

"SEC. 1130A. QUALITY MEASURES FOR MATERNITY AND ADULT HEALTH SERVICES UNDER MEDICAID AND CHIP.

"(a) MATERNITY CARE QUALITY MEASURES UNDER MEDICAID AND CHIP.—

"(1) DEVELOPMENT OF MEASURES.—No later than January 1, 2012, the Secretary shall develop and publish for comment a proposed set of measures that accurately describe the quality of maternity care provided under State plans under titles XIX and XXI. The Secretary shall publish a final recommended set of such measures no later than July 1, 2011.

"(2) STANDARDIZED REPORTING FORMAT.—No later than January 1, 2012, the Secretary shall develop and publish a standardized reporting format for maternal and child care quality measures for use by State programs under titles XIX and XXI to collect data from managed care entities and providers and practitioners that participate in such programs and to report maternal and child care quality measures to the Secretary.

"(b) OTHER ADULT HEALTH QUALITY MEASURES UNDER MEDICAID.—

"(1) DEVELOPMENT OF MEASURES.—The Secretary shall develop quality measures that are not otherwise developed under section 1192 for services received under State plans under title XIX that are needed by individuals who are 21 years of age or older but have not attained age 65; and
(2) REPORTING.—The Secretary shall develop and publish a standardized reporting format for maternity care and child health quality measures under title XIX or child health assistance under title XXI.

"(c) APPROPRIATION.—For purposes of carrying out this section, in addition to funds otherwise available, out of any funds in the Treasury not otherwise appropriated, there are appropriated $40,000,000 for the 5-fiscal-year period beginning with fiscal year 2010. Funds appropriated under this subsection shall remain available until expended."

SEC. 1730A. ACCOUNTABLE CARE ORGANIZATION PILOT PROGRAM.

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish under this section an accountable care organization pilot program under which a State may apply to the Secretary for approval of an accountable care organization pilot program described in subsection (b) in this section referred to as a "pilot program" prior to the close of the accountable care organization concept under title XIX of the Social Security Act.

(b) PILOT PROGRAM

(1) IN GENERAL.—The pilot program described in this subsection is a program that applies only to the accountable care organization models described in section 1866B of the Social Security Act, as added by section 1301 of this Act.

(2) LIMITATION.—The pilot program shall operate for a period of not more than 5 years.

(c) ADDITIONAL INCENTIVES.—In the case of the pilot program under this section, the Secretary may—

(1) waive the requirements of—
(A) section 1902(a)(1) of the Social Security Act (relating to statewideness); and
(B) section 1902(a)(10)(B) of such Act (relating to comparability of risk); and
(2) increase the matching percentage for administrative expenditures up to—
SEC. 1736. MEDICAID COVERAGE FOR CITIZENS OF FREELY ASSOCIATED STATES.

(a) In General.—Section 402(b)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)) is amended by adding at the end the following:

“(G) Medicaid exception for citizens of freely associated states.—With respect to eligibility for benefits for the designated Federal program defined in paragraph (3)(C) (relating to the Medicaid program), section 401(a) and paragraph (1) shall not apply to an individual who lives or lawful resides in any of the 50 States or the District of Columbia in accordance with the Compacts of Free Association between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau and shall not apply, at the option of the Governor of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa as communicated to the Secretary of Health and Human Services in writing, to any individual who lawfully resides in the respective territory in accordance with such Compacts.

(b) Effective Date.—Section 402(b)(2) of such Act (8 U.S.C. 1613(d)) is amended—

(1) in paragraph (1), by striking “or” at the end;

(2) in paragraph (2), by striking the period at the end and inserting “; and”;

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

“(H) Medicaid exception for citizens of freely associated states.—For purposes of paragraphs (1) and (2), the term “freely associated state” means any of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau and shall not apply, at the option of the Governor of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa as communicated to the Secretary of Health and Human Services in writing, to any individual who lawfully resides in the respective territory in accordance with such Compacts.”.

(c) Three-Year Limit.—Section 403(b) of such Act (8 U.S.C. 1614(b)) is amended—

(1) in paragraph (1), by striking “or” at the end;

(2) in paragraph (2), by striking the period at the end and inserting “; and”;

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

“(D) Exception to three-year limit.—Section 403(b) of such Act (8 U.S.C. 1614(b)) is amended—

(1) in paragraph (1), by striking “or” at the end;
(3) by adding at the end the following:—

“(8) an individual who lawfully resides in the United States in accordance with a Compact of Free Association referred to in section 406A of the Compact of Free Association Act of 2000, as designated Federal program defined in section 402(b)(3)(C) (relating to the Medicaid program).”.

SEC. 1737. CONTINUING REQUIREMENT OF MEDICARE COVERAGE OF NON-EMERGENCY TRANSPORTATION TO MEDICALLY NECESSARY SERVICES.

(a) REQUIREMENT.—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) is amended—

(1) in subparagraph (A), in the matter preceding clause (1), by striking “and” and (21) and inserting “, (21), (30)”; and

(2) in subparagraph (C)(iv), by striking “and” (17) and (30)”.

(b) DESCRIPTION OF SERVICES.—Section 1905(a) of such Act (42 U.S.C. 1395d(a)), as amended by sections 1713(a)(1) and 1724(a)(1), is amended—

(1) in paragraph (29), by striking “and” at the end;

(2) by redesignating paragraph (30) as paragraph (31) and inserting the comma at the end and inserting a semicolon; and

(3) by inserting after paragraph (29) the following new paragraph:

“(30)’Medically necessary transportation to medically necessary services, consistent with the requirement of section 431.53 of title 42, Code of Federal Regulations, as in effect as of June 1, 2008; and’.

(c) INCLUSION OF INFORMATION ON SUPPLEMENTAL MEDICAID COVERAGE IN THE NATIONAL CLEARINGHOUSE FOR LONG-TERM CARE INFORMATION; EXTENSION OF FUNDING.—Section 6021(d) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396p note) is amended—

(1) in paragraph (2)(A)—

(A) in clause (ii), by striking “and” at the end;

(B) by adding at the end the following:

“(C) include information regarding the CLASS program established under title XXXII of the Public Health Service Act;”;

(2) in paragraph (3)—

(A) by striking “2010” and inserting “2015”; and

(B) by adding at the end the following:

“In addition to the amount appropriated under the previous sentence, there are authorized to be appropriated to carry out this subsection, $7,000,000 for each of fiscal years 2011, 2012, and 2013.”.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to transportation on or after such date.

SEC. 1738. STATE OPTION TO DISREGARD CERTAIN INCOME IN PROVIDING CONTINUING MEDICAID COVERAGE FOR CERTAIN INDIVIDUALS WITH EXTREMELY HIGH PRESCRIPTION COSTS.

Section 1902(e) of the Social Security Act (42 U.S.C. 1396e(e)), as amended by section 203(a) of the Children’s Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3), is amended by adding at the end the following new paragraph:

“(14) by striking the State, in the case of an individual with extremely high prescription drug costs described in subparagraph (B) who has been determined (without the application of this paragraph) as eligible for medical assistance under this title, the State may, in determining the individual’s eligibility for medical assistance under this title and family income of the individual to the extent such income is less than an amount that is specified by the State and does not exceed the amount specified in subparagraph (C), or, if greater, income equal to the cost of the orphan drugs described in subparagraph (B)(iii).

“(B) An individual with extremely high prescription drug costs described in this subparagraph for a 12-month period is an individual—

(i) who is covered under health insurance or a health benefits plan that has a maximum lifetime limit of not less than $1,000,000 which includes all prescription drug coverage; and

(ii) who has exhausted all available prescription drug coverage under the plan as of the beginning of such period;

(iii) who incurs (or is reasonably expected to incur) annual household costs in excess of the amount specified in subparagraph (C) for the period; and

(iv) whose annual family income (determined without regard to this paragraph) as of the beginning of the period does not exceed 75 percent of the amount incurred for such drugs (as described in clause (iii)).

“(C) The amount specified in this subparagraph for a 12-month period beginning in—

(i) 2009;

(ii) a subsequent year, is the amount specified in clause (i) (or this subparagraph) for the previous year increased by the annual rate of increase in the medical care component of the consumer price index (U.S. city average) for the 12-month period ending in August of the previous year.

Any amount computed under clause (ii) that is not a multiple of $1,000 shall be rounded to the nearest multiple of $1,000.

(D) In applying this paragraph, amounts incurred for prescription drugs for cosmetic purposes shall be accounted for.

(E) With respect to an individual described in subparagraph (A), notwithstanding section 1916, the State plan—

“(1) shall provide for the application of cost-sharing that is at least nominal as determined under section 1916; and

“(2) may provide, consistent with section 1916A, for such additional cost-sharing as does not exceed a maximum level of cost-sharing that is specified by the Secretary and is adjusted by the Secretary on an annual basis.

(F) A State electing the option under this paragraph shall provide for a determination on an individual’s application for continued medical assistance, to take this title within 30 days of the date the application if filed with the State.

(G) In this paragraph—


(ii) The term ‘health benefits plan’ includes coverage under a plan offered under a State high risk pool program.

SEC. 1729. PROVISIONS RELATING TO COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS (CLASS). (a) COORDINATION WITH CLASS PROGRAM PROVISIONS.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by sections 1631(b), 1703(a), 1729, 1753, 1757(a), 1759(a), 1759(b), 1767(a), and 1783(a), is amended—

(1) in paragraph (80), by striking “and” at the end;

(2) in paragraph (81), by striking the period and inserting “; and”;

(3) by inserting after paragraph (81) the following:

“(82) provide that the State will comply with such regulations regarding the application of primary and secondary payor rules with respect to individuals who are eligible for medical assistance under this title and are eligible for benefits under the CLASS program established under title XXXII of the Public Health Service Act as the Secretary shall establish.”.

(b) ASSURANCE OF ADEQUATE INFRASTRUCTURE FOR THE PROVISION OF PERSONAL CARE ATTENDANT WORKERS.—Section 1902(a) of such Act (42 U.S.C. 1396a(a)), as amended by subsection (a), is amended—

(1) in paragraph (81), by striking “and” at the end;

(2) in paragraph (82), by striking the period at the end and inserting “; and”;

(3) by inserting after paragraph (82) the following:

“(83) provide that, not later than 2 years after the enactment of this paragraph, each State shall—

“(A) assess the extent to which entities such as providers of home care, home health services, nursing facilities, personal care service providers, public authorities created to provide personal care services to individuals eligible for medical assistance under the State plan, and nonprofit organizations, are serving or have the capacity to serve as fiscal agents for, employers of, and providers of employer-sponsored benefits for, personal care attendant workers who provide personal care services to individuals receiving benefits under the CLASS program established under title XXXII of the Public Health Service Act, including in rural and underserved areas;

“(B) designate or create such entities to serve as fiscal agents for, employers of, and providers of employer-sponsored benefits for, such workers to ensure an adequate supply of the workers for individuals receiving benefits under the CLASS program, including in rural and underserved areas;

“(C) ensure that the designation or creation of such entities will not negatively alter or impede existing programs, models, methods, or administration of service delivery that provide for consumer controlled or self-directed home and community services and further ensure that such entities will not impede the ability of individuals to direct and control their home and community services, including the ability to select, manage, dismiss, co-employ, or employ such workers, but that inhibit such reliance on family members for the provision of personal care services.”.

SEC. 1739A. SENSE OF CONGRESS REGARDING COMMUNITY FIRST CHOICE OPTION TO PROVIDE MEDICAID COVERAGE OF COMMUNITY-BASED ATTENDANT SERVICES AND SUPPORTS.

It is the sense of Congress that States should be allowed to elect under their Medicaid State plans under title XIX of the Social Security Act to implement a Community First Choice Option under which—

(1) coverage of community-based attendant services and supports furnished in homes and communities is available, at an individual’s option, to individuals otherwise eligible for Medicaid institutional coverage under the respective State plan;

(2) such supports and services include assistance to individuals with disabilities in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks;

(3) the Federal matching assistance percentage (FMAP) under such title for medical assistance for such supports and services is enhanced;

(4) States, consistent with minimum federal standards, ensure quality of such supports and services; and

(5) States collect and provide data to the Secretary of Health and Human Services on
the cost and effectiveness and quality of supports and services provided through such options.

Subtitle E—Financing
SEC. 1741. PAYMENTS TO PHARMACISTS.
(a) PHARMACY REIMBURSEMENT LIMITS.—
(1) IN GENERAL.—Section 1927(c)(2)(A) of such Act (42 U.S.C. 1396r–8(b)(3)(A)) is amended—
(A) by striking paragraph (5) and inserting the following:—
``(5) USE OF AMP IN UPPER PAYMENT LIMITS.—The Secretary shall calculate the Federal upper reimbursement limit established under paragraph (4) as 130 percent of the weighted average (determined on the basis of manufacture of the pharmacy) of monthly average manufacturer prices. Nothing in the previous sentence shall be construed as preventing the Secretary from performing such calculation using a smoothing process as order to reduce significant variations from month to month as a result of rebates, discounts, and other pricing practices, such as in the manner such a process is used by the Secretary in determining the average sales price of a drug or biological under section 1871A.’’,
(B) in the heading, by striking “EXTENDED TO WHSLES.” and inserting “AND OTHER PAYMENTS’’; and
(C) by striking “regard to and all that follows paragraph the period and inserting the following: “regard to—
‘‘(i) customary prompt pay discounts extended to wholesalers;’’
‘‘(ii) bona fide service fees paid by manufacturers;’’
‘‘(iii) reimbursement by manufacturers for recalled, damaged, expired, or otherwise unsalable covered outpatient drugs, including reimbursement for the cost of the goods and any reimbursement of costs associated with return goods handling and processing, reverse logistics, and drug destruction;’’
‘‘(iv) sales directly to, or rebates, discounts, or other price concessions provided to, pharmacy benefit managers, managed care organizations, health maintenance organizations, insurers, mail order pharmacies that are not open to all members of the public, or other providers of covered outpatient drugs, including reimbursement for the cost of the goods and any reimbursement of costs associated with return goods handling and processing, reverse logistics, and drug destruction;’’
‘‘(v) sales directly to, or rebates, discounts, or other price concessions provided to, hospitals, clinics, and physicians, unless the drug is an inhalation, infusion, or injectable drug, or unless the Secretary determines, as allowed for in Agency administrative procedures, that it is necessary to include such sales, rebates, discounts, and price concessions to obtain an accurate AMP for the drug. Such a determination shall not be subject to judicial review; or
‘‘(vi) rebates, discounts, and other price concessions required to be provided under agreements under subsections (f) and (g) of section 1860D–2(f).’’,
(2) DEFINITION OF AMP.—Section 1927(c)(2)(B) of such Act (42 U.S.C. 1396r–8(b)(1)(B)) is amended—
(A) in clause (i), by striking “and” and inserting “or”;
(B) in the second sentence, by striking the period at the end and inserting “; and”;
(C) in the last sentence, by striking “and” and inserting “; and”;
and
(D) by adding at the end the following:
``(xiii) such contract provides that the entity shall report to the State such information, on such timely and periodic basis as determined by the Secretary, as the State may require in order to include, in the information submitted by the State to a manufacturer under section 1276(b)(2)(A) and the Secretary under section 1116(d) the information on covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity and for which the entity is responsible for coverage of such drugs under this subsection.’’
(b) CONFORMING AMENDMENTS.—Section 1927 of such Act (42 U.S.C. 1396r–8) is amended—
(1) in the first sentence of subsection (b)(1), by striking “at the end the following: ‘‘, including such drugs dispensed to individuals enrolled with a Medicaid managed care organization if the organization is responsible for coverage of such drugs’’;’’
(2) in subsection (b)(2), by adding at the end the following new subparagraph:
``(c) REPORTING ON EMO DRUGS.—On a quarterly basis, each State shall report to the Secretary the total amount of rebates in dollars received from pharmacy manufacturers of drugs provided to individuals enrolled with Medicaid managed care organizations that contract under section 1903(m) and such other information as the Secretary may require by section 1927(b)(1) of the Affordable Care Act, taking into account the additional drugs included under the amendments made by section 1743 of such Act. The Secretary shall adjust such payment reduction for a calendar quarter to the extent the Secretary determines, based upon subsequent utilization and other data, that the reduction for such quarter was for less than the amount of payment reduction that should have been made.

SEC. 1742. PRESCRIPTION DRUG REBATES.
(a) ADDITIONAL REBATE FOR NEW FORMULATIONS OF EXISTING DRUGS.—
(1) IN GENERAL.—Section 1927(c)(2) of the Social Security Act (42 U.S.C. 1396r–8(c)(2)) is amended by adding at the end the following new subparagraph:
``(xii) reimbursement by manufacturers for innovative multiple source drug that is an oral solid dosage form, the rebate obligation with respect to such drug under this section shall be the amount computed under this section for such new drug or, if greater, the product of—
‘‘(i) the average manufacturer price of the line extension of a single source drug or an innovator multiple source drug that is an oral solid dosage form;
‘‘(ii) the highest additional rebate (calculated as a percentage of the original innovator multiple source drug price) under this section for any strength of the original single source drug or innovator multiple source drug; and
‘‘(iii) the total cost of each dosage form and strength of the line extension product paid for under the State plan in the rebate period (as reported by the State).
In this subparagraph, ‘‘line extension’’ means, with respect to a drug, a new formulation of the drug, such as an extended release formulation.
(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to drugs dispensed after December 31, 2009.
(b) INCREASE MINIMUM REBATE PERCENTAGE FOR SINGLE SOURCE DRUGS.—
(1) IN GENERAL.—Section 1927(c)(1)(B)(i) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(B)(i)) is amended—
(A) in clause (i), by striking “and” and inserting “; and”;
(B) in the second sentence, by striking the period at the end and inserting “; and”;
and
(C) by adding at the end the following new clause:
``(VI) after December 31, 2009, is 23.1 percent.’’
(2) RECAPTURE OF TOTAL SAVINGS DUE TOCREASED REBATES.—Section 1927(c)(1)(B)(ii) of such Act is amended by adding at the end the following new subparagraph:
``(c) SPECIAL RULE FOR INCREASED MINIMUM REBATE PERCENTAGE.—
‘‘(i) IN GENERAL.—In addition to the amounts applied as a reduction under subsection (b)(2)(B), for rebate periods beginning on or after January 1, 2010, during a fiscal year, the Secretary shall reduce payments to a State under section 1903(a) in the manner specified in clause (ii), in an amount equal to the product of—
‘‘(I) 100 percent minus the Federal medical assistance percentage applicable to the rebate period for the State; and
‘‘(II) the amounts received by the State under such subparagraph that are attributable to the rebate periods for which the Secretary determines that the State is obligated to report to the Secretary pursuant to section 1847A.’’

SEC. 1743. EXTENSION OF PRESCRIPTION DRUG REBATES TO ENROLLEES OF MEDICAID MANAGED CARE ORGANIZATIONS.
(a) IN GENERAL.—Section 1903(m)(2)(A) of the Social Security Act (42 U.S.C. 1396m(m)(2)(A)) is amended—
(1) in clause (x), by striking “and” at the end;
(2) in clause (xi), by striking the at the end and inserting “; and”;
and
(3) by adding at the end the following:
``(xiii) such contract provides that the entity shall report to the State such information, on such timely and periodic basis as determined by the Secretary, as the State may require in order to include, in the information submitted by the State to a manufacturer under section 1276(b)(2)(A) and the Secretary under section 1116(d) the information on covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity and for which the entity is responsible for coverage of such drugs under this subsection.’’
(b) CONFORMING AMENDMENTS.—Section 1927 of such Act (42 U.S.C. 1396r–8) is amended—
(1) in the first sentence of subsection (b)(1), by inserting “; and” at the end the following: ‘‘, including such drugs dispensed to individuals enrolled with a Medicaid managed care organization if the organization is responsible for coverage of such drugs’’;’’
(2) in subsection (b)(2), by adding at the end the following new subparagraph:
``(c) REPORTING ON EMO DRUGS.—On a quarterly basis, each State shall report to the Secretary the total amount of rebates in dollars received from pharmacy manufacturers of drugs provided to individuals enrolled with Medicaid managed care organizations that contract under section 1903(m) and such other information as the Secretary may require by section 1927(b)(1) of the Affordable Care Act, taking into account the additional drugs included under the amendments made by section 1743 of such Act. The Secretary shall adjust such payment reduction for a calendar quarter to the extent the Secretary determines, based upon subsequent utilization and other data, that the reduction for such quarter was for less than the amount of payment reduction that should have been made.

SEC. 1744. CONFORMING AMENDMENTS.—
(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 176(a)(3)(B), 1711(a), and 1713(a), is amended by adding at the end the following new subsection: 

"(b) PAYMENT FOR GRADUATE MEDICAL EDUCATION.—

"(1) IN GENERAL.—The term 'medical assistance' includes payment for costs of graduate medical education consistent with this subsection, whether provided in or outside of a hospital.

"(2) SUBMISSION OF INFORMATION.—For purposes of paragraph (1) and 1902(a)(13)(A)(v), payment for such costs is not consistent with this subsection unless—

"(A) the State submits to the Secretary, in a timely manner and on an annual basis specified by the Secretary, information on total payments for graduate medical education and how such payments are being used for graduate medical education, including—

"(i) the institutions and programs eligible for receiving the funding;

"(ii) the calculation in which such payments are calculated;

"(iii) the types and fields of education being supported;

"(iv) the workforce or other goals to which the funding is being applied; and

"(v) State progress in meeting such goals; and

"(vi) such other information as the Secretary determines will assist in carrying out paragraphs (3) and (4); and

"(B) such expenditures are made consistent with such goals and requirements, as determined by the Secretary, and as adjusted for case mix, wages, and type of facility.

"(3) REVIEW OF INFORMATION.—The Secretary shall make the information submitted under subparagraph (A) available to the Advisory Committee on Health Workforce Evaluation and Assessment (established under section 2261 of the Public Health Service Act). The Secretary and the Advisory Committee shall independently review the information submitted under paragraph (2), taking into account State and local workforce needs.

"(4) SPECIFICATION OF GOALS AND REQUIREMENTS.—The Secretary shall specify by rule, initially published by not later than December 31, 2011—

"(A) program goals for the use of funds described in paragraph (1), taking into account recommendations of the such Advisory Committee and the goals for approved medical residency training programs described in section 1886(h)(1)(B); and

"(B) requirements for use of such funds consistent with such goals.

Such rule may be effective on an interim basis pending revision after an opportunity for public comment.

(b) CONFORMING AMENDMENT.—Section 1902(a)(13)(A) of such Act (42 U.S.C. 1396a(a)(13)(A)), as amended by section 1723(a)(5), is amended—

"(1) by striking "and" at the end of clause (iii);

"(2) by striking the semicolon in clause (iv) and inserting ","; and

"(3) by adding at the end the following new clause:

"(iv) in the case of hospitals and at the option of a State, such rates may include, to the extent consistent with section 1905(bb), payment for graduate medical education;

"(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2010, and shall apply to drugs dispensed on or after such date, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 1744. PAYMENTS FOR GRADUATE MEDICAL EDUCATION.

(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 176(a)(3)(B), 1711(a), and 1713(a), is amended by adding at the end the following new subsection:

"(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, such amounts are subject to the requirements of this section and the Secretary determines will assist in carrying out the funding is being applied;

"(ii) pursuant to the enactment of this Act, funding in this section shall be construed as affecting payments made before such date under a State plan under title XIX of the Social Security Act and for purposes of the Medicare payment program for a year beginning no earlier than 2010.

(2) PAYMENT FOR GRADUATE MEDICAL EDUCATION.—

"(A) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by section 1723(a)(5), is amended—

"(C) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

"(3) LIMITATION OF AUTHORITY.—The Secretary may not make payments under this section that exceed the funds appropriated under paragraph (1).

(4) DISPOSITION OF REMAINING FUNDS INTO MFIF.—Any funds appropriated under paragraph (1) which remain available after the Secretary deposits into the Medicaid Improvement Fund under section 1941 of the Social Security Act (b), shall be used for purposes of this section.

"(1) AUTHORITY TO MAKE PAYMENTS.—From the amounts available for obligation in a year under subsection (a), the Secretary shall make the payments described in section 1915(l)(2) to Medicaid eligible individuals, as determined by the Secretary, for the most recent standard survey period ending during calendar years 2010 through 2013.

(2) DETERMINATION OF PAYMENT AMOUNTS.—

"(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the payment amount determined under this paragraph for a year for an eligible dually-certified facility shall be an amount equal to the Secretary as reported on the facility's most recent available Medicare cost report.

"(B) LIMITATION ON PAYMENT AMOUNT.—In no case shall the amount for an eligible dually-certified facility for a year under subparagraph (A) be more than the payment deficit described in paragraph (3)(B) for the facility as reported on the facility's latest available Medicare cost report.

"(C) PRO-RATA REDUCTION.—If the amount available for obligation under subsection (a) for a year is insufficient to provide payments in such frequency as the Secretary determines appropriate.

"(D) DIRECT PAYMENTS.—Such payment—

"(E) The facility provides quality care, as determined by the Secretary.

"(1) Medicaid eligible individuals; and

"(2) payment for graduate medical education consistent with such goals.

(2) LIMITATION OF AUTHORITY.—The Secretary shall make the payments under this section in a pro-rata manner to ensure that the entire amount available for such payments for the year be paid.

(3) ELIGIBLE DUALLY-CERTIFIED FACILITY DEFINITION.—For purposes of this section, the term "eligible dually-certified facility" means, for a cost reporting period ending during a year (beginning no earlier than 2010) the combined Medicare and Medicaid share of resident days for such facility.

(4) FREQUENCY OF PAYMENT.—Payment of an amount under this subsection to an eligible dually-certified facility shall be made for a year in a lump sum or in such periodic payments in such frequency as the Secretary determines appropriate.

(5) DEDUCTIBLES.—Such payment—

"(1) by striking "and" at the end of clause (iv) and inserting ","; and

"(2) by striking the semicolon in clause (iv) and inserting ","; and

"(3) by adding at the end the following new clause:

"(v) State progress in meeting such goals; and

"(6) The Secretary shall establish a process, including
deadlines, under which facilities may apply on an annual basis to qualify as eligible du-
ably-certified facilities for payment under subsection (b).
(2) DETERMINATION PROVISION.—The Sec-
tary may enter into one or more contracts or agreements with entities for the purpose of implementa-
tion of this section.
(3) LIMITATIONS.—The Secretary may not spend more than 0.75 percent of the amount made available under subsection (a) in any year on the costs of administering the program of payments under this section for the year.
(4) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement this section in any other manner or other-
wise, the provisions of this section.
(5) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review of—
(A) the final rates; and
(B) the methodologies used on which federal payments made to such facility are based.
(e) REFERENCE TO REPORT.—For report by the Medicaid and CHIP Payment and Access Commission on the adequacy of payments to nursing facilities under the Medicaid pro-
gram, see section 1906(b)(2)(B) of the Social Security Act, as amended by section 1784.
(f) DEFINITIONS.—For purposes of this section:
(1) DUALY-CERTIFIED FACILITY.—The term "dual-y-certified facility" means a facility that is participating as a nursing facility under title XVIII of the Social Security Act and as a skilled nursing facility under title XVII, as defined in section 1917. The Secretary may enter into contracts with such facilities with the approval of the Secretary of Health and Human Services, State Medicaid agencies, and local government agencies. The report shall address the following issues:
(A) The extent to which federal funds for such administrative expenditures, such as supervision, survey, quality assurance, and certification expenditures, are being used effectively and efficiently.
(B) The administrative functions on which federal payments are based and the amounts of such expenditures (whether spent directly or by contract).
(2) REPORT.—Not later than February 15, 2011, the Comptroller General shall submit to the appropriate committees of Congress a report on the study conducted under subsection (1).
SEC. 1748. EXTENSION OF DELAY IN MANAGED CARE ORGANIZATION PROVIDER TAX EXEMPTION.
Effective as if included in the enactment of section 4651 of the Deficit Reduction Act of 2005 (Public Law 109–171), subsection (b)(2)(A) of such section is amended by striking " Oc-
tober 1, 2009" and inserting "October 1, 2010".
SEC. 1749. EXTENSION OF ARRA INCREASE IN FMAP.
Section 5001 of the American Recovery and Reinvestment Tax 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)(i), by striking "December 2009" and "January 2010" and inser-
ting "June 2010" and "July 2010", respec-
tively;
(4) in subsection (d), by inserting "and after "respect to fiscal years";
(5) in subsection (g)(1), by striking "September 30, 2011" and inserting "December 31, 2011";
(6) in subsection (h)(3), by striking "December 31, 2011" and inserting "June 30, 2011".
SEC. 1751. HEALTH CARE ACQUIRED CONDIT-
IONS (a) MEDICAID NON-PAYMENT FOR CERTAIN HEALTH CARE-ACQUIRED CONDITIONS.—Section 1902(a)(20) of the Social Security Act (42 U.S.C. 1396a(a)(20)) is amended—
(1) by striking "or" at the end of paragraph (2);
(2) by striking the period at the end of paragraph (2) and inserting "; and"

Subtitle F—Waste, Fraud, and Abuse

SEC. 1751A. MEDICAL LOSS RATIO.—
(a) IN GENERAL.—Section 1902(a)(20) of the Social Security Act (42 U.S.C. 1396a(a)(20)) is amended—
(1) in the first sentence, by inserting "or" at the end of the second sentence, by striking "and;" and
(2) by inserting after paragraph (76) the follow-
ing new paragraph:
"(77) provide that any provider or supplier (other than a physician or nursing facility) providing services under a contract, subject to paragraph (5) of section 1877(d), establish a compliance program described in para-
graph (1) of such section in accordance with subsection (f)."

SEC. 1754. OVERPAYMENTS.
(a) IN GENERAL.—Section 1902(a)(20) of the Social Security Act (42 U.S.C. 1396a(a)(20)) is amended—
(1) in the first sentence, by inserting "or" at the end of the second sentence, by striking "and;" and
(2) by inserting after paragraph (76) the follow-
ing new paragraph:
"(77) provide that any provider or supplier (other than a physician or nursing facility) providing services under a contract, subject to paragraph (5) of section 1877(d), establish a compliance program described in para-
graph (1) of such section in accordance with subsection (f)."

SEC. 1755. MANAGED CARE ORGANIZATIONS.
(a) MINIMUM MEDICAL LOSS RATIO.—
(1) MEDICAID.—Section 1902(a)(20) of the Social Security Act (42 U.S.C. 1396a(a)(20)) is amended—
(1) in the first sentence, by inserting "or" at the end of the second sentence, by striking "and;" and
(2) by inserting after paragraph (76) the follow-

"(xii) 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) as specified by the Secretary."; (2) CHIMP.—Section 2107(e)(1) of such Act (42 U.S.C. 1936f-2(e)(1)) is amended—
(A) by redesignating subparagraphs (H) through (L) as subparagraphs (I) through (M); and
(B) by inserting after subparagraph (G) the following new subparagraph:

"(H) Section 1903(m)(2)(A)(xvi) (relating to application of minimum lose 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)(xii) of the Social Security Act (42 U.S.C. 1396m(2)(A)(xii)) is amended by inserting "and the participation of" for the provision of such data to the Secretary after "patients".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to contracts entered into or renewed on or after January 1, 2011.

SEC. 1756. TERMINATION OF PROVIDER PARTICIPATION UNDER MEDICAID AND CHAMPUS.—Section 1902(a)(26) of the Social Security Act (42 U.S.C. 1396a(a)(26)) is amended—
(A) by striking the period at the end of subparagraph (B); and
(B) by inserting after paragraph (25) the following new paragraph:

"(26) provide that any agent, clearinghouse, or other alternate payee that submits claims on behalf of a health care provider must register with the Secretary in a form and manner specified by the Secretary under section 1902(a)(39); and"

SEC. 1757. DENIAL OF PAYMENTS FOR LITIGATION-RELATED MISCONDUCT.—
(1) IN GENERAL.—Section 1903(r)(1)(F) of the Social Security Act (42 U.S.C. 1396r(1)(F)) is amended by inserting after "federal" the following:

"and other waivers, exceptions, and exclusions of such payments for claims filed on or after October 1, 2010, and no national correct coding methodologies as the Secretary determines to be necessary for detection and prevention of improper payments.";

SEC. 1758. REQUIREMENT TO REPORT EXPANDED SET OF DATA ELEMENTS UNDER MMIS TO DETECT FRAUD AND ABUSE.—Section 1903(r)(1)(F) of the Social Security Act (42 U.S.C. 1396r(1)(F)) is amended by inserting after "federal" the following:

"and, with respect to claims filed on or after October 1, 2010, whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 1759. BILLING AGENTS, CLEARINGHOUSES, OR OTHER ALTERNATE PAYEES REQUIRED TO REGISTER UNDER MEDICAID.—
(a) IN GENERAL.—Section 1903(a)(9)(A) of the Social Security Act (42 U.S.C. 1396a(a)(9)(A)) is amended by inserting after "and including" the following:

"the participation in the program of any individual or entity that has been suspended or excluded from participation under this title or whose participation is terminated under this title during such period determined by the Secretary or the State agency to be delinquent.

(b) SUSPENDED OR EXCLUDED.—"(B) is suspended or excluded from participation under this title during such period; or

CCC is affiliated with an individual or entity that has been suspended or excluded from participation under this title or whose participation is terminated under this title during such period determined by the Secretary or the State agency to be delinquent.

(b) APPROPRIATE ACTION.—The Secretary shall take appropriate action with respect to such claim.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall be deemed applicable to funds available for fiscal years 2010 through 2014.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to amounts expended or to amounts expended on or after January 1, 2010.

SEC. 1761. MANDATORY STATE USE OF NATIONAL CORRECT CODING INITIATIVE.—Section 1903(r)(3) of the Social Security Act (42 U.S.C. 1396r(3)) is amended—
(1) in paragraph (1)(B)—
(A) in clause (i), by striking "and" at the end;
(B) in clause (ii), by adding "and" at the end; and
(C) by adding at the end the following new clause:

"(iv) for claims filed on or after October 1, 2010, incorporate compatible methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) and such other methodologies of that Initiative (or such other national correct coding methodologies) as the Secretary identifies in accordance with paragraph (4);";

2. by adding at the end the following new paragraph:

"(4) Not later than September 1, 2010, the Secretary shall do the following:

"(A) Identify those methodologies of the National Correct Coding Initiative administered by the Secretary (or any successor initiative to promote correct coding and to control improper coding leading to inappropriate payment) that are compatible with claims filed under this title and no national correct coding methodologies have been established under such Initiative with respect to such items or services for which States provide medical assistance under this title;

"(B) Identify those methodologies of such Initiative (or such other national correct coding methodologies) that should be incorporated into claims filed under this title with respect to items or services for which States provide medical assistance under this title.

"(C) Notify States of—

(i) the methodologies identified under subparagraphs (A) and (B) (and of any other national correct coding methodologies identified under subparagraph (B)); and

(ii) how States are to incorporate such methodologies into claims filed under this title.

"(D) Submit a report to Congress that includes notice to States under subparagraph (C) and an analysis supporting the identification of the methodologies made under subparagraphs (A) and (B)."

Subtitle G—Payments to the Territories

SEC. 1771. PAYMENTS TO TERRITORIES.

(a) INCREASE IN CAP.—Section 1108 of the Social Security Act (42 U.S.C. 1368) is amended—
(1) in subsection (f), by striking "subsection (g)" and inserting "subsections (g) and (h)";

(2) in subsection (g), by striking "With respect to" and inserting "With respect to subsection (h), with respect to";

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

"(i) This paragraph (h) is added by the Affordable Care Act, with respect to fiscal years 2011 through 2019, the amounts otherwise determined under subsection (i) and (g) for Puerto Rico, the Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa shall be increased by the following amounts:
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‘‘(1) For Puerto Rico, for fiscal year 2011,
$727,600,000; for fiscal year 2012, $775,000,000;
for fiscal year 2013, $850,000,000; for fiscal
year 2014, $925,000,000; for fiscal year 2015,
$1,000,000,000;
for
fiscal
year
2016,
$1,075,000,000;
for
fiscal
year
2017,
$1,150,000,000;
for
fiscal
year
2018,
$1,225,000,000; and for fiscal year 2019,
$1,396,400,000.
‘‘(2) For the Virgin Islands, for fiscal year
2011, $34,000,000; for fiscal year 2012,
$37,000,000; for fiscal year 2013, $40,000,000; for
fiscal year 2014, $43,000,000; for fiscal year
2015, $46,000,000; for fiscal year 2016,
$49,000,000; for fiscal year 2017, $52,000,000; for
fiscal year 2018, $55,000,000; and for fiscal year
2019, $58,000,000.
‘‘(3) For Guam, for fiscal year 2011,
$34,000,000; for fiscal year 2012, $37,000,000; for
fiscal year 2013, $40,000,000; for fiscal year
2014, $43,000,000; for fiscal year 2015,
$46,000,000; for fiscal year 2016, $49,000,000; for
fiscal year 2017, $52,000,000; for fiscal year
2018, $55,000,000; and for fiscal year 2019,
$58,000,000.
‘‘(4) For the Northern Mariana Islands, for
fiscal year 2011, $13,500,000; fiscal year 2012,
$14,500,000; for fiscal year 2013, $15,500,000; for
fiscal year 2014, $16,500,000; for fiscal year
2015, $17,500,000; for fiscal year 2016,
$18,500,000; for fiscal year 2017, $19,500,000; for
fiscal year 2018, $21,000,000; and for fiscal year
2019, $22,000,000.
‘‘(5) For American Samoa, fiscal year 2011,
$22,000,000; fiscal year 2012, $23,687,500; for fiscal year 2013, $24,687,500; for fiscal year 2014,
$25,687,500; for fiscal year 2015, $26,687,500; for
fiscal year 2016, $27,687,500; for fiscal year
2017, $28,687,500; for fiscal year 2018,
$29,687,500;
and
for
fiscal
year
2019,
$30,687,500.’’.
(b) REPORT ON ACHIEVING MEDICAID PARITY
PAYMENTS BEGINNING WITH FISCAL YEAR
2020.—
(1) IN GENERAL.—Not later than October 1,
2013, the Secretary of Health and Human
Services shall submit to Congress a report
that details a plan for the transition of each
territory to full parity in Medicaid with the
50 States and the District of Columbia in fiscal year 2020 by modifying their existing
Medicaid programs and outlining actions the
Secretary and the governments of each territory must take by fiscal year 2020 to ensure
parity in financing. Such report shall include
what the Federal medical assistance percentages would be for each territory if the formula applicable to the 50 States were applied. Such report shall also include any recommendations that the Secretary may have
as to whether the mandatory ceiling
amounts for each territory provided for in
section 1108 of the Social Security Act (42
U.S.C. 1308) should be increased any time before fiscal year 2020 due to any factors that
the Secretary deems relevant.
(2) PER CAPITA DATA.—As part of such report the Secretary shall include information
about per capita income data that could be
used to calculate Federal medical assistance
percentages under section 1905(b) of the Social Security Act, under section 1108(a)(8)(B)
of such Act, for each territory on how such
data differ from the per capita income data
used to promulgate Federal medical assistance percentages for the 50 States. The report under this subsection shall include recommendations on how the Federal medical
assistance percentages can be calculated for
the territories beginning in fiscal year 2020
to ensure parity with the 50 States.
(3) SUBSEQUENT REPORTS.—The Secretary
shall submit subsequent reports to Congress
in 2015, 2017, and 2019 detailing the progress
that the Secretary and the governments of
each territory have made in fulfilling the actions outlined in the plan submitted under
paragraph (1).

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(c) APPLICATION OF FMAP FOR ADDITIONAL
FUNDS.—Section 1905(b) of such Act (42
U.S.C. 1396d(b)) is amended by adding at the
end the following sentence: ‘‘Notwithstanding the first sentence of this subsection
and any other provision of law, for fiscal
years 2011 through 2019, the Federal medical
assistance percentage for Puerto Rico, the
Virgin Islands, Guam, the Northern Mariana
Islands, and American Samoa shall be the
highest Federal medical assistance percentage applicable to any of the 50 States or the
District of Columbia for the fiscal year involved, taking into account the application
of subsections (a) and (b)(1) of section 5001 of
division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5) to
such States and the District for calendar
quarters during such fiscal years for which
such subsections apply.’’.
(d) WAIVERS.—
(1) IN GENERAL.—Section 1902(j) of the Social Security Act (42 U.S.C. 1396a(j)) is
amended—
(A) by striking ‘‘American Samoa and the
Northern Mariana Islands’’ and inserting
‘‘Puerto Rico, the Virgin Islands, Guam, the
Northern Mariana Islands, and American
Samoa’’; and
(B) by striking ‘‘American Samoa or the
Northern Mariana Islands’’ and inserting
‘‘Puerto Rico, the Virgin Islands, Guam, the
Northern Mariana Islands, or American
Samoa’’.
(2) EFFECTIVE DATE.—The amendments
made by paragraph (1) shall apply beginning
with fiscal year 2011.
(e) TECHNICAL ASSISTANCE.—The Secretary
shall provide nonmonetary technical assistance to the governments of Puerto Rico, the
Virgin Islands, Guam, the Northern Mariana
Islands, and American Samoa in upgrading
their existing computer systems in order to
anticipate meeting reporting requirements
necessary to implement the plan contained
in the report under subsection (b)(1).
Subtitle H—Miscellaneous
SEC. 1781. TECHNICAL CORRECTIONS.
(a) TECHNICAL CORRECTION TO SECTION 1144
OF THE SOCIAL SECURITY ACT.—The first sen-

tence of section 1144(c)(3) of the Social Security Act (42 U.S.C. 1320b—14(c)(3)) is amended—
(1) by striking ‘‘transmittal’’; and
(2) by inserting before the period the following: ‘‘as specified in section 1935(a)(4)’’.
(b) CLARIFYING AMENDMENT TO SECTION 1935
OF
THE
SOCIAL SECURITY ACT.—Section
1935(a)(4) of the Social Security Act (42
U.S.C. 1396u—5(a)(4)), as amended by section
113(b) of Public Law 110–275, is amended—
(1) by striking the second sentence;
(2) by redesignating the first sentence as a
subparagraph (A) with appropriate indentation and with the following heading: ‘‘IN
GENERAL.—’’;
(3) by adding at the end the following subparagraphs:
‘‘(B) FURNISHING MEDICAL ASSISTANCE WITH
REASONABLE PROMPTNESS.—For the purpose
of a State’s obligation under section
1902(a)(8) to furnish medical assistance with
reasonable promptness, the date of the electronic transmission of low-income subsidy
program data, as described in section 1144(c),
from the Commissioner of Social Security to
the State Medicaid Agency, shall constitute
the date of filing of such application for benefits under the Medicare Savings Program.
‘‘(C) DETERMINING AVAILABILITY OF MEDICAL
ASSISTANCE.—For the purpose of determining
when medical assistance will be made available, the State shall consider the date of the
individual’s application for the low income
subsidy program to constitute the date of filing for benefits under the Medicare Savings
Program.’’.

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Fmt 0636

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(c) EFFECTIVE DATE RELATING TO MEDICAID
AGENCY CONSIDERATION OF LOW-INCOME SUBSIDY APPLICATION AND DATA TRANSMITTAL.—
The amendments made by subsections (a)
and (b) shall be effective as if included in the
enactment of section 113(b) of Public Law
110–275.
(d) TECHNICAL CORRECTION TO SECTION 605
OF CHIPRA.—Section 605 of the Children’s
Health Insurance Program Reauthorization
Act of 2009 (Public Law 111–3) is amended by
striking ‘‘legal residents’’ and inserting
‘‘lawfully residing in the United States’’.
(e) TECHNICAL CORRECTION TO SECTION 1905
OF
THE
SOCIAL SECURITY ACT.—Section
1905(a) of the Social Security Act (42 U.S.C.
1396d(a)) is amended by inserting ‘‘or the
care and services themselves, or both’’ before
‘‘(if provided in or after’’.
(f) CLARIFYING AMENDMENT TO SECTION 1115
OF
THE
SOCIAL SECURITY ACT.—Section
1115(a) of the Social Security Act (42 U.S.C.
1315(a)) is amended by adding at the end the
following: ‘‘If an experimental, pilot, or demonstration project that relates to title XIX
is approved pursuant to any part of this subsection, such project shall be treated as part
of the State plan, all medical assistance provided on behalf of any individuals affected by
such project shall be medical assistance provided under the State plan, and all provisions of this Act not explicitly waived in approving such project shall remain fully applicable to all individuals receiving benefits
under the State plan.’’.
SEC. 1782. EXTENSION OF QI PROGRAM.

(a) IN GENERAL.—Section 1902(a)(10)(E)(iv)
of the Social Security Act (42 U.S.C.
1396b(a)(10)(E)(iv)) is amended—
(1) by striking ‘‘sections 1933 and’’ and by
inserting ‘‘section’’; and
(2) by striking ‘‘December 2010’’ and inserting ‘‘December 2012’’.
(b) ELIMINATION OF FUNDING LIMITATION.—
(1) IN GENERAL.—Section 1933 of such Act
(42 U.S.C. 1396u–3) is amended—
(A) in subsection (a), by striking ‘‘who are
selected to receive such assistance under
subsection (b)’’;
(B) by striking subsections (b), (c), (e), and
(g);
(C) in subsection (d), by striking ‘‘furnished in a State’’ and all that follows and
inserting ‘‘the Federal medical assistance
percentage shall be equal to 100 percent.’’;
and
(D) by redesignating subsections (d) and (f)
as subsections (b) and (c), respectively.
AMENDMENT.—Section
(2)
CONFORMING
1905(b) of such Act (42 U.S.C. 1396d(b)) is
amended by striking ‘‘1933(d)’’ and inserting
‘‘1933(b)’’.
(3) EFFECTIVE DATE.—The amendments
made by paragraph (1) shall take effect on
January 1, 2011.
SEC. 1783. ASSURING TRANSPARENCY OF INFORMATION.

(a) IN GENERAL.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as
amended by sections 1631(b), 1703(a), 1729,
1753, 1757(a), 1759(a), and 1907(b), is amended—
(1) by striking ‘‘and’’ at the end of paragraph (79);
(2) by striking the period at the end of
paragraph (80) and inserting ‘‘; and’’; and
(3) by inserting after paragraph (80) the following new paragraph:
‘‘(81) provide that the State will establish
and maintain laws, in accordance with the
requirements of section 1921A, to require disclosure of information on hospital charges
and quality and to make such information
available to the public and the Secretary.’’;
and
(4) by inserting after section 1921 the following new section:

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HOSPITAL PRICE TRANSPARENCY

"SEC. 1921A. (a) In General.—The requirements referred to in section 1902(a)(8) are that the laws of a State must—

"(1) require, if a patient is referred by a hospital to the State (or its agent) by each hospital located therein, of information on—

"(A) the charges for the most common inpatient and outpatient hospital services;

"(B) the Medicare and Medicaid reimbursement amount for such services; and

"(C) if the hospitals allow for or provide reduced charges for individuals based on financial need, the factors considered in making determinations for reductions in charges, including any formula for such determinations and an identification of the specific department of a hospital that responds to such inquiries;

"(2) provide for notice to individuals seeking care regarding the availability of information on charges described in paragraph (1); and

"(3) provide for timely access to such information and the availability of information on charges described in paragraph (1);

"(B) establish a mechanism for in-stay review to determine if the quality of care at each hospital has been publicly available in accordance with section 301 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173), section 1311A, or section 1311B.

The Secretary shall consult with stakeholder groups, including entities in section 1380(d)(6) and the National Governors Association, to design a process to ensure hospitals are able to make the required information available to patients, and shall—

"(b) HOSPITAL DEFINED.—For purposes of this section, the term "hospital" means a hospital that meets the requirements of paragraphs (1) and (7) of section 1511(e) and includes those to which section 1521(c) applies.

SEC. 1784. MEDICAID AND CHIP PAYMENT AND PROVIDER POLICIES

(a) REPORT ON NURSING FACILITY PAYMENT POLICIES.—Section 1900(b) of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end the following new paragraph:

"(10) a study by the Secretary of Health and Human Services of any changes to the nursing facility payment policies under the Social Security Act, that are reported by the Secretary to Congress on progress in implementing targeted outreach and enrollment of individuals who are not lawfully present in the United States.

SEC. 1785. OUTREACH AND ENROLLMENT OF MEDICAID AND CHIP ELIGIBLE INDIVIDUALS

SEC. 1786. PROHIBITIONS ON FEDERAL MEDICAID AND CHIP PAYMENT FOR UNDOCUMENTED INDIVIDUALS

Nothing in this title shall change current prohibitions against Federal Medicaid and CHIP payments to any individual who is not lawfully present in the United States.
determine whether or not the patient has been stabilized (as defined in subsection (h)(5)). This mechanism shall commence before the third day of the inpatient stay. State legislature that begins after the date of the demonstration project may manage the provision of these benefits under the demonstration project through utilization review, authorization, or management practices that ensure the medical necessity and appropriateness criteria applicable to behavioral health.

(c) ELIGIBLE STATE DEFINED. —

(1) To qualify for approval of an application submitted by a State described in paragraph (2), the State shall be an eligible State for purposes of conducting a demonstration project under this section.

(2) STATE DISCERNED. — States shall be selected by the Secretary in a manner so as to provide geographic diversity on the basis of the application to conduct a demonstration project under this section submitted by such States.

(d) LENGTH OF DEMONSTRATION PROJECT. —

The demonstration project established under this section shall be conducted for a period of 3 consecutive years.

(e) LIMITATIONS ON FEDERAL FUNDING. —

(1) APPROPRIATION. — (A) IN GENERAL. — Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out this section, $75,000,000 for fiscal year 2010.

(B) BUDGET AUTHORITY. — Subparagraph (A) constitutes budget authority in advance of appropriations Act and represents the obligation of the Federal Government to provide for the payment of the amounts appropriated under that subparagraph.

(2) 3-YEAR AVAILABILITY. — Funds appropriated under paragraph (1) shall remain available for obligation through December 31, 2012.

(3) LIMITATION ON PAYMENTS. — In no case may —

(A) the aggregate amount of payments made by the Secretary to eligible States under this section exceed $75,000,000; or

(B) payments be provided by the Secretary under this section after December 31, 2012.

(4) FUNDSALLOCATED TO STATES. — The Secretary shall allocate funds to eligible States based on their applications and the availability of funds.

(5) PAYMENTS TO STATES. — The Secretary shall pay to each eligible State, from its allocation provided in paragraph (1), an amount equal to the Federal medical assistance percentage of expenditures in the quarter for medical assistance described in subsection (b) that are incurred during the quarter ending December 31, 2012.

(6) REPORTS. —

(1) ANNUAL PROGRESS REPORTS. — The Secretary shall submit annual reports to Congress on the progress of the demonstration project conducted under this section.

(2) FINAL REPORT AND RECOMMENDATION. — An evaluation shall be conducted of the demonstration project’s impact in improving the functioning of the health and mental health service system and on individuals enrolled in the Medicaid program. This evaluation shall include collection of baseline data for one-year prior to the initiation of the demonstration project as well as collection of data from matched comparison states not participating in the demonstration. The evaluation measures shall include the following:

(A) A determination, by State, as to whether the demonstration project resulted in improved access to inpatient and institutional mental health services under the Medicaid program and whether average length of stays were longer (or shorter) for individuals admitted under the demonstration project compared with individuals otherwise admitted in comparison sites.

(B) An analysis, by State, regarding whether the demonstration project produced a significant reduction in emergency room visits for individuals eligible for assistance under the Medicaid program in the duration of emergency room lengths of stay.

(C) An assessment of discharging plans by participating hospitals that ensures access to funds to meet the needs of inpatient or residential care as well as continuity of care for those discharged to outpatient care.

(D) An assessment of the impact of the demonstration project on the costs of the full range of mental health services (including inpatient, emergency and ambulatory care) under the plan as contrasted with the comparison areas.

(E) Data on the percentage of consumers with Medicaid coverage who are admitted to inpatient facilities as a result of the demonstration project as compared to those admitted to these same facilities through other means.

(F) A recommendation regarding whether the demonstration project should be continued after December 31, 2012, and expanded on a national basis.

(g) WAIVER AUTHORITY. —

(1) IN GENERAL. — The Secretary shall waive the limitations on payments (as follows) under paragraph (2) of section 1905(a) of the Social Security Act (42 U.S.C. 1396a(a)), (relating to limitations on payments for care or services for individuals who are patients in an institution for mental diseases) for purposes of carrying out the demonstration project under this section.

(2) LIMITED OTHER WAIVER AUTHORITY. — The Secretary may waive other requirements of the Social Security Act (including the requirements of sections 1902(a)(1) (relating to statewide maintenance of operations) and 1902(10)(B) (relating to comparability) only to extent necessary to carry out the demonstration project under this section.

(h) DEFINITIONS. — In this section:

(1) EMERGENCY MEDICAL CONDITION. — The term “emergency medical condition” means, with respect to an individual, an individual who expresses suicidal or homicidal thoughts or gestures, if determined dangerous to self or others.

(2) FEDERAL MEDICAL ASSISTANCE PERCENTAGE. — The term “Federal medical assistance percentage” means, with respect to an individual, the amount that is determined, in accordance with section 1905(i) of the Social Security Act (42 U.S.C. 1396i(i)), to be the percentage of care furnished to the individual by a State or the Federal Government and paid for by the Federal Government under title XIX of the Social Security Act (includ-

SEC. 1789. TREATMENT OF CERTAIN MEDICARE BROKERS. Section 1903(b)(4) of the Social Security Act (42 U.S.C. 1395w(b)(4)) is amended by inserting after “the Medicare prescription drug program” the following: “(1) in the matter before paragraph (A), by inserting after ‘respect to the broker’ the following: ‘(or, in the case of subparagraph (B), the Inspector General of the Department of Health and Human Services finds that the broker has established and maintains procedures to ensure the independence of its enrollment activities from the interests of any managed care entity or provider’; and (2) in subparagraph (B) —

(A) by inserting ‘(ii)’ after ‘either’; and (B) by inserting ‘(iii)’ after ‘health care provider or’.

SEC. 1790. RULE FOR CHANGES REQUIRING STATE LEGISLATION. In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services finds otherwise made available by law.’’.

TITHE VIII—REVENUE-RELATED PROVISIONS

SEC. 1801. DISCLOSURES TO FACILITATE IDENTIFICATION OF INDIVIDUALS LIKELY TO BE INELIGIBLE FOR THE LOW-INCOME ASSISTANCE UNDER THE MEDICARE PRESCRIPTION DRUG PROGRAM TO ASSIST SOCIA L SECURITY ADMINISTRATION’S OUTREACH TO ELIGIBLE INDIVIDUALS. (a) IN GENERAL. — Paragraph (19) of section 6103(l) of the Internal Revenue Code of 1986 is amended to read as follows:

“(19) DISCLOSURES TO FACILITATE IDENTIFICATION OF INDIVIDUALS LIKELY TO BE INELIGIBLE FOR LOW-INCOME SUBSIDIES UNDER MEDICA RE PRESCRIPTION DRUG PROGRAM TO ASSIST SOCIAL SECURITY ADMINISTRATION’S OUTREACH TO ELIGIBLE INDIVIDUALS. —

(A) IN GENERAL. — Upon written request from the Commissioner of Social Security, the following return information (including such information disclosed to the Social Security Administration under paragraph (1) or (5)) shall be disclosed to officers and employees of the Social Security Administration, with respect to each taxpayer identified by the Commissioner of Social Security:

(i) the individual’s earning history and income from self-employment with respect to such year (as defined in section 3121(a) or 3401(a)), and

(ii) the unreached income information and income information of the taxpayer from partnerships, trusts, estates, and subchapter S corporations for the taxable year (as defined in section 3121(a) or 3401(a)), and

(iii) if the individual filed an income tax return for the applicable year, the filing status, number of dependents, income from wages, and income from self-employment, on such return.

(iv) if the individual is a married individual filing a separate return for the applicable year, the other income (if reasonably available) of the spouse on such return.
“(v) if the individual files a joint return for the applicable year, the social security number, unearned income information, and income information from partnerships, trusts, estates, and S corporations of the individual’s spouse on such return, and
“(vi) such other return information relating to the individual (or the individual’s spouse) on such return, as is prescribed by the Secretary by regulation as might indicate that the individual is likely to be ineligible for a low-income prescription drug subsidy under section 1800D–14 of the Social Security Act.”

“(B) APPLICABLE YEAR.—For the purposes of this paragraph, the term ‘applicable year’ means the taxable year beginning after the date on which information is available in the Internal Revenue Service’s taxpayer information records.

“(C) RESTRICTION ON INDIVIDUALS FOR WHOM DISCLOSURE MAY BE REQUESTED.—The Commissioner of Social Security shall request information under this paragraph only with respect to—
“(1) individuals the Social Security Administration has identified as having an annual income that is likely to be subject to tax under section 6103(a) of the Internal Revenue Code, or
“(2) any individual the Social Security Administration has identified, using all other reasonably available information, as likely to be eligible for a low-income prescription drug subsidy under section 1800D–14 of the Social Security Act and who have not applied for such subsidy, and
“(3) any individual who has been identified by the Social Security Administration as a spouse of a person entitled to benefits under part A, or enrolled under part B, of title XVIII of the Social Security Act during such fiscal year.

“(2) ADMINISTRATIVE PROVISIONS. — (A) TRANSFERS FROM OTHER TRUST FUNDS.—The amounts appropriated by subparas (B) and (C) of paragraph (1) shall be transferred from the Veterans Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (established under section 1811 of title XV of the Social Security Act) to the Medicare Prescription Drug Account within such Trust Fund, in proportion (as estimated by the Secretary) to the total expenditures during such fiscal year for the applicable year under title XVIII of such Act from the respective trust fund or account.

“(B) APPROPRIATIONS NOT SUBJECT TO FISCAL YEAR LIMITATION.— Appropriations made by paragraph (1) shall not be subject to any fiscal year limitation.

“(C) PERIODIC TRANSFERS, ESTIMATES, AND ADJUSTMENTS.— As provided in subparagraph (A), the provisions of section 6601 shall apply to the amounts appropriated by paragraph (1).

“(D) FAIR SHARE PER CAPITA AMOUNT.—
“(1) COMPUTATION. — (A) IN GENERAL.—Subject to subparagraph (B), the fair share per capita amount under this paragraph for a fiscal year, beginning with fiscal year 2013, is an amount computed by the Secretary of Health and Human Services for each year that is applied under this section and subchapter B of chapter 34 of the Internal Revenue Code of 1986, will result in revenues to the CERTF of $375,000,000 for the fiscal year.

“(B) ALTERNATIVE COMPUTATION.—
“(1) IN GENERAL.—If the Secretary is unable to compute the fair share per capita amount under subparagraph (A) for a fiscal year, the fair share per capita amount under this paragraph for the fiscal year shall be the default amount determined under clause (ii) for the fiscal year.

“(ii) DEFAULT AMOUNT.—The default amount under this clause for—
“(1) fiscal year 2010, $2; or
“(2) a subsequent year is equal to the default amount under this clause for the preceding fiscal year increased by the annual percentage increase in the medical care component of the consumer price index (United States city average) for the 12-month period ending with April of the preceding fiscal year.

“Any amount determined under subclause (II) shall be rounded to the nearest penny.

“(2) LIMITATION ON MEDICARE FUNDING.—In no case shall the amount transferred under subparagraph (b)(4)(B) for any fiscal year exceed $90,000,000.

“(d) EXPENDITURES FROM FUND.—
“(1) IN GENERAL.—Subject to paragraph (2), amounts in the CERTF are available, without the need for further appropriations and without fiscal year limitation, to the Secretary of Health and Human Services to carry out section 1181 of the Social Security Act.

“(2) ALLOCATION FOR COMMISSION.—The following amounts shall be available, without the need for further appropriations and without fiscal year limitation, to the Commission to carry out the activities of the Health Care Comparative Effectiveness Research Commission established under section 1181(b) of the Social Security Act:

“(A) For fiscal year 2010, $7,000,000.

“(B) For fiscal year 2011, $9,000,000.

“(C) For each fiscal year beginning with 2012, 2.6 percent of the total amount appropriated to the CERTF under subsection (b) for the fiscal year.

“(e) NET REVENUES.—For purposes of this section, the term ‘net revenues’ means the amount determined by the Secretary based on the excess of—
“(1) the fees received in the Treasury under subchapter B of chapter 34, over the decrease in the tax imposed by chapter 1 resulting from the fees imposed by such subchapter.’’.

“(2) CLERICAL AMENDMENT.—The table of sections in the Internal Revenue Code of 1986 is amended by adding at the end thereof the following new item:

“Sec. 9511. Health Care Comparative Effectiveness Research Trust Fund.”

“(b) FINANCING FROM FEES ON INSURED AND SELF-INSURED HEALTH PLANS.—

“(1) GENERAL RULE.—Chapter 34 of the Internal Revenue Code of 1986 is amended by adding at the end of the following subchapter:

“Subchapter B—Insured and Self-Insured Health Plans

“Sec. 4375. Health insurance.

“Sec. 4376. Self-insured health plans.

“Sec. 4377. Definitions and special rules.

“Sec. 4378. Health insurance.

“(a) IMPOSITION OF FEE.—There is hereby imposed on each specified health insurance policy for each policy year a fee equal to the fair share per capita amount determined under section 9511(c)(1) multiplied by the average number of lives covered under the policy.

“(b) LIABILITY FOR FEE.—The fee imposed by subsection (a) shall be paid by the issuer of the policy.

“Specified Health Insurance Policy.—For purposes of this section—

“(1) IN GENERAL.—Except as otherwise provided in this section, the term ‘specified health insurance policy’ means any accident or health insurance policy issued with respect to individuals residing in the United States.

“(2) EXEMPTION FOR CERTAIN POLICIES.—The term ‘specified health insurance policy’ does not include any insurance if substantially all of its coverage is of excepted benefits described in section 9832.

“(3) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS.—

“(a) IN GENERAL.—In the case of any arrangement described in this section, the term ‘specified health insurance policy’ shall include a specified health insurance policy, and

“(b) DESCRIPTION OF ARRANGEMENT.—An arrangement is described in this subparagraph if under such arrangement fixed payment is made to an employer and consideration for any person’s agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided.

“Sec. 4378. Self-Insured Health Plans.

“(a) IMPOSITION OF FEE.—In the case of any applicable self-insured health plan for each plan year, there is hereby imposed a fee equal to the fair share per capita amount determined under section 9511(c)(1) multiplied by the average number of lives covered under the plan.

“(b) LIABILITY FOR FEE.—

“(1) IN GENERAL.—The fee imposed by subsection (a) shall be paid by the plan sponsor.

“(2) PLAN SPONSOR.—For purposes of paragraph (1) the term ‘plan sponsor’ means—
“(A) the employer in the case of a plan established or maintained by a single employer, or

(B) the employee organization in the case of a plan established or maintained by two or more employers and 1 or more employee organizations,

(C) in the case of—

(i) a plan established or maintained by 2 or more employers jointly by 1 or more employee organizations, or

(ii) a multiple employer welfare arrangement, or

(iii) a voluntary employees’ beneficiary association associated in section 501(c)(9), the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan, or

(D) the cooperative or association described in subsection (c)(2)(A)(v) in the case of a plan established or maintained by such a cooperative or association.

(c) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term ‘applicable self-insured health plan’ means any plan for providing accident or health coverage if—

(1) such coverage is provided other than through an insurance policy, and

(2) such plan is established or maintained—

(A) by one or more employers for the benefit of their employees or former employees, or

(B) by one or more employee organizations for the benefit of their members or former members,

(C) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees,

(D) by a voluntary employees’ beneficiary association associated in section 501(c)(9), or

(E) by any organization described in section 501(c)(7), or

(F) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement (as defined in section 3(40)(B)(iv) of the preceding subparagraphs, by a multiple employer welfare arrangement, or

(ii) a multiple employer welfare arrangement, or

(iii) a voluntary employees’ beneficiary association associated in section 501(c)(9), or

(iv) any other organization described in section 501(c)(7), or

(v) a trust or other similar group of representatives established or maintained for the benefit of their members or former members,

(vi) any other organization described in section 501(c)(7), or

(vii) a trust or other similar group of representatives established or maintained for the benefit of their employees or former employees, or

(viii) a multiple employer welfare arrangement (as defined in section 3(40)(B)(iv) of the preceding subparagraphs, by a multiple employer welfare arrangement, or

(ix) a voluntary employees’ beneficiary association associated in section 501(c)(9), or

section 4375(c)).

(d) ACCIDENT AND HEALTH COVERAGE.—The term ‘accident and health coverage’ means any coverage which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4375(c)).

(e) INSURANCE POLICY.—The term ‘insurance policy’ means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended.

(f) UNITED STATES.—The term ‘United States’ includes any possession of the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands (under title XVIII of the Social Security Act), and Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

(2) TREATMENT OF EXEMPT GOVERNMENTAL PROGRAMS.—(A) the term ‘person’ includes any governmental entity, and

(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the fees imposed by this subsection except as provided in paragraph (2).

(2) CLERICAL AMENDMENTS.—(A) the number, quality, and capacity of home visitation programs for families with young children and families expecting children that will be funded under this section, the outcomes the programs are intended to achieve, and the evidence supporting the effectiveness of the programs.

(2) RESULTS OF NEEDS ASSESSMENT.—The results of a statewide needs assessment that describes—

(a) the number, quality, and capacity of home visitation programs for families with young children and families expecting children that will be funded under this section, the outcomes the programs are intended to achieve, and the evidence supporting the effectiveness of the programs.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to plans and policies for portions of policy or plan years beginning on or after October 1, 2012.

TITLE IX—MISCELLANEOUS PROVISIONS

SEC. 1901. REPEAL OF TRIGGER PROVISION. Subtitle A of title V of the Community Health Care Act of 2000 (Public Law 106–554) is repealed and the provisions of law amended by such subtitle are restored as if such subtitle had never been enacted.

SEC. 1902. REPEAL OF COMPARATIVE COST ADJUSTMENT (CCA) PROGRAM. Section 1902 of the Community Health Care Act of 2000 (Public Law 106–554), is repealed.

SEC. 1903. EXTENSION OF GAINSHARING DEMONSTRATION PROJECTS. (a) IN GENERAL.—Subsection (c)(3) of section 3407 of the Deficit Reduction Act of 2005 (Public Law 109–171) is amended by inserting “demonstration project in operation as of October 1, 2012.”

(b) IN GENERAL.—Subsection (d)(3) of section 3407 of the Deficit Reduction Act of 2005 (Public Law 109–171) is amended by inserting “demonstration project in operation as of October 1, 2012.”

(c) IN GENERAL.—Subsection (d)(3) of section 3407 of the Deficit Reduction Act of 2005 (Public Law 109–171) is amended by inserting “demonstration project in operation as of October 1, 2012.”

(d) IN GENERAL.—Subsection (d)(3) of section 3407 of the Deficit Reduction Act of 2005 (Public Law 109–171) is amended by inserting “demonstration project in operation as of October 1, 2012.”

(e) IN GENERAL.—Subsection (d)(3) of section 3407 of the Deficit Reduction Act of 2005 (Public Law 109–171) is amended by inserting “demonstration project in operation as of October 1, 2012.”

(f) IN GENERAL.—Subsection (d)(3) of section 3407 of the Deficit Reduction Act of 2005 (Public Law 109–171) is amended by inserting “demonstration project in operation as of October 1, 2012.”

(g) IN GENERAL.—Subsection (d)(3) of section 3407 of the Deficit Reduction Act of 2005 (Public Law 109–171) is amended by inserting “demonstration project in operation as of October 1, 2012.”
(c) ALLOCATIONS.—

(1) INDIAN TRIBES.—From the amount reserved under subsection (1)(2) for a fiscal year, the Secretary shall allot to each Indian tribe whose families have income that bears the same ratio to the amount so reserved as the number of children in such Indian tribe whose families have income that does not exceed 200 percent of the poverty line bears to the total number of children in such Indian tribes whose families have income that does not exceed 200 percent of the poverty line.

(2) STATES AND TERRITORIES.—From the amount appropriated under subsection (m) for a fiscal year that remains after making the reservations required by subsection (1), the Secretary shall allot to each State that is not an Indian tribe whose families have income that bears the same ratio to the remainder of the amount that bears the same ratio to the remainder of the amount appropriated under subsection (d) or, if applicable, for the fiscal year that amount bears the same ratio to the amount so reserved as the number of children in such States whose families have income that does not exceed 200 percent of the poverty line bears to the total number of children in such States whose families have income that does not exceed 200 percent of the poverty line.

(3) REALLOCATIONS.—The amount of any allotment made under paragraph (2) of this subsection for any fiscal year that the State certifies to the Secretary will not be expended by the State pursuant to this section and that is reallocated under the allotment methodology specified in that paragraph. Any amount so reallocated to a State is deemed part of the allotment of the State under this section.

(d) MAINTENANCE OF EFFORT.—Beginning with fiscal year 2011, a State meets the requirement of this subsection, for a fiscal year if the State certifies to the Secretary that the aggregate expenditures by the State from State and local sources for programs of home visitation for families with young children and families expecting children for the then preceding fiscal year was not less than 100 percent of such aggregate expenditures for the then 2nd preceding fiscal year.

(e) PAYMENT OF GRANT.—

(1) IN GENERAL.—The Secretary shall make a grant to each State that meets the requirements of subsections (b) and (d) if, applicable, for a fiscal year for which funds are appropriated under subsection (m), in an amount equal to the reimbursable percentage of the eligible expenditures of the State for the fiscal year, but not more than the amount allotted to the State under subsection (c) for the fiscal year.

(2) REIMBURSABLE PERCENTAGE DEFINED.—In paragraph (1), the term ‘reimbursable percentage’ means, with respect to a fiscal year,

(A) 85 percent, in the case of fiscal year 2010;

(B) 80 percent, in the case of fiscal year 2011;

(C) 75 percent, in the case of fiscal year 2012 and any succeeding fiscal year.

(f) ELIGIBLE EXPENDITURES.—

(1) IN GENERAL.—In this section, the term ‘eligible expenditures’—

(A) means expenditures to provide voluntary home visitation for as many families with young children that are eligible for such services as possible, and that enhances age-appropriate development in cognitive, language, social, emotional, and motor domains (including the number of English language learners),

(B) includes expenditures for training, technical assistance, and evaluations related to the programs;

(C) does not include any expenditure with respect to which a State has submitted a claim for payment under any other provision of Federal law.

(2) PRIORITY FUNDING FOR PROGRAMS WITH STRONGEVIDENCE OF EFFECTIVENESS.—

(A) IN GENERAL.—The expenditures, described in paragraph (1), of a State for a fiscal year that are attributable to the cost of implementing a program that is in the model of the State that has the strongest evidence of effectiveness shall not be considered eligible expenditures for the fiscal year for purposes of this section.

(B) APPLICABLE PERCENTAGE DEFINED.—In subparagraph (A), the term ‘applicable percentage’ means, with respect to a fiscal year—

(i) 60 percent for fiscal year 2010;

(ii) 55 percent for fiscal year 2011;

(iii) 50 percent for fiscal year 2012;

(iv) 45 percent for fiscal year 2013; or

(v) 40 percent for fiscal year 2014.

(g) NO USE OF OTHER FEDERAL FUNDS FOR STATE MATCH.—A State to which a grant is made under this section may not expend any Federal funds to meet the State share of the cost of an eligible expenditure for which the State receives a payment under this section.

(h) WAIVER AUTHORITY.—

(1) IN GENERAL.—The Secretary may waive or modify the application of any provision of this section, other than subsection (b) or (f), to an Indian tribe if the Secretary determines that doing so would impose an undue burden on the Indian tribe.

(2) SPECIAL RULE.—An Indian tribe is deemed to meet the requirement of subsection (d) for purposes of subsections (c) and (e) if—

(A) the Secretary waives the requirement; or

(B) the Secretary modifies the requirement and the Indian tribe meets the modified requirement.

(i) STATE REPORTS.—Each State to which a grant is made under a paragraph of this section shall submit to the Secretary an annual report on the progress made by the State in addressing the purposes of this section. Each such report shall include a description of—

(1) the services delivered by the programs that received funds from the grant;

(2) the characteristics of each such program, including information on the service model used by the program and the performance of the program;

(3) the characteristics of the providers of services through the program, including staff qualifications, work experience, and demographic characteristics;

(4) the characteristics of the recipients of services provided through the program, including the number of the recipients, the demographic characteristics of the recipients, and family retention;

(5) the annual cost of implementing the program, including the cost per family served under the program;

(6) the outcomes experienced by recipients of services through the program;

(7) the training and technical assistance provided to aid implementation of the program, and how the training and technical assistance contributed to the outcomes achieved through the program;

(8) the methods used to monitor whether the program is being implemented as designed; and

(9) other information as determined necessary by the Secretary.

(j) EVALUATION.—

(1) IN GENERAL.—The Secretary shall, by grant, contract, or cooperative agreement, conduct an independent evaluation of the effectiveness of home visitation programs receiving funds provided under this section, which shall examine the following:

(A) The effect of home visitation programs on child and parent outcomes, including child maltreatment, child health and development, school readiness, and links to community services.

(B) The effectiveness of home visitation programs on different populations, including the extent to which the ability of programs to improve outcomes varies across programs and populations.

(2) REPORTS TO THE CONGRESS.—

(A) INTERIM REPORT.—Within 3 years after the date of the enactment of this section, the Secretary shall submit to Congress an interim report on the evaluation conducted pursuant to paragraph (1).

(B) FINAL REPORT.—Within 5 years after the date of the enactment of this section, the Secretary shall submit to Congress a final report on the evaluation conducted pursuant to paragraph (1).

(k) ANNUAL REPORTS TO THE CONGRESS.—The Secretary shall submit annually to Congress a report on the activities carried out using funds made available under this section, which shall include a description of the following:

(i) The high need communities targeted by States for programs carried out under this section.

(ii) The characteristics of the programs, including—

(A) the qualifications and demographic characteristics of program staff; and

(B) recipient characteristics including the number of families served, the demographic characteristics of the families served, and family retention and duration of services.

(iii) The outcomes reported by the programs that received funds from the grant.

(iv) The research-based instruction, materials, and activities being used in the activities funded under the grant.

(v) The training and technical assistance activities, including on-going professional development, provided to the programs.
‘(7) The annual costs of implementing the programs, including the cost per family served under the programs.

‘(8) The indicators and methods used by States to determine whether the programs are being implemented as designed.

‘(1) RESERVATIONS OF FUNDS.—From the amounts appropriated for a fiscal year under subsection (a), the Secretary shall—

‘(1) an amount equal to 5 percent of the amounts to pay the cost of the evaluation provided for in subsection (f), and the provision to States to train and technical assistance, including the dissemination of best practices in early childhood home visitation; and

‘(2) after making the reservation required by paragraph (1), an amount equal to 3 percent of the amount so appropriated, to pay for grants to Indian tribes under this section.

‘(m) APPROPRIATIONS.—Out of any money in the Treasury of the United States not otherwise appropriated, there is appropriated to the Secretary to carry out this section—

‘(1) $50,000,000 for fiscal year 2010;

‘(2) $100,000,000 for fiscal year 2011;

‘(3) $150,000,000 for fiscal year 2012;

‘(4) $200,000,000 for fiscal year 2013; and

‘(5) $250,000,000 for fiscal year 2014.

‘(n) INDIAN TRIBES TREATED AS STATES.—In this section, paragraphs (4), (5), and (6) of section 413(a) shall apply.’.

SEC. 1905. IMPROVED COORDINATION AND PROTECTION FOR DUAL ELIGIBLES.

Title XI of the Social Security Act is amended by inserting after section 1150 the following new section:

‘IMPROVED COORDINATION AND PROTECTION FOR DUAL ELIGIBLES

‘SEC. 1150A. (a) IN GENERAL.—The Secretary shall provide, through an identifiable office or program within the Centers for Medicare & Medicaid Services, for a focused effort to provide for improved coordination between Medicare and Medicaid and protection in the case of dual eligibles (as defined in subsection (g)). The office or program shall—

‘(1) review Medicare and Medicaid policies related to enrollment, benefits, service delivery, payment, and grievance and appeals processes under parts A and B of title XVIII, and the Medicare Advantage program under part C of such title, and under title XIX;

‘(2) identify areas of such policies where better coordination and protection could be improved and coordinated;

‘(3) issue guidance to States regarding improving such coordination and protection.

‘(b) ELEMENTS.—The improved coordination and protection under this section shall include efforts—

‘(1) to simplify access of dual eligibles to benefits and services under Medicare and Medicaid;

‘(2) to improve care continuity for dual eligibles and ensure safe and effective care transitions;

‘(3) to harmonize regulatory conflicts between Medicare and Medicaid rules with regard to dual eligibles; and

‘(4) to improve total cost and quality performance under Medicare and Medicaid for dual eligibles.

‘(c) RESPONSIBILITIES.—In carrying out this section, the Secretary shall provide for the following:

‘(1) An examination of Medicare and Medicaid payment systems to develop strategies to foster more integrated and higher quality care.

‘(2) Development of methods to facilitate access to post-acute and community-based services used to identify actions that could lead to better coordination of community-based care.

‘(3) A study of enrollment of dual eligibles in the Medicare Savings Program (as defined in section 1144(c)(7)), under Medicaid, and in the low-income subsidy program under section 1906D to identify methods to more efficiently and effectively reach and enroll dual eligibles.

‘(4) An assessment of communication strategies to determine whether additional informational materials or outreach is needed, including an assessment of the Medicare website, 1-800-MEDI- CARE, and Medicaid websites.

‘(5) Research and evaluation of areas where service utilization, quality, and access to cost sharing protection could be improved and coordinated to enhance satisfaction with services and care delivery.

‘(6) Collection (and making available to the public) of data and a database that describe the eligibility, benefit and cost-sharing assistance available to dual eligibles by State.

‘(7) Support for coordination of State and Federal contracting and oversight for dual coordination programs supportive of the goals described in subsection (b).

‘(8) Support to agencies through the provision of technical assistance for Medicare and Medicaid coordination initiatives designed to improve acute and long-term care coordination for Medicare and Medicaid beneficiaries.

‘(9) Monitoring total combined Medicare and Medicaid program costs in serving dual eligibles and making recommendations for optimizing total quality and cost performance across both programs.

‘(10) Coordination of activities relating to Medicare and Medicaid programs, plans under 1861(b) of title XVIII, and 1920(c) of title XIX.

‘(11) Reporting.—The Office or program shall work with relevant State agencies and other stakeholders to identify entities to improve and coordinate reporting requirements for Medicare and Medicaid. In addition, the Office or program shall seek to minimize duplication in reporting requirements, where appropriate, and to identify opportunities to combine assessment requirements, where appropriate. The Office or program shall seek to improve quality metrics and assessment requirements that facilitate comparisons of the quality of care received by beneficiaries enrolled in or entitled to benefits under Medicare, the Medicare Advantage program, fee-for-service Medicaid, and Medicaid managed care, and combination thereof (including integrated Medicare-Medicaid programs for dual eligibles).

‘(e) ENDORSEMENT.—The Secretary shall seek endorsement by the entity with a contract under section 1890(a) of quality measures and benchmarks developed under this section.

‘(f) CONSULTATION WITH STAKEHOLDERS.—

‘(1) The Office or program shall consult with relevant stakeholders, including dual eligible beneficiaries representatives for dual eligible beneficiaries, beneficiary advocates, providers, and relevant State agencies, in the development of policies related to integrated Medicare-Medicaid programs for dual eligibles.

‘(g) PERIODIC REPORTS.—Not later than 1 year after the date of the enactment of this section and every 3 years thereafter the Secretary shall submit a report on progress in activities conducted under this section.

‘(h) DEFINITIONS.—In this section:

‘(1) Dual eligible means an individual who is dually eligible for benefits under title XVIII and title XIX, including such benefits provided for benefits under the Medicare Savings Program (as defined in section 1144(c)(7)).

‘(2) Medicare; Medicaid.—The terms ‘Medicare’ and ‘Medicaid’ mean the programs under titles XVIII and XIX, respectively.

SEC. 1906. ASSESSMENT OF MEDICARE COST-INTEGRATIVE DISEASES AND CONDITIONS.

‘(a) INITIAL ASSESSMENT.

‘(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct an assessment of the diseases and conditions that are the most cost-intensive for the Medicare program and, to the extent possible, assess the diseases and conditions that could become cost-intensive for Medicare in the future.

‘(2) MEDI CARE; MEDICAID.—The terms ‘Medicare’ and ‘Medicaid’ mean the programs under titles XVIII and XIX, respectively.'
"(A) APPLICABLE INDIVIDUAL.—The term ‘applicable individual’ means—

(i) an individual who is enrolled under part B and entitled to benefits under part A of title XVIII;

(ii) an individual who is eligible for medical assistance under title XIX; or

(iii) an individual who meets the criteria of categories (i) and (ii).

(B) APPLICABLE TITLE.—The term ‘applicable title’ means title XVIII, title XIX, or both.

(2) TESTING OF MODELS (PHASE I).

(1) IN GENERAL.—The CMI shall test payment and service delivery models in accordance with selection criteria under paragraph (2) to determine the effect of applying such models under the applicable title (as defined in subsection (a)(4)(B)) on program expenditures under such titles and the quality of care received by individuals receiving benefits under such title.

(C) EXPANSION OF MODELS (PHASE II).

(1) THE SECRETARY.—The Secretaries for Medicare & Medicaid Services and using such input from outside the Centers as the Administrator determines appropriate, there is evidence that the model addresses a defined population for which there are deficits in hospital clinical outcomes or potentially avoidable expenditures. The Administrator shall focus on models expected to reduce program costs under the applicable title while preserving or enhancing the quality of care received by individuals receiving benefits under such title.

(2) APPLICATION TO OTHER DEMONSTRATIONS AND TESTING.—The Administrator shall operate the demonstration programs under sections 1222 and 1226 of the Affordable Care Act through the CMI in accordance with the rules under this section, including those relating to evaluations, terminations, and expansions.

(3) BUDGET NEUTRALITY.

(A) INITIAL PERIOD.—The Secretary shall not require, as a condition for testing a model under paragraph (1), that the design of such model ensure that such model is budget neutral initially with respect to expenditures under the applicable title.

(B) TERMINATION.—The Secretary shall terminate or modify the design and implementation of a model under paragraph (a) if the model is not expected to meet criteria described in paragraphs (1) or (2) of such subsection.

(3) ADMINISTRATION.—Chapter 35 of title 44, United States Code shall not apply to the testing and implementation of a model under this section. Each such report shall describe the termination or modification of a model under this subsection.

(4) FUNDING FOR TESTING ITEMS AND SERVICES AND ADMINISTRATIVE COSTS.

(A) ADDITIONAL BENEFITS.—There shall be available to the Centers for Medicare & Medicaid Services (and such additional amounts as the Administrator determines) for each model described in this subsection, amounts appropriated under such title for applicable individuals.

(B) MEDICAID CONFORMING AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a), as amended by sections 1631(b), 1703(a), 1729, 1753, 1757(a), and 1759(a), is amended—

(1) in paragraph (78), by striking “and” at the end;

(2) in paragraph (79), by striking the period at the end and inserting “; and”;

(3) by adding at the end the following:

“(b) MEDICAID CONFORMING AMENDMENT.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a), as amended by sections 1631(b), 1703(a), 1729, 1753, 1757(a), and 1759(a), is amended—

(1) in paragraph (78), by striking “and” at the end; and

(2) in paragraph (79), by striking the period at the end and inserting “; and”; and

(3) by adding at the end the following:

“(d) RESOURCES DISREGARDED UNDER THE SUPPLEMENTAL SECURITY INCOME INCOME PROGRAM OF COMPENSATION FOR PARTICIPATION IN CLINICAL TRIALS FOR RARE DISEASES OR CONDITIONS.

(a) INCOME DISREGARD.—Section 1612(b) of the Social Security Act (42 U.S.C. 1382a(b)) is amended—

(1) by striking “and” at the end of paragraph (5); and

(2) by striking the period at the end of paragraph (25) and inserting “; and”; and

(3) by adding at the end the following:

“(26) The first $2,000 per year received by such individual (or such spouse) for participation in a clinical trial to test a treatment for a rare disease or condition (within the meaning of section 505(c)(2) of the Orphan Drug Act (Public Law 97–414)), that—

“(A) has been reviewed and approved by an institutional review board that—

“(i) was established to protect the rights and welfare of human subjects participating in research; and

“(ii) meet the standards for such bodies set forth in part 46 of title 45, Code of Federal Regulations; and

“(B) meets the standards for protection of human subjects for clinical research (as set forth in part 46 of title 45, Code of Federal Regulations); and

“(C) by striking “and” at the end of paragraph (5) and inserting “; and”; and

“(b) RESOURCES DISREGARDED.—Section 1613(a) of such Act (42 U.S.C. 1382a(b)) is amended—

(1) by striking “and” at the end of paragraph (5); and

(2) by striking the period at the end of paragraph (16) and inserting “; and”; and

“(c) EXPANSION OF MODELS (PHASE II).—The Secretary shall focus on models ex-
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(3) by inserting after paragraph (16) the following:

“(17) the first $2,000 per year received by such individual (or such spouse) for participation in a clinical trial, as described in section 1612(b)(26);”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to benefits payable for calendar months beginning after the earlier of—

(1) the date the Commissioner of Social Security promulgates regulations to carry out the amendments; or

(2) the 180-day period that begins with the date of the enactment of this Act.

DIVISION C—PUBLIC HEALTH AND WORKFORCE DEVELOPMENT

SEC. 2001. TABLE OF CONTENTS; REFERENCES.

(a) TABLE OF CONTENTS.—The table of contents of this division is as follows:

Sec. 2001. Table of contents; references.


TITLES I—COMMUNITY HEALTH CENTERS

TITLES II—WORKFORCE

Subtitle A—Primary Care Workforce

PART 1—NATIONAL HEALTH SERVICE CORPS

Sec. 2201. Authorizations of appropriations.

Sec. 2202. National Health Service Corps.

Sec. 2203. Authorizations of appropriations.

PART 2—PROMOTION OF PRIMARY CARE AND DISEASE PREVENTION

Sec. 2210. Increased funding.

Sec. 2211. Frontline health providers.

“SUBPART XI—HEALTH PROFESSIONAL NEEDS AREAS

“Sec. 340H. In general.

“Sec. 340I. Loan repayments.

“Sec. 340J. Loan forgiveness.

“Sec. 340K. Allocation.

Sec. 2212. Primary care student loan funds.

Sec. 2213. Training in family medicine, general internal medicine, general pediatrics, geriatrics, and physician assistants.

Sec. 2214. Training of medical residents in community-based settings.

Sec. 2215. Training for general, pediatric, and public health dentists and dental hygienists.

Sec. 2216. Authorization of appropriations.

Sec. 2217. Study on effectiveness of scholarships and loan repayments.

Subtitle B—Nursing Workforce

Sec. 2218. Amendments to Public Health Service Act.

Subtitle C—Public Health Workforce

Sec. 2219. Public Health Workforce Corps.

“SUBPART XII—PUBLIC HEALTH WORKFORCE

“Sec. 340L. Public Health Workforce Corps.

“Sec. 340M. Public Health Workforce Scholarship Program.

“Sec. 340N. Public Health Workforce Loan Repayment Program.

Sec. 2220. Enhancing the public health workforce.

Sec. 2221. Public health training centers.

Sec. 2222. Preventive medicine and public health training grant program.

Sec. 2223. Authorization of appropriations.

Subtitle D—Adapting Workforce to Evolving Health System Needs

PART 1—HEALTH PROFESSIONS TRAINING FOR DIVERSITY

Sec. 2211. School-based health centers.

Sec. 2212. Nurse-Managed health centers.

Sec. 2213. Federally qualified behavioral health centers.

PART 2—OTHER GRANTS

Sec. 2221. Comprehensive programs to provide education to nurses and create a pipeline to nursing.

Sec. 2222. Nursing workforce diversity grants.

Sec. 2223. Coordination of diversity and cultural competency programs.

PART 2—INTERDISCIPLINARY TRAINING PROGRAMS

Sec. 2231. Cultural and linguistic competency training for health professionals.

Sec. 2232. Innovation in interdisciplinary training care training.

PART 3—ADVISORY COMMITTEE ON HEALTH WORKFORCE EVALUATION AND ASSESSMENT

Sec. 2271. Health workforce assessment.

PART 4—HEALTH WORKFORCE ASSESSMENT

Sec. 2272. Health workforce assessment.

PART 5—AUTHORIZATION OF APPROPRIATIONS

Sec. 2233. Public health training centers.

Sec. 2234. Preventive medicine and public health training grant program.

Sec. 2235. Authorization of appropriations.

Sec. 2236. Enhancing the public health workforce.

Sec. 2237. Authorization of appropriations.

Sec. 2238. Improving the public health workforce.

PART 6—STUDENT STUDY AND FELLOWSHIP PROGRAMS

Sec. 2241. Scholarships for disadvantaged students, loan repayments and fellowships regarding faculty positions, and educational assistance in the health professions regarding individuals from disadvantaged backgrounds.

Sec. 2242. Health profession diversity grants.

Sec. 2243. Coordination of diversity and cultural competency programs.

PART 2—INTERDISCIPLINARY TRAINING PROGRAMS

Sec. 2251. Cultural and linguistic competency training for health professionals.

Sec. 2252. Innovation in interdisciplinary training care training.

PART 3—ADVISORY COMMITTEE ON HEALTH WORKFORCE EVALUATION AND ASSESSMENT

Sec. 2301. Prevention and wellness.

“TITLE XXXI—PREVENTION AND WELLNESS

“Subtitle A—Prevention and Wellness Trust

“Sec. 3111. Prevention and Wellness Trust.


“PART 1—EMERGENCY CARE-RELATED PROGRAMS

Sec. 2522. Infant mortality pilot programs.

Sec. 2523. Reducing student-to-school nurse ratios.

Sec. 2524. Medical-legal partnerships.

Sec. 2525. Extension of Wisewoman Program.

Sec. 2526. Healthy teen initiative to prevent teen pregnancy.

Sec. 2527. National training initiatives on autism spectrum disorders.

Sec. 2528. Implementation of medication management services in treatment of chronic diseases.

Sec. 2529. Postpartum depression.

Sec. 2530. Grants to promote positive health behaviors and outcomes.

Sec. 2531. Medical liability alternatives.

Sec. 2532. Infant mortality pilot programs.

Sec. 2533. Secondary school health science training programs.

Sec. 2534. Community-based collaborative care networks.

Sec. 2535. Community-based overweight and obesity prevention program.

Sec. 2536. Reducing student-to-school nurse ratios.

Sec. 2537. Medical-legal partnerships.

Sec. 2538. Screening, Brief Intervention, referral, and treatment for mental health and substance abuse disorders.

Sec. 2539. Grants to assist in developing medical schools in federally-designated health professional shortage areas.

PART 3—EMERGENCY CARE-RELATED PROGRAMS

Sec. 2541. Prevention and wellness.

Sec. 2542. Medical-legal partnerships.

Sec. 2543. Screening, Brief Intervention, referral, and treatment for mental health and substance abuse disorders.

Sec. 2544. Grants to assist in developing medical schools in federally-designated health professional shortage areas.

PART 4—PAIN CARE AND MANAGEMENT PROGRAMS

Sec. 2551. Trauma care centers.

Sec. 2552. Emergency care coordination.

Sec. 2553. Pilot programs to improve emergency medical care.

Sec. 2554. Assisting veterans with military emergency medical training to become State-licensed or certified emergency medical technicians (EMTs).

Sec. 2555. Dental emergency responders: public health and medical response.

Sec. 2556. Dental emergency responders: homeland security.

Subtitle C—Food and Drug Administration

PART 1—GENERAL

Sec. 2561. Institute of Medicine Conference on Pain.

Sec. 2562. Pain research at National Institutes of Health.

Sec. 2563. Public awareness campaign on pain management.

Subtitle D—Community Living Assistance Services and Supports

Sec. 2571. National medical device registry.

Sec. 2572. Nutrition labeling of standard menu items at chain restaurants and of articles of food sold from vending machines.

Sec. 2573. Protecting consumer access to generic drugs.

PART 2—BIOLOGICAL PRODUCTS

Sec. 2574. Licensure pathway for biosimilar biological products.

Sec. 2575. Fees relating to biosimilar biological products.

Sec. 2576. Amendments to certain patent provisions.

Subtitle D—Community Living Assistance Services and Supports

Sec. 2581. Establishment of national voluntary insurance program for purchase of voluntary living assistance services and support (CLASS program).
"TITLE XXXI—COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS

Sec. 3201. Purpose.
Sec. 3202. Definitions.
Sec. 3203. CLASS Independence Benefit Express Plan.
Sec. 3204. Enrollment and disenrollment requirements.
Sec. 3205. Benefits.
Sec. 3206. CLASS Independence Fund.
Sec. 3207. CLASS Independence Advisory Council.
Sec. 3208. Regulations; annual report.

Subtitle E—Miscellaneous

Sec. 2583. States failing to adhere to certain employment obligations.
Sec. 2584. Health centers under Public Health Service Act; liability protections for volunteer practitioners.
Sec. 2587. Report to Congress on the current status of the Health Investment Fund (referred to in this division as the "Fund").

Sec. 2591. Online health workforce training programs.
Sec. 2592. Access for individuals with disabilities.
Sec. 2593. Duplicative Grant programs.
Sec. 2594. Diabetes screening collaboration under the Diabetes Prevention Program.
Sec. 2595. Improvement of vital statistics collection.
Sec. 2596. National health service corps demonstration on incentive payments.

(b) REFERENCES.—Except as otherwise specified, whenever in this division an amendment is expressed in terms of an amount or amounts in the Fund, the amounts specified, whenever in this division an amendment is expressed in terms of an amount or amounts in any other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act (42 U.S.C. 201 et seq.).

(b) ESTIMATION OF BUDGETARY IMPACT.—(a) AVAILABILITY.—Funds appropriated or made available pursuant to sections 330(a), 338(b), 338(c), 338H–1, 799C, 872, or 3111 of the Public Health Service Act, as added by this division, are only available for the purposes set forth in this section and no funds appropriated under this Act are treated as new direct spending and attributed to this Act.

(b) TREATMENT.—For the purposes of estimating the spending effects of this Act, the authorization of appropriations from the Fund, to the extent amounts to the general revenues of the Treasury, shall be treated as new direct spending and attributed to this Act.

(b) REAPPOINTMENT TO NATIONAL ADVISORY COUNCIL.—Reappointment to the National Advisory Council may not be reappointed to the Council.

(b) LOAN REPAYMENT.—Section 330(b)(4) is amended by striking "$35,000" and inserting "$50,000, plus, beginning with fiscal year 2012, an amount determined by the Secretary on an inflationary basis to reflect inflation.

(b) TREATMENT OF AS OBVIOUSLY SUPPORTED.—Subsection (a) of section 338C (42 U.S.C. 338C(4)) is amended —

"(d) ADDITIONAL FUNDING.—For the purpose of carrying out this section, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated out of any amounts in the Public Health Investment Fund, the following:

"(1) For fiscal year 2011, $1,000,000,000.
"(2) For fiscal year 2012, $1,500,000,000.
"(3) For fiscal year 2013, $2,500,000,000.
"(4) For fiscal year 2014, $3,000,000,000.
"(5) For fiscal year 2015, $4,000,000,000."
SEC. 2202. ADMINISTRATIONS OF APPROPRIATIONS.

(a) National Health Service Corps Program.—Section 338 (42 U.S.C. 254k) is amended—

(1) in subsection (a), by striking “2012” and inserting “2015”; and

(2) by adding at the end the following:

"(c) To the purpose of carrying out this subpart, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated in the Public Health Investment Fund, the following:

"(1) $85,000,000,000 for fiscal year 2011.

"(2) $85,000,000,000 for fiscal year 2012.

"(3) $70,000,000,000 for fiscal year 2013.

"(4) $73,000,000,000 for fiscal year 2014.

"(5) $77,000,000,000 for fiscal year 2015."

(b) Scholarship and Loan Repayment Programs.—Subpart III of part D of title III of the Public Health Service Act (42 U.S.C. 254l et seq.) is amended—

(1) in section 338H(a)—

(A) in paragraph (4), by striking “and” at the end;

(B) in paragraph (5), by striking the period at the end and inserting “; and”;

and

(2) by inserting after section 338H the following:

"SEC. 338H-1. ADDITIONAL FUNDING."

For the purpose of carrying out this subpart, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

"(1) $364,000,000,000 for fiscal year 2011.

"(2) $266,000,000,000 for fiscal year 2012.

"(3) $278,000,000,000 for fiscal year 2013.

"(4) $292,000,000,000 for fiscal year 2014.

"(5) $306,000,000,000 for fiscal year 2015."

PART 2—PROMOTION OF PRIMARY CARE AND DENTISTRY

SEC. 2211. FRONTLINE HEALTH PROVIDERS. Part D of title III (42 U.S.C. 254b et seq.) is amended by adding at the end the following:

"Subpart XI—Health Professional Needs Areas"

"SEC. 340H. IN GENERAL."

(a) Program.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall establish a program, to be known as the Frontline Health Providers Loan Repayment Program, to address unmet health care needs in health professional needs areas through loan repayments under section 340l.

(b) Designation of Health Professional Needs Areas.—

(1) General.—In this subpart, the term ‘health professional needs area’ means an area, population, or facility that is designated by the Secretary in accordance with paragraph (2).

(2) Designation.—To be designated by the Secretary as a health professional needs area under this subpart:

(A) in the case of an area, the area must be a rational area for the delivery of health services.

(B) The area, population, or facility must have, for the purpose of delivering health services, more health disciplines, specialties, or subspecialties for the population served, as determined by the Secretary—

(i) insufficient capacity of health professional organizations or entities.

(ii) high needs for health services, including services to address health disparities.

(C) With respect to the delivery of primary health services, the area, population, or facility must not include a health professional shortage area (as designated under section 342(b)(2)) in the population, for the area, population, or facility may include such a health professional shortage area in which there is an unmet need for such services.

(D) Eligible Individuals.—To be eligible to participate in the Program, an individual shall—

(1) hold a degree in a course of study or program (approved by the Secretary) from a school of public health or a school described in paragraph (1)(A) other than a school of public health;

(2) hold a degree in a course of study or program (approved by the Secretary) from a school described in subparagraph (C), (D), or (E) of section 799B(1), as designated by the Secretary;

(3) be enrolled as a full-time student—

(A) in a school or program defined in subparagraph (C), (D), or (E) of section 799B(1), as designated by the Secretary, or a school described in paragraph (1); and

(B) in the final year of a course of study or program, offered by such school or program and approved by the Secretary, leading to a degree in a discipline referred to in subparagraph (1)(A), (C), or (D) in public health, (C), (D), or (E) of section 799B(1);

(4) be a practitioner described in section 1866(a)(1)(C) or 1866(a)(3)(B)(iii) or (iv) of the Social Security Act; or

(5) be a practitioner in the field of respiratory therapy, medical technology, or radiologic technology.

(d) Definitions.—In this subpart:

(1) The term ‘primary health services’ has the meaning given to the term in section 3171.

(2) The term ‘health professional services’ has the meaning given to such term in section 331(a)(3)(D).

SEC. 340L. LOAN REPAYMENTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall enter into contracts with individuals under which—

(1) the individual agrees—

(A) to serve as a full-time primary health services provider or as a full-time part-time provider of other health services for a period of time equal to 2 years or such longer period as the individual may agree to;

(B) to serve in a health professional needs area in the health discipline, specialty, or subspecialty for which the area, population, or facility is designated as a health professional needs area under section 340H; and

(C) in the case of an individual described in section 340H(c)(3) who is in the final year of study and who has accepted employment as a primary health services provider or as a temporary provider of other health services in accordance with subparagraphs (A) and (B), to complete the education or training and maintain an acceptable level of academic standing (as determined by the Secretary) (as defined in paragraph (d)(1)) in the course of study or training; and

(2) the Secretary agrees to pay, for each year of such service, an amount on the principal of the undergraduate or graduate educational loan(s) (or both) of the individual that is not more than 50 percent of the average award made under the National Health Service Corps Loan Repayment Program under subpart III in that year.

(2) Practice Setting.—A contract entered into under this section shall allow the individual to use the loan repayment to satisfy the service requirement described in subsection (a)(1) through employment in a solo or group practice, a clinic, an accredited public or private hospital, or any other health care entity, as deemed appropriate by the Secretary.

(c) Application of Certain Provisions.—The provisions of subpart III of part D shall, except as inconsistent with this section, apply to the loan repayment program under this subpart in the same manner and to the same extent as such provisions apply to the National Health Service Corps Loan Repayment Program established under section 399c.

(d) Insufficient Number of Applicants.—If there are an insufficient number of applicants for loan repayments under this subpart to obligate all appropriated funds, the Secretary shall transfer the unobligated funds to the National Health Service Corps for the purpose of recruiting applicants and designating individuals so as to ensure a sufficient number of participants in the National Health Service Corps for the following year.

SEC. 340J. REPORT.

The Secretary shall submit to the Congress an annual report on the program carried out under this subpart.

SEC. 340K. ALLOCATIONS.

Of the amount of funds obligated under this subpart each fiscal year for loan repayments—

(1) 80 percent shall be for physicians and other health professionals providing primary health services; and

(2) 20 percent shall be for health professionals described in paragraph (1).

SEC. 2212. PRIMARY CARE STUDENT LOAN FUNDS.

(a) In General.—Section 735 (42 U.S.C. 292y) is amended—

(1) by redesignating subsection (f) as subsection (g); and

(2) by inserting after section 338H the following:

"SEC. 338H-1. ADDITIONAL FUNDING."

For the purpose of carrying out this subpart, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

"(1) $354,000,000,000 for fiscal year 2011.

"(2) $266,000,000,000 for fiscal year 2012.

"(3) $278,000,000,000 for fiscal year 2013.

"(4) $292,000,000,000 for fiscal year 2014.

"(5) $306,000,000,000 for fiscal year 2015."

SEC. 2213. TRAINING IN FAMILY MEDICINE, GENERAL INTERNAL MEDICINE, GENERAL PEDIATRICS, OBSTETRICIANS, AND PHYSICIAN ASSISTANTS.

Section 747 (42 U.S.C. 293k) is amended—

(1) by amending the section heading to read as follows: ‘‘PRIMARY CARE TRAINING AND ENHANCEMENT’’;

(2) by redesignating subsection (e) as subsection (g); and

(3) by striking subsections (a) through (d) and inserting the following:

(a) Program.—The Secretary shall establish a primary care training and capacity building program consisting of awarding grants and contracts under subsections (b) and (c).

(b) Support and Development of Primary Care Training Programs.—

(1) In General.—The Secretary shall make grants to, or enter into contracts with, eligible entities—

(A) to plan, develop, operate, or participate in an accredited professional training
program, including an accredited residency or internship program, in the field of family medicine, general internal medicine, general pediatrics, or geriatrics; medical specialties, including in community-based settings;

(2) To provide financial assistance in the form of traineeships and fellowships to practicing physicians who are participants in any such programs and who plan to teach in a family medicine, general internal medicine, general pediatrics, or geriatrics training programs including in community-based settings;

(3) To plan, develop, operate, or participate in an accredited program for the training of physicians who plan to teach in family medicine, general internal medicine, general pediatrics, or geriatrics training programs including in community-based settings;

(4) To provide grants to, or enter into contracts with, public or private nonprofit entities that involve the training of individuals who plan to teach in programs to provide such training.

(2) Eligibility. —To be eligible for a grant or contract under paragraph (1), an entity shall be—

(A) an accredited school of medicine or osteopathic medicine, public or nonprofit hospital, or a physician assistant training program;

(B) a public or private nonprofit entity;

(C) a consortium of 2 or more entities described in subparagraphs (A) and (B).

(c) Capacity Building in Primary Care.—

(1) In general. —The Secretary shall make grants to, or enter into contracts with, eligible entities to establish, maintain, or improve—

(A) academic administrative units (including departments, divisions, or other appropriate units) in the specialties of family medicine, general internal medicine, general pediatrics, or geriatrics;

(B) programs to improve clinical teaching in such specialties;

(2) Eligibility. —To be eligible for a grant or contract under paragraph (1), an entity shall be—

(A) a public or private nonprofit entity able to demonstrate a recognized need for the program; or

(B) a public or private nonprofit entity as described in paragraph (1).

(d) Preference. —In awarding grants or contracts under this section, the Secretary shall give preference to entities that have a demonstrated record of at least one of the following:

(1) Training a high or significantly improved percentage of health professionals who provide primary care.

(2) Training individuals who are from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among primary care professionals).

(3) A high rate of placing graduates in practice settings having the principal focus of serving in underserved areas or populations experiencing health disparities (including serving patients eligible for medical assistance under title XIX of the Social Security Act or for child health assistance under title XXI of such Act or those with special health care needs).

(4) Supporting teaching programs that address the health care needs of vulnerable populations;

(5) Providing educational programs that address the health care needs of vulnerable populations.

(6) Report. —The Secretary shall submit to the Congress an annual report on the program carried out under this section.

(7) In this section, the term ‘health disparities’ has the meaning given in section 3171.

SEC. 2214. TRAINING OF MEDICAL RESIDENTS IN UNDERSERVED COMMUNITY-BASED SETTINGS.

Title VII (42 U.S.C. 292 et seq.) is amended—

(1) by redesignating section 748 as 749A; and

(2) by inserting after section 747 the following:

SEC. 748. TRAINING OF MEDICAL RESIDENTS IN UNDERSERVED COMMUNITY-BASED SETTINGS.

(a) PROGRAM. —The Secretary shall establish a program for the training of medical residents in community-based settings consisting of awarding grants and contracts under this section.

(b) DEVELOPMENT AND OPERATION OF COMMUNITY-BASED PROGRAMS. —The Secretary shall make grants to, or enter into contracts with, eligible entities—

(1) to plan and develop a new primary care residency training program, which may include—

(A) planning and developing curricula;

(B) recruiting and training residents and faculty; and

(C) other activities designated to result in accreditation of such a program; or

(2) to operate or participate in an established primary care residency training program, which may include—

(A) planning and developing curricula;

(B) recruiting and training residents; and

(C) retention of faculty.

(c) ELIGIBLE ENTITY. —To be eligible to receive a grant or contract under subsection (b), an entity shall—

(1) be designated as a recipient of payment for the direct costs of medical education under section 1886(k) of the Social Security Act;

(2) be designated as an approved teaching health center under section 3502(b) of the Affordable Care Act for America Act and continuing to participate in the demonstration project under such section;

(3) be an applicant for designation described in paragraph (1) or (2) and have demonstrated to the Secretary appropriate involvement of an accredited teaching hospital to carry out the inpatient responsibilities associated with a primary care residency training program; or

(4) be eligible to be designated as described in paragraph (1) or (2), not be an applicant as described in paragraph (3), and have demonstrated appropriate involvement of an accredited teaching hospital to carry out the inpatient responsibilities associated with a primary care residency training program.

(d) PREFERENCES. —In awarding grants and contracts under paragraph (1) or (2) of subsection (b), the Secretary shall give preference to entities that—

(1) support educational programs that address the health care needs of vulnerable populations; or

(2) are a Federally qualified health center as defined in section 330(a)(2) of the Social Security Act or a rural health clinic as defined in section 1861(aa)(4) of such Act.

(e) ADDITIONAL PREFERENCES FOR ESTABLISHED PROGRAMS. —In awarding grants and contracts under subsection (b)(2), the Secretary shall give preference to entities that have a demonstrated record of training—

(1) a high rate of placing graduates in practice settings having the principal focus of serving in underserved areas or populations experiencing health disparities (including serving patients eligible for medical assistance under title XIX of the Social Security Act or for child health assistance under title XXI of such Act or those with special health care needs);

(2) to provide financial assistance to oral health professionals who plan to teach in general, pediatric, or public health dentistry, or dental hygiene;

(3) to plan, develop, operate, or participate in a program for the training of oral health professionals who are in need thereof, who are participants in any such program, and who plan to work in general, pediatric, or public health dentistry, or dental hygiene; or

(e) Report. —The Secretary shall submit to the Congress annual reports on the program carried out under this section.

(2) Special Rules.—

(1) IN GENERAL.—The period of a grant or contract under this section—

(A) shall not exceed 3 years for awards under subsection (b)(1); and

(B) shall not exceed 5 years for awards under subsection (b)(2).

(2) ALLOCATION OF FUNDS.—Of the amount appropriated pursuant to section 799C(a) for a fiscal year, not more than 17 percent of such amount shall be made available to carry out this section.

SEC. 2215. TRAINING FOR GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTS AND DENTAL HYGIENISTS.

Title VII (42 U.S.C. 292 et seq.) is amended—

(1) in section 791(a)(1), by striking ‘‘747 and 750’’ and inserting ‘‘749, 749, and 750’’; and

(2) by inserting after section 748, as added, the following:

SEC. 749. TRAINING FOR GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTS AND DENTAL HYGIENISTS.

(a) PROGRAM. —The Secretary shall establish a training program for oral health professionals consisting of awarding grants and contracts under this section.

(b) SUPPORT AND DEVELOPMENT OF ORAL HEALTH RESIDENT TRAINING PROGRAMS.—The Secretary shall make grants to, or enter into contracts with, eligible entities—

(1) to plan, develop, operate, or participate in an approved teaching health center for the training of oral health professionals; or

(2) to provide financial assistance to oral health professionals who are in need thereof, who are participants in any such program, and who plan to work in general, pediatric, or public health dentistry, or dental hygiene;

(3) to plan, develop, operate, or participate in a program for the training of oral health professionals who plan to teach in general, pediatric, or public health dentistry, or dental hygiene;

(4) to provide financial assistance in the form of traineeships and fellowships to oral health professionals who plan to teach in oral health professional;
general, pediatric, or public health dentistry or dental hygiene;

"(5) to establish, maintain, or improve—

"(A) academic administrative units (including divisions, or other appropriate units) in the specialties of general, pediatric, or public health dentistry; or

"(B) programs that improve clinical teaching in such specialties;

"(6) to plan, develop, operate, or participate in predoctoral and postdoctoral training in general, pediatric, or public health dentistry programs;

"(7) to plan, develop, operate, or participate in a loan repayment program for full-time faculty in a program of general, pediatric, or public health dentistry;

"(8) to provide technical assistance to pediatric dental training programs in developing and implementing instruction regarding the oral health status, dental care needs, and risk-based clinical disease management of all pediatric populations with an emphasis on underserved children.

"(c) Eligibility.—To be eligible for a grant or contract under this section, an entity shall be—

"(1) an accredited school of dentistry, training program in dental hygiene, or public or private hospital;

"(2) a training program in dental hygiene at an accredited institution of higher education;

"(3) a public or private nonprofit entity; or

"(4) a consortium of—

"(A) 1 or more of the entities described in paragraphs (1) through (3); and

"(B) an accredited school of public health.

"(d) Preference.—In awarding grants or contracts under this section, the Secretary shall give preference to entities that have a demonstrated record of at least one of the following:

"(1) Training a high or significantly improved percentage of oral health professionals who practice general, pediatric, or public health dentistry;

"(2) Training individuals who are from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among health professionals); and

"(3) A high rate of placing graduates in practice settings having the principal focus of serving in underserved areas or populations with health disparities (including serving patients eligible for medical assistance under title XIX of the Social Security Act or for child health assistance under title XXI of such Act or those with special health care needs);

"(4) Supporting teaching programs that address the oral health needs of vulnerable populations;

"(5) Providing instruction regarding the oral health status, oral health care needs, and risk-based clinical disease management of all pediatric populations with an emphasis on underserved children.

"(e) Report.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.

"(f) Definitions.—In this section:

"(1) The term ‘health disparities’ has the meaning given in the term in section 3171.

"(2) The term ‘oral health professional’ means an individual training or practicing—

"(A) in general dentistry, pediatric dentistry, public health dentistry, or dental hygiene;

"(B) in another oral health specialty, as determined by the Secretary.

SEC. 2216. AUTHORIZATION OF APPROPRIATIONS.

(a) In General.—Part F of title VII (42 U.S.C. 295 et seq.) is amended by adding at the end the following:

"SEC. 790C. FUNDING THROUGH PUBLIC HEALTH INVESTMENT FUND.

"(a) PROMOTION OF PRIMARY CARE AND DENTISTRY.—For the purpose of carrying out subpart XI of part D of title III and sections 747, 748, and 749, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Investment Fund, the following:

"(1) $240,000,000 for fiscal year 2011.

"(2) $250,000,000 for fiscal year 2012.

"(3) $265,000,000 for fiscal year 2013.

"(4) $278,000,000 for fiscal year 2014.

"(5) $292,000,000 for fiscal year 2015.

"(b) EXISTING AUTHORIZATION OF APPROPRIATIONS.—Subsection (g)(1), as so redesignated, of section 747 (42 U.S.C. 293k) is amended by striking ‘$262,000’ and inserting ‘$278,000’.

SEC. 2217. STUDY ON EFFECTIVENESS OF SCHOLARSHIPS AND LOAN REPAYMENTS.

(a) Study.—The Comptroller General of the United States shall conduct a study to determine the effectiveness of scholarship and loan repayment programs under parts III and XI of part D of title III of the Public Health Service Act, as amended or added by sections 2201 and 2211, including whether scholarships or loan repayments are more effective in—

"(1) recruiting physicians, and other providers, to pursue careers in primary care specialties;

"(2) retaining such primary care providers; and

"(3) encouraging such primary care providers to practice in underserved areas.

(b) Report.—Not later than 12 months after the date of the enactment of this Act, the Comptroller General shall submit to the Congress a report on the results of the study under subsection (a).

Subtitle B—Nursing Workforce

SEC. 2221. AMENDMENTS TO PUBLIC HEALTH SERVICE ACT.

(a) Definitions.—Section 801 (42 U.S.C. 296 et seq.) is amended—

"(1) in paragraph (1), by inserting “nurse-managed health centers,” after “nursing centers,”; and

"(2) by adding at the end the following:

"(16) NURSE-MANAGED HEALTH CENTER.—The term ‘nurse-managed health center’—

"(A) means a nurse-practice arrangement, managed by advanced practice nurses, that provides primary care or wellness services to underserved or vulnerable populations and is associated with an accredited school of nursing; a federally qualified health center, or independent non-profit health or social services agency; and

"(B) shall not be construed as changing State law requirements applicable to an advanced practice nurse or the authorized scope of practice of such a nurse."

"(b) Grants for Health Professional Education.—Title VIII (42 U.S.C. 296 et seq.) is amended by striking section 807.

"(c) Reports.—Part A of title VIII (42 U.S.C. 296 et seq.) is amended by adding at the end the following:

"SEC. 809. REPORTS.

"The Secretary shall submit to the Congress a report on the activities carried out under each of sections 811, 821, 836, 846A, and 861."

"(d) Advanced Education Nursing Grants.—Section 811(f) (42 U.S.C. 296f-6) is amended—

"(1) by striking paragraph (2); and

"(2) by redesignating paragraph (3) as paragraph (2)."
**SEC. 872. FUNDING THROUGH PUBLIC HEALTH INVESTMENT FUND.**

For the purpose of carrying out this title, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any moneys in the Public Health Investment Fund, an amount determined by the Secretary to be necessary for each fiscal year.

SEC. 2231. PUBLIC HEALTH WORKFORCE CORPS.

The Secretary may be necessary for each fiscal year to enter into contracts, or to exercise other authorities provided for under section 340L(a), as follows:

(1) an accredited graduate school or program of nursing; health administration, management, or policy; preventive medicine; laboratory science; veterinary medicine; or dental medicine; or

(2) another accredited graduate school or program, as deemed appropriate by the Secretary.

SEC. 871. FUNDING.

For the purpose of carrying out parts B, C, and D (subject to section 851(g)), there are authorized to be appropriated, out of any moneys in the Public Health Investment Fund, the following:

(a) SECTIONS 831, 846, 846A, AND 861.—Sections 831(g) (as so redesignated), 846(1)(k) (42 U.S.C. 297n(1)(k)), 846A(f) (42 U.S.C. 297n-1(f)), and 861(e) (as so redesignated) are amended by striking "2007" each place it appears and inserting "2015".

(b) SECTION 871.—Section 871, as so redesignated by subsection (j), is amended to read as follows:

SEC. 2231. PUBLIC HEALTH WORKFORCE CORPS.

Part D of title III (42 U.S.C. 254b et seq.), as amended by section 2211, is amended by adding at the end the following:

"Subpart XII—Public Health Workforce

SEC. 340L. PUBLIC HEALTH WORKFORCE CORPS.

(a) Establishment.—There is established, within the Service, the Public Health Workforce Corps (in this subpart referred to as the ‘Corps’), for the purpose of ensuring an adequate supply of public health professionals throughout the Nation. The Corps shall consist of:

(1) such officers of the Regular and Reserve Corps of the Service as the Secretary may designate;

(2) such civilian employees of the United States as the Secretary may appoint; and

(3) such other individuals who are not employees of the United States.

(b) Contract.—Except as provided in subsection (c), the Secretary shall carry out this subpart acting through the Administrator of the Health Resources and Services Administration.

(c) Placement and Assignment.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall develop a methodology for placing and assigning Corps participants as public health professionals. Such methodology may allow for placing and assigning such participants in State, local, and tribal health departments and Federally qualified health centers (as defined in section 1903(aa)(4) of the Social Security Act).

(d) Application of Certain Provisions.—The provisions of subpart II shall, except as inconsistent with this subpart, apply to the Public Health Workforce Corps in the same manner and to the same extent as such provisions apply to the National Health Service Corps established under section 338A.

(e) Report.—The Secretary shall submit to the Congress an annual report on the programs carried out under this subpart.

SEC. 340M. PUBLIC HEALTH WORKFORCE SCHOLARSHIP PROGRAM.

(a) Establishment.—The Secretary shall establish the Public Health Workforce Scholarship Program (referred to in this section as the ‘Program’) for the purpose described in section 340L(a).

(b) Eligibility.—To be eligible to participate in the Program, an individual shall:

(1)(A) be accepted for enrollment, or be enrolled, as a full-time or part-time student in a course of study or program (approved by the Secretary) at an accredited graduate school or program described in subsection (b)(1), or

(2) demonstrate expertise in public health and be accepted for enrollment, or be enrolled, as a full-time or part-time student in a course of study or program (approved by the Secretary) at—

(i) an accredited graduate school or program of public health; health administration, management, or policy; preventive medicine; laboratory science; veterinary medicine; or dental medicine; or

(ii) another accredited graduate school or program, as deemed appropriate by the Secretary.

(2) be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Service or be eligible for selection for civilian service in the Corps;

(3) sign and submit to the Secretary a written contract (described in subsection (c)) to serve full-time as a public health professional, upon the completion of the course of study or program involved, the individual shall be eligible for selection for civilian service in the Corps;

(4) provide the individual with a scholarship for a period of years (not to exceed 4 academic years) during which the individual serves in the Corps.

(c) Contract.—The written contract between the Secretary and an individual under subsection (b) shall contain—

(1) an agreement on the part of the Secretary that the individual will—

(A) provide the individual with a scholarship for a period of years (not to exceed 4 academic years) during which the individual serves in the Corps; and

(B) accept (subject to the availability of appropriated funds) the individual into the Corps;

(2) an agreement on the part of the individual that the individual will—

(A) accept provision of such scholarship to the individual;

(B) maintain full-time or part-time enrollment in the approved course of study or program described in subsection (b)(1) until the individual completes that course of study or program;

(C) while enrolled in the approved course of study or program, have an acceptable level of academic standing (as determined by the educational institution offering such course of study or program); and

(D) if applicable, complete a residency or internship; and

(E) serve full-time as a public health professional for a period of time equal to the greater of—

(i) 1 year for each academic year for which the individual was provided a scholarship under the Program; or

(ii) 2 years;

(3) an agreement by both parties as to the nature and extent of the scholarship assistance, which may include—

(A) payment of reasonable educational expenses of the individual, including tuition, fees, books, equipment, and laboratory expenses; and

(B) payment of a stipend of not more than $1,289 (plus, beginning with fiscal year 2012, an amount determined by the Secretary on an annual basis to reflect inflation) per month for each of the academic years involved, with the dollar amount of such a stipend determined by the Secretary taking into consideration whether the individual is enrolled full-time or part-time;

(4) Application of Certain Provisions.—The provisions of subpart III shall, except as inconsistent with this subpart, apply to the scholarship program under this section in the same manner and to the same extent as such provisions apply to the National Health Service Corps Scholarship Program established under section 338A.

SEC. 340N. PUBLIC HEALTH WORKFORCE LOAN REPAYMENT PROGRAM.

(a) Establishment.—The Secretary shall establish the Public Health Workforce Loan Repayment Program referred to in this section as the ‘Program’ for the purpose described in section 340L(a).

(b) Eligibility.—To be eligible to participate in the Program, an individual shall—

(1)(A) have a graduate degree from an accredited school or program of public health;

(B) have demonstrated expertise in public health and have a graduate degree in a course of study or program (approved by the Secretary) from—

(i) an accredited school or program of public health administration, management, or policy; preventive medicine; laboratory science; veterinary medicine; or dental medicine;

(ii) another accredited school or program approved by the Secretary; or

(C) be enrolled as a full-time or part-time student in the final year of a course of study or program (approved by the Secretary) offered by a school or program described in paragraph (A) or (B), leading to a graduate degree;

(2) be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Service or be eligible for selection for civilian service in the Corps;

(3) if applicable, complete a residency or internship; and

(4) sign and submit to the Secretary a written contract (described in subsection (c)) to serve full-time as a public health professional for the period of obligated service described in subsection (c)(2).

(c) Contract.—The written contract between the Secretary and an individual under subsection (b) shall contain—

(1) an agreement by the Secretary to repay on behalf of the individual loans incurred by the individual in the pursuit of the relevant public health workforce educational degree in accordance with the terms of the contract;

(2) an agreement by the individual to serve full-time as a public health professional for a period of time equal to 2 years or such longer period as the individual may agree to; and

(3) in the case of an individual described in paragraph (1)(C) who completes the final year of study or program involved, an agreement to accept gainful employment as a public health professional, in accordance with section 340L(c), an agreement on the part of the individual to complete the education or training, maintain an acceptable level of academic standing (as determined by the educational institution offering the course of study or training), and repay the period of obligated service described in paragraph (2).

(d) Payments.—In General.—A loan repayment program provided for an individual under a written contract under the Program shall consist of payment, in accordance with paragraph (2), on behalf of the individual of the principal, interest, and related expenses on government and commercial loans received by the individual during the undergraduate or graduate education period as the Secretary determines. The term "education period" means the period of time that began on the first day of attendance at an educational institution and ended on the first day of attendance at another educational institution.

(2) Payments for Years Served.—

(A) In General.—For each year of obligated service that an individual contracts to serve under a written contract, the Secretary may pay up to $35,000 (plus, beginning with fiscal year 2012, an amount determined by...
the Secretary on an annual basis to reflect inflation) on behalf of the individual for loans described in paragraph (1).

(2) REPAYMENT SCHEDULE.—Any arrangement (a) Program.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the Centers for Disease Control and Prevention, shall establish a public health workforce training and enhancement program consisting of awarding grants and contracts under subsection (b).

(b) Grants and Contracts.—The Secretary shall award grants to, or enter into contracts with, eligible entities to—

(1) plan, develop, operate, or participate in, an accredited professional training program in the field of public health including such a program in nursing; health administration, management, or policy; preventive medicine; laboratory science; veterinary medicine; or dental medicine; and

(2) to provide financial assistance in the form of traineeships and fellowships to public health professionals who plan to teach in preventive medicine and public health; or

(3) establish, maintain, or improve—

(A) academic administrative units (including departments, divisions, or other appropriate units) in preventive medicine and public health;

(B) programs that improve clinical teaching in preventive medicine and public health.

(c) Eligibility.—To be eligible for a grant or contract under subsection (a), an entity shall be—

(1) an accredited health professions school or program of public health; nursing; health administration, management, or policy; preventive medicine; laboratory science; veterinary medicine; or dental medicine;

(2) a State, local, or tribal health department;

(3) a public or private nonprofit entity; or

(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

(d) Preference.—In awarding grants or contracts under this section, the Secretary shall give preference to entities that have a demonstrated record of at least one of the following:

(1) Training a high or significantly improved percentage of public health professionals who serve in underserved communities;

(2) Training individuals who are from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among public health professionals);

(3) Training individuals in public health specialties experiencing a significant short-age of public health professionals as determined by the Secretary;

(4) Training individuals in any program described in paragraph (1); and

(5) Training individuals in any program described in paragraph (1); and

(e) Application of Certain Provisions.—The provisions of subsection (d) and paragraphs (1) through (3) shall apply to the loan repayment program under this section in the same manner and to the same extent as applicable to the loan repayment program under section 338B.

SEC. 2251. CULTURAL AND LINGUISTIC COMPETENCY TRAINING GRANTS.

(a) In General.—Section 799C, as added by section 107(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 293k), is amended by striking the last sentence and inserting the following:

"(4) $59,000,000 for fiscal year 2014.

SEC. 2253. AUTHORIZATION OF APPROPRIATIONS.

(a) In General.—Section 799C, as added by section 107(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 293k), is amended—

(1) in subsection (b)(1), by striking "in furtherance of the goals established by the Secretary in the national prevention and wellness strategy under section 321"; and

(2) by adding at the end the following:

"(c) Application of Certain Provisions.—Subsection (a) of section 770 (42 U.S.C. 295b) is amended by striking "2002" and inserting "2012".

SEC. 2252. SCHOLARSHIPS FOR DISADVANTAGED WORKFORCE.

(a) In General.—The Secretary shall award scholarships to institutions of higher education to assist individuals in completing a degree or certificate in a health professions field in which the individual completes such year.

(b) Eligibility.—To be eligible for a grant under this section, the Secretary shall submit to the Congress an annual report on the program carried out under this section.

SEC. 2235. AUTHORIZATION OF APPROPRIATIONS.

(a) In General.—Section 799C, as added by section 107(a) of the Patient Protection and Affordable Care Act (42 U.S.C. 293k), is amended—

(1) in subsection (b)(1), by striking "in furtherance of the goals established by the Secretary in the national prevention and wellness strategy under section 321"; and

(2) by adding at the end the following:

"(a) Program.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Director of the Centers for Disease Control and Prevention, shall establish a public health workforce training and enhancement program consisting of awarding grants and contracts under subsection (b).

(b) Grants and Contracts.—The Secretary shall award grants to, or enter into contracts with, eligible entities to—

(1) plan, develop, operate, or participate in, an accredited professional training program in the field of public health; or

(2) to provide financial assistance in the form of traineeships and fellowships to public health professionals who plan to teach in preventive medicine and public health; or

(3) establish, maintain, or improve—

(A) academic administrative units (including departments, divisions, or other appropriate units) in preventive medicine and public health;

(B) programs that improve clinical teaching in preventive medicine and public health.

(c) Eligibility.—To be eligible for a grant or contract under subsection (a), an entity shall be—

(1) an accredited health professions school or program of public health or hospital;

(2) a State, local, or tribal health department;

(3) a public or private nonprofit hospital;

(4) a consortium of 2 or more entities described in paragraphs (1) through (3); or

(5) an organization, entity, or group of entities that have a demonstrated record of at least one of the following:

(1) Training a high or significantly improved percentage of public health professionals who serve in underserved communities;

(2) Training individuals who are from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among public health professionals);

(3) Training individuals in public health specialties experiencing a significant shortage of public health professionals as determined by the Secretary;

(4) Training individuals in any program described in paragraph (1); and

(5) Training individuals in any program described in paragraph (1); and

(e) Application of Certain Provisions.—The provisions of subsection (d) and paragraphs (1) through (3) shall apply to the loan repayment program under this section in the same manner and to the same extent as applicable to the loan repayment program under section 338B.

SEC. 2254. COORDINATION OF DIVERSITY AND CULTURAL COMPETENCY PROGRAMS.

(a) In General.—The Secretary shall, to the extent practicable, coordinate the activities carried out under this part and section 821 in order to enhance the effectiveness of such activities and avoid duplication of effort.

(b) Report.—Section 736 (42 U.S.C. 293) is amended—

(1) by redesignating subsection (h) as subsection (i); and

(2) by inserting after subsection (g) the following:

"(h) Report.—The Secretary shall submit to the Congress an annual report on the activities carried out under this section.

PART 2—INTERDISCIPLINARY TRAINING PROGRAMS

SEC. 2255. CULTURAL AND LINGUISTIC COMPETENCY TRAINING FOR HEALTH PROFESSIONALS.

(a) In General.—Section 741 (42 U.S.C. 293e) is amended—

(1) in the section heading, by striking "GRANTS FOR HEALTH PROFESSIONS EDUCATION" and inserting "CULTURAL AND LINGUISTIC COMPETENCY TRAINING FOR HEALTH PROFESSIONALS"; and

(2) by redesigning subsection (b) as subsection (h); and

(3) by striking subsection (a) and inserting the following:

"(a) Program.—The Secretary shall establish a cultural and linguistic competency training program for public health professionals, including nurse professionals, consisting of awarding grants and contracts under subsection (b)."

"(b) Cultural and Linguistic Competency Training.—The Secretary shall award grants..."
to, or enter into contracts with, eligible entities—

“(1) to test, develop, and evaluate models of cultural and linguistic competency training programs (including continuing education) for health professionals; and

“(2) to implement cultural and linguistic competency training programs for health professionals developed under paragraph (1) or otherwise.

“(c) ELIGIBILITY.—To be eligible for a grant or contract under subsection (b), an entity shall be—

“(1) an accredited health professions school or program;

“(2) an academic health center;

“(3) a public or private nonprofit entity; or

“(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

“(d) PREFERENCES.—In awarding grants and contracts under this section, the Secretary shall give preference to entities that have a demonstrated record of at least one of the following:

“(1) Addressing, or partnering with an entity with experience addressing, the cultural and linguistic competency needs of the population to be served through the grant or contract.

“(2) Addressing health disparities.

“(3) Addressing health disparities in regions experiencing significant changes in the cultural and linguistic demographics of populations, including communities along the United States-Mexico border.

“(4) Carrying out activities described in subsection (b) with respect to more than one health profession discipline, specialty, or subspecialty.

“(e) CONSULTATION.—The Secretary shall carry out this section in consultation with the heads of appropriate health agencies and offices in the Department of Health and Human Services, including the Office of Minority Health and the National Center on Minority Health and Health Disparities.

“(1) NUMBER; APPOINTMENT.—The Secretary shall, in consultation with the Advisory Committee on Health Workforce Evaluation and Assessment, appoint an Advisory Committee to the Health Workforce Evaluation and Assessment, and the Secretary shall carry out this section in consultation with the Advisory Committee.

“(2) Terms.—

“(A) the delivery of health services through interdisciplinary and team-based models, which may include patient-centered medical homes, medication therapy management models, and models integrating physical, mental, or oral health services; and

“(B) the identification of the delivery of health care within and across settings, including health care institutions, community-based settings, and the patient’s home; and

“(2) to implement such training programs developed under paragraph (1) or otherwise.

“(c) ELIGIBILITY.—To be eligible for a grant or contract under subsection (b), an entity shall be—

“(1) an accredited health professions school or program;

“(2) an academic health center;

“(3) a public or private nonprofit entity (including an area health education center or a geriatric education center); or

“(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

“(d) PREFERENCES.—In awarding grants and contracts under this section, the Secretary shall give preference to entities that have a demonstrated record of at least one of the following:

“(1) Training a high or significantly improved percentage of health professionals who serve in underserved communities.

“(2) Broader interdisciplinary team-based collaborations.

“(3) Addressing health disparities.

“(e) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.

“SEC. 764. HEALTH WORKFORCE EVALUATION AND ASSESSMENT

“SEC. 2261. HEALTH WORKFORCE EVALUATION AND ASSESSMENT

“A. ADVISORY COMMITTEE ON HEALTH WORKFORCE EVALUATION AND ASSESSMENT

“‘(A) PROGRAM.—The Secretary shall establish an Advisory Committee on Health Workforce Evaluation and Assessment (referred to in this section as the ‘Advisory Committee’), a group of individuals who shall be composed of health care providers and administrators, representatives of health care payors, consumers and their families, and community members, including individuals who represent the health workforce.

“(B) STAGGERED TERMS.—Notwithstanding paragraph (A), the members first appointed to the Advisory Committee under paragraph (1) shall (i) serve for a term of 3 years, (ii) shall be—

“(1) 5 shall be appointed for a term of 1 year;

“(2) 5 shall be appointed for a term of 2 years;

“(3) 5 shall be appointed for a term of 3 years;

“(B) TERMS.—In appointing members of the Advisory Committee, the Secretary shall—

“(1) include no less than one representative of each of—

“(i) health professionals within the health workforce;

“(ii) health care patients and consumers;

“(iii) employers;

“(iv) labor unions; and

“(v) third-party health payors; and

“(2) ensure that—

“(i) all areas of expertise described in paragraph (1) are represented;

“(ii) the members of the Advisory Committee include members who, collectively, have significant experience working with—

“(i) populations in urban and federally designated rural and nonmetropolitan areas; and

“(ii) populations who are underrepresented in health professions, including underrepresented minority groups; and

“(iii) individuals who are directly involved in health professions education or practice do not constitute a majority of the members of the Advisory Committee.

“(3) TERMINATION.—The term of office of members of the Advisory Committee shall not be extended.

“(4) PANELS.—The Secretary may establish one or more panels to advise the Advisory Committee on health workforce needs.

“B. PUBLIC PARTICIPATION

“‘(A) INVITATION.—The Secretary shall invite representatives from affected or interested parties to participate in the activities of the Advisory Committee, and the Secretary shall provide such representatives with reasonable opportunities to comment on the activities and decisions of the Advisory Committee.

“(B) MEETINGS.—The Advisory Committee shall meet at such times as may be necessary and determined by the Secretary.

“(C) PUBLIC REMARKS.—The Secretary shall ensure that the Advisory Committee provides a mechanism for public participation in the Advisory Committee’s activities and decision making.

“(D) PUBLIC REPORT.—The Secretary shall ensure that the Advisory Committee prepares a report that describes its activities and decisions, including the recommendations made by the Advisory Committee.

“(E) FOLLOW-UP.—The Secretary shall ensure that the Advisory Committee’s recommendations are followed up by appropriate authorities.

“(F) COSTS.—The Secretary shall ensure that the Advisory Committee’s costs are covered by the Federal budget.

“(G) PUBLIC INQUIRIES.—The Secretary shall ensure that the Advisory Committee responds to public inquiries in a timely manner.

“(H) PUBLIC RECORD.—The Secretary shall ensure that the Advisory Committee maintains a public record of its activities and decisions.

“C. PUBLIC PARTICIPATION

“‘(A) INVITATION.—The Secretary shall invite representatives from affected or interested parties to participate in the activities of the Advisory Committee, and the Secretary shall provide such representatives with reasonable opportunities to comment on the activities and decisions of the Advisory Committee.

“(B) MEETINGS.—The Advisory Committee shall meet at such times as may be necessary and determined by the Secretary.

“(C) PUBLIC REMARKS.—The Secretary shall ensure that the Advisory Committee provides a mechanism for public participation in the Advisory Committee’s activities and decision making.

“(D) PUBLIC REPORT.—The Secretary shall ensure that the Advisory Committee prepares a report that describes its activities and decisions, including the recommendations made by the Advisory Committee.

“(E) FOLLOW-UP.—The Secretary shall ensure that the Advisory Committee’s recommendations are followed up by appropriate authorities.

“(F) COSTS.—The Secretary shall ensure that the Advisory Committee’s costs are covered by the Federal budget.

“(G) PUBLIC INQUIRIES.—The Secretary shall ensure that the Advisory Committee responds to public inquiries in a timely manner.

“(H) PUBLIC RECORD.—The Secretary shall ensure that the Advisory Committee maintains a public record of its activities and decisions.
Interdisciplinary, Community-Based Linkages (as authorized in section 756), the Advisory Council on Graduate Medical Education and Practice (as authorized in section 755).

“(g) FACA.—The Federal Advisory Committee Act (5 U.S.C. App.) except for section 3 of title I of such Act (as designated, of section 741 is amended—

“(i) this section, the term ‘health workforce’ includes all health care providers with direct patient care and support responsibilities, including physicians, nurse practitioners, physician assistants, pharmacists, oral health professionals (as defined in section 749(f)(2)), allied health professionals, mental and behavioral health professionals (as defined in section 715(f)(2)), and public health professionals (including veterinarians engaged in public health practice).”

PART 4—HEALTH WORKFORCE ASSESSMENT

SEC. 2271. HEALTH WORKFORCE ASSESSMENT.

(a) IN GENERAL.—Section 761 (42 U.S.C. 294n) is amended—

(1) by redesigning subsection (c) as subsection (a); and

(2) by striking subsections (a) and (b) and inserting the following:

“(a) IN GENERAL.—The Secretary shall, based upon the classifications and standardized methodologies and procedures developed by the Advisory Committee on Health Workforce Evaluation and Assessment under section 764(b) of the Public Health Service Act, as added by section 2261, the Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration and in consultation with such Advisory Committee, may make a judgment about the classifications, methodologies, and procedures to be used or collection of data under section 761(a) of the Public Health Service Act, as amended by this section.

(b) REPORT.—The Secretary shall submit to the Congress an annual report on the activities of the Advisory Committee.

(1) this section, the term ‘health workforce’ includes all health care providers with direct patient care and support responsibilities, including physicians, nurse practitioners, physician assistants, pharmacists, oral health professionals (as defined in section 749(f)(2)), allied health professionals, mental and behavioral health professionals (as defined in section 715(f)(2)), and public health professionals (including veterinarians engaged in public health practice).”

PART 5—AUTHORIZATION OF APPROPRIATIONS

SEC. 2281. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—Section 790C, as added and amended, is further amended by adding at the end the following:

“(g) HEALTH PROFESSIONS TRAINING FOR DIVERSITY.—For the purpose of carrying out sections 736, 737, 738, 739, and 739A, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any moneys in the Public Health Investment Fund, the following:

(1) $90,000,000 for fiscal year 2011.

(2) $97,000,000 for fiscal year 2012.

(3) $102,000,000 for fiscal year 2013.

(4) $104,000,000 for fiscal year 2014.

(5) $107,000,000 for fiscal year 2015.

(b) EXISTING AUTHORIZATIONS OF APPROPRIATIONS.—

(1) Section 736.—Paragraph (1) of section 736(i) of the Public Health Service Act, as amended by striking “2002” and inserting “2015”.

(2) Sections 737, 738, and 739.—Subsections (a), (b), and (c) of section 738 are amended by striking “2002” each place it appears and inserting “2015”.

(3) Section 741.—Subsection (b), as so redesignated, of section 741 is amended—

(A) by striking “and” after “fiscal year 2003;” and

(B) by inserting “, and such sums as may be necessary for fiscal year 2015 through the end of fiscal year 2015” before the period at the end.

(4) Section 742.—Subsection (b)(1), as so redesignated, of section 742 is amended by striking “2002” and inserting “2015”.

TITLE III—PREVENTION AND WELLNESS

SEC. 2301. PREVENTION AND WELLNESS.

(a) IN GENERAL.—The Public Health Service Act (42 U.S.C. 294 et seq.) is amended by inserting after title XXX the following:

“TITLE XXXI—PREVENTION AND WELLNESS

Subtitle A—Prevention and Wellness Trust

SEC. 3111. PREVENTION AND WELLNESS TRUST.

(a) CYCLIC FUNDS.—There is established a Prevention and Wellness Trust. There are authorized to be appropriated to the Trust, out of any moneys in the Public Health Investment Fund, the following:

(1) for fiscal year 2011, $2,400,000,000;

(2) for fiscal year 2012, $2,845,000,000;

(3) for fiscal year 2013, $3,100,000,000;

(4) for fiscal year 2014, $3,455,000,000; and

(5) for fiscal year 2015, $3,600,000,000.

(b) AVAILABILITY OF FUNDS.—Amounts in this title shall be available, as provided in advance in appropriation Acts, for carrying out this title.

(c) ALLOCATION.—Of the amounts authorized to be appropriated under this title, there are authorized to be appropriated—

(1) for carrying out subtitle C (Prevention Task Forces), $30,900,000 for each of fiscal years 2011 through 2013;

(2) for carrying out subtitle D (Prevention and Wellness Research)—

(A) for fiscal year 2011, $155,000,000;

(B) for fiscal year 2012, $205,000,000;

(C) for fiscal year 2013, $255,000,000;

(D) for fiscal year 2014, $305,000,000; and

(E) for fiscal year 2015, $355,000,000;

(3) for carrying out subtitle E (Delivery of Community Preventive and Wellness Services)—

(A) for fiscal year 2011, $1,065,000,000;

(B) for fiscal year 2012, $1,260,000,000;

(C) for fiscal year 2013, $1,365,000,000;

(D) for fiscal year 2014, $1,570,000,000; and

(E) for fiscal year 2015, $1,775,000,000.

(4) for carrying out section 3161 (Core Public Health Infrastructure for State, Local, and Tribal Health Departments)—

(A) for fiscal year 2011, $1,000,000,000;

(B) for fiscal year 2012, $1,260,000,000;

(C) for fiscal year 2013, $1,100,000,000;

(D) for fiscal year 2014, $1,200,000,000; and

(E) for fiscal year 2015, $1,250,000,000.

(5) for carrying out section 3162 (Core Public Health Infrastructure and Activities for CDC), $350,000,000 for each of fiscal years 2011 through 2015.

Subtitle B—National Prevention and Wellness Strategy

SEC. 3121. NATIONAL PREVENTION AND WELLNESS STRATEGY.

(a) IN GENERAL.—The Secretary shall submit to the Congress an annual report after the date of the enactment of this section, and at least every 2 years thereafter, a national strategy that is designed to improve the Nation’s health through evidence-based clinical and community prevention and wellness activities (in this section referred to as the ‘‘strategy’’), including core public health improvement activities.

(b) CONTENTS.—The strategy under subsection (a) shall include each of the following:

(1) Identification of specific national goals and objectives in prevention and wellness activities that take into account appropriate public health measures and standards, including departmental measures and standards (including Healthy People and National Public Health Performance Standards).

(2) Establishment of national priorities for prevention and wellness, taking into account national prevent and wellness needs.

(3) Establishment of national priorities for research on prevention and wellness, taking into account unmet research questions on prevention and wellness, including health disparities in prevention and wellness.

(4) Identification of health disparities in prevention and wellness.

(5) Review of payment incentives for prevention and wellness activities, taking into account delivery system capacity.

(6) A plan for addressing and implementing paragraphs (1) through (5).

(c) CONSULTATION.—The Secretary shall consult with the following:

(1) The heads of appropriate health agencies, organizations, and professional societies for the purpose of carrying out subsection (a).

(2) Before Completion of National Strategy.—Pending completion of the classifications and standardized methodologies and procedures developed by the Advisory Committee on Health Workforce Evaluation and Assessment under section 764(b) of the Public Health Service Act, as added by section 2261, the Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration and in consultation with such Advisory Committee, may make a judgment about the classifications, methodologies, and procedures to be used or collection of data under section 761(a) of the Public Health Service Act, as amended by this section.

(3) for fiscal year 2011, $3,100,000,000;

(4) for fiscal year 2012, $3,455,000,000; and

(5) for fiscal year 2013, $3,600,000,000.
Health, the Office on Women's Health, and the Substance Abuse and Mental Health Services Administration.

"(2) As appropriate, the heads of other Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary).

"(3) As appropriate, nonprofit and for-profit entities.

"(4) The Association of State and Territorial Health Officials and the National Association of County and City Health Officials.


**Subtitle C—Prevention Task Forces**

**SEC. 3131. TASK FORCE ON CLINICAL PREVENTIVE SERVICES.**

"(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall establish a permanent task force to be known as the Task Force on Clinical Preventive Services (in this section referred to as the 'Task Force').

"(b) RESPONSIBILITIES.—The Task Force shall—

"(1) identify clinical preventive services for review;

"(2) review the scientific evidence related to the benefits, effectiveness, appropriateness, and costs of clinical preventive services identified under paragraph (1) for the purpose of developing, updating, publishing, and disseminating evidence-based recommendations on the use of such services;

"(3) as appropriate, take into account health disparities in developing, updating, publishing, and disseminating evidence-based recommendations on the use of such services;

"(4) identify gaps in clinical preventive services research and evaluation and recommend priority areas for such research and evaluation;

"(5) pursuant to section 3143(c), determine whether subsidies and rewards meet the criteria for funding and evaluate the Task Force's standards for a grade of A or B;

"(6) as appropriate, consult with the clinical prevention stakeholders board in accordance with subsection (f);

"(7) consult with the Task Force on Community Preventive Services established under section 3132; and

"(8) as appropriate, in carrying out this section, consider the national strategy under section 3131.

"(c) ROLE OF AGENCY.—The Secretary shall provide ongoing administrative, research, and technical support for the operations of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force.

"(d) MEMBERSHIP.—

"(1) NUMBER; APPOINTMENT.—The Task Force shall be composed of 30 members, appointed by the Secretary.

"(2) TERMS.—

"(i) 10 shall be appointed for a term of 2 years.

"(ii) 10 shall be appointed for a term of 4 years; and

"(iii) 10 shall be appointed for a term of 6 years.

"(3) QUALIFICATIONS.—Members of the Task Force shall be appointed from among individuals who possess expertise in at least one of the following areas:

"(A) Health promotion and disease prevention.

"(B) Evaluation of research and systematic evidence reviews.

"(C) Application of systematic evidence reviews to clinical decisionmaking or health policy.

"(D) Clinical primary care in child and adolescent health.

"(E) Clinical primary care in adult health, including women's health.

"(F) Clinical primary care in geriatrics.

"(G) Clinical counseling and behavioral services for primary care patients.

"(H) Members representing members of the Task Force, the Surgeon General of the Public Health Service, and the Secretary shall ensure that—

"(i) all areas of expertise described in paragraph (3) are represented; and

"(ii) the members of the Task Force include individuals with expertise in health disparities.

"(e) SUBGROUPS.—As appropriate to maximize efficiency, the Task Force may delegate authority for conducting reviews and making recommendations to subgroups consisting of Task Force members, subject to final approval by the Task Force.

"(f) CLINICAL PREVENTION STAKEHOLDERS BOARD.—

"(1) IN GENERAL.—The Task Force shall convene a clinical prevention stakeholders board composed of representatives of appropriate public and private entities with an interest in clinical preventive services to advise the Task Force on developing, updating, publishing, and disseminating evidence-based recommendations on the use of clinical preventive services.

"(2) MEMBERSHIP.—The members of the clinical prevention stakeholders board shall include representatives of the following:

"(A) Health care consumers and patient groups.

"(B) Providers of clinical preventive services, including community-based providers.

"(C) Federal departments and agencies, including—

"(i) appropriate health agencies and offices in the Department, including the Office of the Surgeon General of the Public Health Service, the Office of Minority Health, the National Institutes of Health and Health Disparities, and the Office on Women's Health; and

"(ii) as appropriate, other Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary).

"(3) REPRESENTATION.—In appointing members to the clinical prevention stakeholders board the Secretary shall—

"(A) recommend clinical preventive services for review;

"(B) review the scientific evidence related to the benefits, effectiveness, appropriateness, and costs of community preventive services identified under paragraph (1) for the purpose of developing, updating, publishing, and disseminating evidence-based recommendations on the use of such services;

"(3) as appropriate, take into account health disparities in developing, updating, publishing, and disseminating evidence-based recommendations on the use of such services;

"(4) identify gaps in community preventive services research and evaluation and recommend priority areas for such research and evaluation;

"(5) pursuant to section 3143(d), determine whether subsidies and rewards are effective; and

"(6) as appropriate, consult with the community prevention stakeholders board in accordance with subsection (f);

"(g) DISCLOSURE AND CONFLICTS OF INTEREST.—The Federal Advisory Committee Act (5 U.S.C. App.) except for section 14 of such Act shall apply to the Task Force to the extent that the provisions of such Act do not conflict with the provisions of this title.

"(1) REPORT.—The Secretary shall submit to the Congress an annual report on the Task Force, including with respect to gaps identified and recommendations made under subsection (b)(4).

**SEC. 3132. TASK FORCE ON COMMUNITY PREVENTIVE SERVICES.**

"(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a permanent task force to be known as the Task Force on Community Preventive Services (in this section referred to as the 'Task Force').

"(b) RESPONSIBILITIES.—The Task Force shall—

"(1) identify community preventive services for review;

"(2) review the scientific evidence related to the benefits, effectiveness, appropriateness, and costs of community preventive services identified under paragraph (1) for the purpose of developing, updating, publishing, and disseminating evidence-based recommendations on the use of such services;

"(3) as appropriate, take into account health disparities in developing, updating, publishing, and disseminating evidence-based recommendations on the use of such services;

"(d) SUBGROUPS.—As appropriate to maximize efficiency, the Task Force may delegate authority for conducting reviews and making recommendations to subgroups consisting of Task Force members, subject to final approval by the Task Force.

"(e) CLINICAL PREVENTION STAKEHOLDERS BOARD.—

"(1) IN GENERAL.—The Task Force shall convene a clinical prevention stakeholders board composed of representatives of appropriate public and private entities with an interest in clinical preventive services to advise the Task Force on developing, updating, publishing, and disseminating evidence-based recommendations on the use of clinical preventive services.

"(2) MEMBERSHIP.—The members of the clinical prevention stakeholders board shall include representatives of the following:

"(A) Health care consumers and patient groups.

"(B) Providers of clinical preventive services, including community-based providers.

"(C) Federal departments and agencies, including—

"(i) appropriate health agencies and offices in the Department, including the Office of the Surgeon General of the Public Health Service, the Office of Minority Health, the National Institutes of Health and Health Disparities, and the Office on Women's Health; and

"(ii) as appropriate, other Federal departments and agencies whose programs have a significant impact upon health (as determined by the Secretary).

"(D) Private health care payors.

"(3) REPRESENTATION.—In accordance with subsection (b)(6), the clinical prevention stakeholders board shall—

"(A) recommend clinical preventive services for review;

"(B) suggest scientific evidence for consideration by the Task Force related to reviews undertaken by the Task Force;

"(C) provide feedback regarding draft recommendations by the Task Force; and

"(D) assist with efforts regarding dissemination of recommendations by the Director of the Agency for Healthcare Research and Quality.

"(g) DISCLOSURE AND CONFLICTS OF INTEREST.—Members of the Task Force or the clinical prevention stakeholders board shall not receive any pay for service on the Task Force or the clinical prevention stakeholders board shall be considered to be special Government employees within the meaning of section 107 of the Ethics in Government Act of 1978 (5 U.S.C. App.) and section 208 of title 18, United States Code, for the purposes of disclosure and management of conflicts of interest under those sections.

"(h) NO PAY; RECEIPT OF TRAVEL EXPENSES.—Members of the Task Force or the clinical prevention stakeholders board shall not receive any pay for service on the Task Force or the clinical prevention stakeholders board shall be considered to be special Government employees within the meaning of section 107 of the Ethics in Government Act of 1978 (5 U.S.C. App.) and section 208 of title 18, United States Code.
significant impact upon health (as deter-

Health Disparities, and the Office on Wom-

service, the Office of Minority Health, the

including—

community-based pro-

updating, publishing, and disseminating evi-

dience-based recommendations on the use of

community preventive services.

Payment authority for conducting reviews and

members, subject to

provisions of this title.

the Task Force; and

(e) REPRESENTATION.—In appointing mem-

holders board consisting of representatives of

individuals who possess expertise in at least one

(interests in community preventive serv-

in appropriate and in-kind subsidies and rewards to en-

section (b)(4).

(3) a consortium of 2 or more entities de-

(1) a State, local, or tribal department of

in subparagraph (A) or (B); and

(e) NONDISCRIMINATION; NO TIE TO PRE-

(2) to plan such services.

Against the concept of healthy behavior and adop-

鼠选 seed 2 or more entities described in para-

in subparagraph 2 or more entities described in para-

(2) HEALTH EMPOWERMENT ZONE.—In this

(1) DEFINITION.—To be eligible for a grant

(2) ELIGIBILITY.—To be eligible for a grant

(state A or B, the Secretary shall ensure that the subsidy or reward is included

(1) IN GENERAL.—The Secretary shall con-

under this section, an entity shall be—

(2) FOCUS.—Research and demonstration

(1) DEFINITION.—To be eligible for a grant

(1) IN GENERAL.—The Secretary shall con-

for the purposes of disclosure and management of

section 107 of the Ethics in Gov-

y, the Director of the National Institutes of

the heads of other agencies within

the Department of Health and Human

sections of such Act shall apply to the

(1) State health officers;

(iii) health care practitioners; and

(1) State health officers;

(ii) local health officers; and

(iii) public health practitioners; and

(3) QUALIFICATIONS.—Members of the Task

(1) State health officers; (ii) local health

(i) appropriate public and private entities with

the Task Force or the community prevention

stakeholders board, including—

stakeholders board composed of representatives of

the Task Force shall convene a community prevention

services for review by the Task Force.

following:

(A) Health care consumers and patient

(B) Providers of community preventive

(C) Federal departments and agencies, in-

(i) appropriate health agencies and offices

in paragraphs (3) are represented;

(ii) appropriate, other Federal depart-

and demonstration projects under subsection

(1) the basis of the findings of research and
demonstration projects under subsection (a) or other sources consistent

(1) DEFINITION.—To be eligible for a grant

(2) DISCLOSURE AND CONFLICTS OF INTER-

members of the Task Force or the community prevention

stakeholders board, except members of the

Task Force or the community prevention

stakeholders board shall be considered to be

Special Government employees within the

meaning of section 107 of the Ethics in Gov-

of 5 U.S.C. App.) and section 2308 of title 18, United States Code, for

health promotion; disease prevention; chronic disease;

workplace; and school-site health; qualita-

tive and quantitative analysis; and health

economic, policy, law, and statistics.

(4)—In appointing mem-

(1) the basis of the findings of research and
demonstration projects under subsection (a) or other sources consistent

(1) IN GENERAL.—The Secretary, acting

through the Director of the Centers for Dis-

a per diem, in accordance with app-

lications of such chapter 37 of title 5, United States Code.

Travel Expenses.—Members of the Task Force or the

community prevention stakeholders board shall not receive any pay for service on

enities, including—

and subsection, the term 'Health Empowerment

ZONE' means an area—

and demonstration projects under subsection

(2) CONTENT.—The Federal Advisory Committee

Except for a per diem, in accordance with app-

subsection, the term ‘Health Empowerment

ZONE’ means an area—

same or cost sharing of an individual under any qualified

health benefits plan (as defined in section 100(c)).

(2) ELIGIBILITY.—To be eligible for a grant

or cost sharing of an individual under any qualified

health benefits plan (as defined in section 100(c)).

(1) IN GENERAL.—The Secretary shall con-

the basis of the findings of research and demonstration projects under subsection

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the basis of the findings of research and demonstration projects under subsection

(1) IN GENERAL.—The Secretary shall con-

(2) DISCLOSURE AND CONFLICTS OF INTER-

members of the Task Force or the community prevention

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(2) ELIGIBILITY.—To be eligible for a grant

(1) IN GENERAL.—The Secretary shall con-

(2) DISCLOSURE AND CONFLICTS OF INTER-

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members of the Task Force or the community prevention

stakeholders board, except members of the
"(A) in which multiple community prevention and wellness services are implemented in order to address one or more health disparities, including those identified by the Secretary in the national strategy under section 3121; and

"(B) which is represented by a community partnership that demonstrates community support and coordination with State, local, or tribal health departments and includes—

(i) a broad cross section of stakeholders;

(ii) residents of the community; and

(iii) representatives of entities that have a history of working within and serving the community.

"(c) PREFERENCES.—In awarding grants under this section, the Secretary shall give preference to entities that—

(1) will identification of more goals or objectives identified by the Secretary in the national strategy under section 3121;

(2) will address significant health disparities, including those identified by the Secretary in the national strategy under section 3121;

(3) will address unmet community prevention and wellness needs and avoid duplication of effort;

(4) have been demonstrated to be effective in implementing interventions comparable to the proposed target community;

(5) will contribute to the evidence base for community prevention and wellness services;

(6) demonstrate that the community prevention and wellness services to be funded will be sustainable; and

(7) demonstrate coordination or collaboration across governmental and nongovernmental partners.

"(d) HEALTH DISPARITIES.—Of the funds awarded under this section for a fiscal year, the Secretary shall award not less than 50 percent to grants to State health departments under paragraph (1)(A); and

(2) demonstration of effort;

(3) demonstration that the State's health department will—

(A) in which multiple community prevention and wellness services are implemented in order to address one or more health disparities, including those identified by the Secretary in the national strategy under section 3121;

(B) will address unmet community prevention and wellness needs and avoid duplication of effort;

(C) have been demonstrated to be effective in implementing interventions comparable to the proposed target community;

(D) will contribute to the evidence base for community prevention and wellness services;

(E) demonstrate that the community prevention and wellness services to be funded will be sustainable; and

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(3) demonstration that the State's health department will—

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(3) demonstration that the State's health department will—

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(3) demonstration that the State's health department will—

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(B) will address unmet community prevention and wellness needs and avoid duplication of effort;

(C) have been demonstrated to be effective in implementing interventions comparable to the proposed target community;

(D) will contribute to the evidence base for community prevention and wellness services;

(E) demonstrate that the community prevention and wellness services to be funded will be sustainable; and

(F) demonstrate coordination or collaboration across governmental and nongovernmental partners.
and the Task Force on Community Preventive Services, as in existence on the day before the date of the enactment of this Act, shall be considered to be recommendations of the Task Force on Clinical Preventive Services and the Task Force on Community Preventive Services, respectively, established under sections 3131 and 3132 of the Public Health Service Act, as added by subsection (a).

(2) MEMBERS ALREADY SERVING.—(A) INITIAL MEMBERS.—The Secretary of Health and Human Services may select the individuals already serving on the Preventive Services Task Force and the Task Force on Community Preventive Services, as in existence on the day before the date of the enactment of this Act, to be among the first members appointed to the Task Force on Clinical Preventive Services and the Task Force on Community Preventive Services, respectively, under sections 3131 and 3132 of the Public Health Service Act, as added by subsection (a).

(3) CALCULATION OF TOTAL SERVICE.—In calculating the total years of service of a member of a task force for purposes of section 3131(d)(2)(A) or 3132(d)(2)(A) of the Public Health Service Act, as added by subsection (a), the Secretary of Health and Human Services shall not include any period of service by the member on the Preventive Services Task Force or the Task Force on Community Preventive Services, respectively, as in existence on the day before the date of the enactment of this Act.

(c) PERIOD BEFORE COMPLETION OF NATIONAL STRATEGY.—Pending completion of the national strategy under section 3121 of the Public Health Service Act, as added by subsection (a), the Secretary of Health and Human Services, acting through the relevant agency head, may make a judgment about how the strategy will address an issue and rely on such judgment in carrying out any provision of subtitle C, D, E, or F of title XXXI of such Act, as added by subsection (a), that requires the Secretary—

(1) to take into consideration such strategy;

(2) to conduct or support research or provide services in priority areas identified in such strategy; or

(3) to take any other action in reliance on such strategy.

(d) CONFORMING AMENDMENTS.—

(1) Paragraph (61) of section 3(b) of the Indian Health Care Improvement Act (25 U.S.C. 1602) is amended by striking “United States Preventive Services Task Force” and inserting “Task Force on Clinical Preventive Services”.

(2) Section 126 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Appendix F of Public Law 106–554) is amended by striking “United States Preventive Services Task Force” and inserting “Task Force on Clinical Preventive Services”.

(3) Paragraph (7) of section 317(a) of the Public Health Service Act (42 U.S.C. 300b–7(a)) is amended by striking “United States Preventive Services Task Force” and inserting “Task Force on Clinical Preventive Services”.

(4) Section 915 of the Public Health Service Act (42 U.S.C. 299b–4) is amended by striking subsection (a).

(5) Sections 882(2)(D), 111(1), 121(1), 122(1)(B), and 1861(h)(1)(C)(i) of the Social Security Act (42 U.S.C. 1395x et seq.) are amended by striking “United States Preventive Services Task Force” and inserting “Task Force on Clinical Preventive Services”.

(e) IDENTIFYING EXISTING BEST PRACTICES.—The Director shall identify best practices that are—

(1) currently utilized by health care providers (including hospitals, physicians, and other clinician practices, community co-operatives, and other health care entities) that deliver consistently high-quality, efficient health care services; and

(2) easily adapted for use by other health care providers and for use across a variety of health care settings.

(f) DEVELOPING NEW BEST PRACTICES.—The Director shall develop best practices that are—

(1) based on a review of existing scientific evidence;

(2) sufficiently detailed for implementation and incorporation into the workflow of health care providers; and

(3) designed to be easily adapted for use by health care providers across a variety of health care settings.

(g) EVALUATION OF BEST PRACTICES.—The Director shall evaluate best practices identified or developed under this section. Such evaluation shall—

(1) include determinations of which best practices—

(A) most reliably and effectively achieve significant progress in improving the quality of patient care; and

(B) are easily adapted for use by health care providers across a variety of health care settings;

(2) shall include regular review, updating, and improvement of such best practices; and

(3) may include in-depth case studies or empirical assessments of health care providers (including hospitals, physician and other clinician practices, community co-operatives, and other health care entities) and simulations of such best practices for determinations under paragraph (1).

(h) IMPLEMENTATION OF BEST PRACTICES.—

(1) IN GENERAL.—The Director shall enter into arrangements with entities in a State or region to implement best practices identified or developed under this section. Such implementation—

(A) may include forming collaborative or multi-institutional teams; and

(B) shall include an evaluation of the best practices being implemented, including the measurement of patient outcomes before, during, and after implementation of such best practices;

(2) PREFERENCES.—In carrying out this subsection, the Director shall give priority to health care providers implementing best practices that—

(A) have the greatest impact on patient outcomes and satisfaction;

(B) are the most easily adapted for use by health care providers across a variety of health care settings;

(C) promote coordination of health care practitioners across the continuum of care; and

(D) engage patients and their families in improving patient care and outcomes.

(i) PUBLIC DISSEMINATION OF INFORMATION.—The Director shall provide for the public dissemination of information with respect to best practices and activities under this section. Such information shall be made available in appropriate formats and languages to reflect the varying needs of consumers and diverse levels of health literacy.

(j) REPORT.—

(1) IN GENERAL.—The Director shall submit an annual report to the Congress and the Secretary on activities under this section.

(2) CONTENT.—Each report under paragraph (1) shall include—

(A) information on activities conducted pursuant to grants and contracts awarded;
(B) summary data on patient outcomes before, during, and after implementation of best practices; and
(C) recommendations on the adaptability of best practices for use by health providers.

(2) Initial Quality Improvement Activities to Be Implemented

Until the Director of the Agency for Healthcare Research and Quality has established initial priorities under section 811(b) of the Public Health Service Act, as added by subsection (a), the Director shall, for purposes of such section, prioritize the followings:


2. Surgery.—Increasing hospital and outpatient perioperative patient safety, including reducing surgical-site infections and surgical errors (such as wrong-side surgery and retained foreign bodies).

3. Emergency Room.—Improving care in hospital emergency rooms, including through the use of principles of efficiency of design and delivery to improve patient flow.

4. Obstetrics.—Improving the provision of obstetrical and neonatal care, including the identification of interventions that are effective in reducing the risk of preterm and premature labor and the implementation of best practices for labor and delivery care.

5. Design and delivery to improve patient flow.

6. Appropriate priorities of such section, prioritize the followings:

A. The Assistant Secretary shall coordinate the collection, collation, and dissemination of public and proprietary data on health threatening conditions and risk factors, including—

(a) standardized information.

(b) in consultation with the Director of the Office of the Surgeon General of the Public Health Service, the Office of Minority Health, and the Director of the Office of Civil Rights of the Department.

(c) public and private entities that collect and disseminate information on health and health care, including foundations; and

(d) the head of the Office of the National Coordinator for Health Information Technology to ensure optimal use of health information technology.

(e) Request for Information From Department, Agencies, and Entities, With Applicable Law, the Assistant Secretary may secure directly from any Federal department or agency information necessary to enable the Assistant Secretary to carry out this section.

(f) Report.—

(1) Submission.—The Assistant Secretary shall submit to the Congress an annual report containing—

(A) a description of national, regional, or State changes in health or health care, as reflected by the key health indicators identified under subsection (c)(1);

(B) a description of gaps in the collection, collation, reporting, and publishing of information regarding the Nation’s health and the performance of the Nation’s health care;

(C) recommendations for addressing such gaps and identification of the appropriate Federal department or other entity to address such gaps;

(D) a description of analyses of health disparities, including the results of completed and ongoing longitudinal studies, proposed or planned research; and

(E) a plan for actions to be taken by the Assistant Secretary to address gaps described in subparagraph (B).

(2) Consideration.—In preparing a report under paragraph (1), the Assistant Secretary shall take into consideration the findings and conclusions in the reports under sections 308, 903(a)(6), and 913(b)(2).

(g) Proprietary and Privacy Protections.—Nothing in this section shall be construed to affect applicable proprietary or privacy protections.

(h) Consultation.—In carrying out this section, the Assistant Secretary shall consult with—

(1) the heads of appropriate health agencies and offices in the Department, including the Office of the Secretary of the Department, the Office of the Surgeon General of the Public Health Service, the Office of Minority Health, and the Office on Women’s Health; and

(2) the appropriate offices of other Federal departments and agencies whose programs have a significant impact upon health as determined by the Assistant Secretary.

(i) Definitions.—In this section:

(1) the terms ‘agency’ and ‘agencies’ include an epidemiology center established under section 214 of the Indian Health Care Improvement Act.

(2) The term ‘Department’ means the Department of Health and Human Services.

(b) Other Coordination Responsibilities.—Title III (42 U.S.C. 241 et seq.) is amended—

(1) in paragraphs (1) and (2) of section 306(c) (42 U.S.C. 2424(c)), by inserting ‘‘, acting through the Assistant Secretary for Health Information Technology’’ after ‘‘The Secretary’’ each place it appears; and

(2) in section 306(j) (42 U.S.C. 2424(k)), by inserting ‘‘, acting through the Assistant Secretary for Health Information Technology’’ after ‘‘of this section, the Secretary’’.

SEC. 2403. AUTHORIZATION OF APPROPRIATIONS.

Section 790C, as added and amended, is further amended by adding at the end the following:

(e) Quality and Surveillance.—For the purpose of carrying out part D of title IX and
section 1709, in addition to any other amounts authorized to be appropriated for such purpose, there are authorized to be appropriated, out of any monies in the Public Health Service Fund, $380,000,000 for each of fiscal years 2011 through 2015.

**TITLE V—OTHER PROVISIONS**

Subtitle A—Drug Discount for Rural and Other Hospitals; 340B Program Integrity

SEC. 2501. EXPANSION OF PARTICIPATION IN 340B PROGRAM.

(a) Expansion of Covered Entities Required.—Section 340B(a)(4) (42 U.S.C. 256b(a)(4)) is amended by adding at the end the following:

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(4) In this section—
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(M) A children’s hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(iii) of the Social Security Act, or a free-standing cancer center hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(v)(I) of the Social Security Act that would meet the requirements of subparagraph (L), including the disproportionate share adjustment percentage requirement under clause (ii) of such subparagraph, if the hospital were a subsection (d) hospital as defined by section 1886(d)(1)(B) of the Social Security Act.
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(N) An entity that is a critical access hospital (as determined under section 1820(c)(2) of the Social Security Act) (as defined in section 1861(r)(7) of the Social Security Act).
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(O) An entity receiving funds under part I of part B of title XIX of the Public Health Service Act (relating to comprehensive mental health services) for the provision of community mental health services.
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(P) An entity receiving funds under subpart I of part B of title XIX of the Public Health Service Act (relating to maternal and child health) for the provision of health services.
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(Q) An entity receiving funds under subpart I of part B of title XIX of the Public Health Service Act (relating to maternal and child health) for the provision of treatment services for substance abuse.
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(R) An entity that is a Medicare-dependent, small rural hospital (as defined in section 1866(d)(1)(B)(iv) of the Social Security Act).
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(S) An entity that is a sole community hospital (as defined in section 1866(d)(5)(C) of the Social Security Act).
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(T) An entity that is classified as a rural referral center under section 1886(d)(5)(C) of the Social Security Act.
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(b) Prohibition on Group Purchasing Arrangements.—Section 340B(a) (42 U.S.C. 256b(a)) is amended—

(1) in paragraph (b)—

(A) by adding “and” at the end of clause (I);

(B) by striking “; and” at the end of clause (I) and inserting a period; and

(C) by striking clause (iii); and

(2) in paragraph (c), by redesignating subparagraphs (B) and (E), respectively, as subparagraphs (C) and (E), respectively, and by inserting after subparagraph (B) the following:

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(C) Promoting Use of Group Purchasing Arrangements.—Notwithstanding any prohibition described in paragraph (L), (M), (N), (R), (S), or (T) of paragraph (4) shall not obtain covered outpatient drugs through a group purchasing organization or other group purchasing arrangement.
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SEC. 2502. IMPROVEMENTS TO 340B PROGRAM INTEGRITY.

(a) Integrity Improvements.—Section 340B (42 U.S.C. 256b) is amended—

(1) by striking subsections (c) and (d); and

(2) by inserting after subsection (b) the following:

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(c) Improvements in Program Integrity.—

(1) MANUFACTURER COMPLIANCE.—

(A) IN GENERAL.—From amounts appropriated under paragraph (4), the Secretary shall provide for improvements in compliance by manufacturers with the requirements of this section in order to prevent overcharges and other violations of the discounted pricing requirements specified in this section.

(B) IMPROVEMENTS.—The improvements described in subparagraph (A) shall include the following:

(i) The establishment of a process to enable the Secretary to verify the accuracy of ceiling prices calculated by manufacturers under subsection (a)(5), and provided to covered entities, which shall include the following:

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(D) Developing and publishing, through an appropriate policy or regulatory issuance, standards and methodology for the calculation of ceiling prices under such subsection.
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(ii) The development of procedures for the issuance of refunds to covered entities by manufacturers in the event that the Secretary finds that such payments have been overcharged, including the following:

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(1) Submission to the Secretary by manufacturers of an explanation of why and how the overcharge occurred, how the refunds will be calculated, and to whom the refunds will be issued.
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(iii) Notwithstanding any other provision of law prohibiting the disclosure of ceiling prices or data used to calculate the ceiling price, the provision of access to covered entities and State Medicaid agencies through an Internet website of the Department of Health and Human Services, or contractor to the applicable ceiling prices for covered drugs as calculated and verified by the Secretary.

(iv) The imposition of sanctions in the form of civil monetary penalties, which—

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(I) shall be assessed according to standards and procedures established in regulations promulgated by the Secretary, or to covered entities under this section, for a period of time to be determined by the Secretary, in cases in which the Secretary determines, in accordance with standards and procedures established in regulations, that—

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(1) a violation of a requirement of this section was repeated and knowing; and

(ii) the imposition of a monetary penalty would be insufficient to reasonably ensure compliance.

(v) The referral of matters as appropriate to the Office of Inspector General of Department of Health and Human Services, or other Federal agencies.

(b) DISPUTE RESOLUTION PROCESS.—From amounts appropriated under paragraph (4), the Secretary shall establish and implement an administrative process for the resolution of the Secretary or to covered entities under this section.

(2) COVERED ENTITY COMPLIANCE.—

(A) IN GENERAL.—From amounts appropriated under paragraph (4), the Secretary shall provide for improvements in compliance by covered entities with the requirements of this section in order to prevent diversion and violations of the duplicate discount provision and other requirements under subsection (a)(5).

(B) IMPROVEMENTS.—The improvements described in subparagraph (A) shall include the following:

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(i) The development of procedures to enable and require covered entities to update annually the information on the Internet Web site of the Department of Health and Human Services relating to this section.
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(ii) The development of procedures for the Secretary to verify the accuracy of information regarding covered entities that is listed on the Web site described in clause (i).

(iii) The development of more detailed guidance describing methodologies and options available to covered entities for billing manufacturers and wholesalers in a manner that avoids duplicate discounts pursuant to subsection (a)(5).

(iv) The establishment of a single, universal, and standardized identification system by which each covered entity site can be identified by manufacturers, distributors, covered entities, and the Secretary for purposes of facilitating the ordering, purchasing, and delivery of covered drugs under this section, including the processing of chargebacks for such drugs.

(v) The imposition of sanctions in the form of civil monetary penalties, which—

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(I) shall be assessed according to standards and procedures established in regulations promulgated by the Secretary, or to covered entities under this section, for a period of time to be determined by the Secretary, in cases in which the Secretary determines, in accordance with standards and procedures established in regulations, that—

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(1) a violation of a requirement of this section was repeated and knowing; and

(ii) The imposition of a monetary penalty would be insufficient to reasonably ensure compliance.

(vi) The referral of matters as appropriate to the Food and Drug Administration, the Office of Inspector General of Department of Health and Human Services, or other Federal agencies.

(3) IMPROVEMENTS TO 340B PROGRAM.—From amounts appropriated under paragraph (4), the Secretary shall provide for improvements in compliance by covered entities with the requirements of this section in order to prevent diversion and violations of the duplicate discount provision and other requirements under subsection (a)(5).

(A) Claims by covered entities that manufacturers have violated the terms of their
agreement with the Secretary under subsection (a)(1).

“(B) Claims by manufacturers that covered entities have violated subsection (a)(5)(A) or (a)(5)(C) shall apply to drugs dispensed on or after such date.

(b) EFFECTIVENESS.—The amendments made by this subtitle shall be effective, and shall be taken into account in determining whether a manufacturer is deemed to meet the requirements of section 340B(a) of the Public Health Service Act (42 U.S.C. 256b(a)), and of section 1227(a)(5) of the Social Security Act (42 U.S.C. 1396s-8(a)(5)), notwithstanding any other provision of law.

Subtitle B—Programs

PART 1—GRANTS FOR CLINICS AND CENTERS

SEC. 3511. SCHOOL-BASED HEALTH CLINICS. (a) In general.—Part Q of title III (42 U.S.C. 280h et seq.) is amended by adding at the end the following:

“SEC. 399Z–1. SCHOOL-BASED HEALTH CLINICS.

“(a) Program.—The Secretary shall establish a school-based health clinic program consisting of awarding grants to eligible entities to support the operation of school-based health clinics (referred to in this section as ‘SBHCs’).

“(b) Eligibility.—To be eligible for a grant under this section, an entity shall—

“(1) be an SBHC (as defined in subsection (l)(3)); and

“(2) submit an application at such time, in such manner, and containing such information as the Secretary may require, including at a minimum—

“(A) evidence that the applicant meets all criteria necessary to be designated as an SBHC;

“(B) evidence of local need for the services to be provided by the SBHC;

“(C) an assurance that—

“(i) SBHC services will be provided in accordance with Federal, State, and local laws;

“(ii) the SBHC has established and maintains collaborative relationships with other health care providers in the catchment area of the SBHC;

“(iii) the SBHC will provide onsite access during the academic day when school is in session and has an established network of support services with in-state health providers when the school or SBHC is closed;

“(iv) the SBHC will be integrated into the school environment and will coordinate health services with appropriate school personnel and other community providers co-located at the school; and

“(v) the SBHC providing facility assumes all responsibility for the SBHC administration, operations, and oversight; and

“(D) such other information as the Secretary may require.

“(c) Use of Funds.—Funds awarded under a grant under this section may be used for—

“(1) providing training related to the provision of comprehensive primary health services and additional health services;

“(2) the management and operation of SBHC programs, including through subcontracts; and

“(3) the payment of salaries for health professionals and other appropriate SBHC personnel;

“(d)不得用于支付保险。—In determining the amount of a grant under this section, the Secretary shall take into consideration—

“(1) the financial need of the SBHC;

“(2) State, local, or other sources of funding provided to the SBHC; and

“(3) other factors as determined appropriate by the Secretary.

“(e) Preferences.—In awarding grants under this section, the Secretary shall give preference to SBHCs that—

“(1) have a demonstrated record of service to at least one of the following:

“(A) evidence that the applicant meets all criteria necessary to be designated as an SBHC;

“(B) evidence of local need for the services to be provided by the SBHC;

“(C) an assurance that—

“(i) SBHC services will be provided in accordance with Federal, State, and local laws;

“(ii) the SBHC has established and maintains collaborative relationships with other health care providers in the catchment area of the SBHC;

“(iii) the SBHC will provide onsite access during the academic day when school is in session and has an established network of support services with in-state health providers when the school or SBHC is closed;

“(iv) the SBHC will be integrated into the school environment and will coordinate health services with appropriate school personnel and other community providers co-located at the school;

“(v) the SBHC providing facility assumes all responsibility for the SBHC administration, operations, and oversight; and

“(D) such other information as the Secretary may require.

“(f) Use of Funds.—Funds awarded under a grant under this section may be used for—

“(1) providing training related to the provision of comprehensive primary health services and additional health services;

“(2) the management and operation of SBHC programs, including through subcontracts; and

“(3) the payment of salaries for health professionals and other appropriate SBHC personnel;

“(g)不得用于支付保险。—In determining the amount of a grant under this section, the Secretary shall give preference to SBHCs that—

“(1) have a demonstrated record of service to at least one of the following:

“(A) evidence that the applicant meets all criteria necessary to be designated as an SBHC;

“(B) evidence of local need for the services to be provided by the SBHC;

“(C) an assurance that—

“(i) SBHC services will be provided in accordance with Federal, State, and local laws;

“(ii) the SBHC has established and maintains collaborative relationships with other health care providers in the catchment area of the SBHC;

“(iii) the SBHC will provide onsite access during the academic day when school is in session and has an established network of support services with in-state health providers when the school or SBHC is closed;

“(iv) the SBHC will be integrated into the school environment and will coordinate health services with appropriate school personnel and other community providers co-located at the school;

“(v) the SBHC providing facility assumes all responsibility for the SBHC administration, operations, and oversight; and

“(D) such other information as the Secretary may require.

“(h) Use of Funds.—Funds awarded under a grant under this section may be used for—

“(1) providing training related to the provision of comprehensive primary health services and additional health services;

“(2) the management and operation of SBHC programs, including through subcontracts; and

“(3) the payment of salaries for health professionals and other appropriate SBHC personnel;

“(i) Preferences.—In awarding grants under this section, the Secretary shall give preference to SBHCs that—

“(1) have a demonstrated record of service to at least one of the following:

“(A) evidence that the applicant meets all criteria necessary to be designated as an SBHC;

“(B) evidence of local need for the services to be provided by the SBHC;

“(C) an assurance that—

“(i) SBHC services will be provided in accordance with Federal, State, and local laws;

“(ii) the SBHC has established and maintains collaborative relationships with other health care providers in the catchment area of the SBHC;

“(iii) the SBHC will provide onsite access during the academic day when school is in session and has an established network of support services with in-state health providers when the school or SBHC is closed;

“(iv) the SBHC will be integrated into the school environment and will coordinate health services with appropriate school personnel and other community providers co-located at the school;

“(v) the SBHC providing facility assumes all responsibility for the SBHC administration, operations, and oversight; and

“(D) such other information as the Secretary may require.

“(j) Technical Assistance.—The Secretary shall provide such technical assistance as necessary to the Secretary to carry out the requirements of this section. Such assistance may include fiscal and program management assistance, training in fiscal and program management, operational and administrative support, and the provision of information to the SBHCs of the variety of resources available under this title and how those resources can be best used to meet the health needs of the communities served by the SBHCs.

“(k) Evaluation; Report.—The Secretary shall—

“(1) develop and implement a plan for evaluating SBHCs and monitoring quality performances under the awards made under this section; and

“(2) submit to the Congress on an annual basis a report on the program under this section.

“(l) Definitions.—In this section:

“(1) Comprehensive primary health services.—The term ‘comprehensive primary health services’ means the core services offered by SBHCs, which—

“(A) shall include—

“(i) comprehensive health assessments, diagnosis, and treatment of minor, acute, and chronic medical conditions and referrals to, and followup for, specialty care; and

“(ii) mental health assessments, crisis intervention, counseling, treatment, and referrals for a continuum of services including emergency psychiatric care, community support programs, inpatient care, and outpatient programs; and

“(3) additional services, such as oral health, social, and age-appropriate health education services, including nutritional counseling.

“(2) Medically underserved children and adolescents.—The term ‘medically underserved children and adolescents’ means a population of children and adolescents who are residents of an area designated by the Secretary as an area with a shortage of personal health services and health infrastructure for such children and adolescents.

“(3) School-based health clinic.—The term ‘school-based health clinic’ means a health clinic that—
SEC. 2512. NURSE-MANAGED HEALTH CENTERS.

Title III (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

"PART 5—NURSE-MANAGED HEALTH CENTERS"

"SEC. 399FF. NURSE-MANAGED HEALTH CENTERS."

(a) Program.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall establish a nurse-managed health center program consisting of awarding grants to entities under subsection (b).

(b) Grant.—The Secretary shall award grants to entities—

(1) to plan and develop a nurse-managed health center; or

(2) to operate a nurse-managed health center.

(c) Use of Funds.—Amounts received as a grant under subsection (b) may be used for activities including the following:

(1) Purchasing or leasing equipment.

(2) For the following:

(3) Other activities for planning, developing, or operating as applicable, a nurse-managed health center.

(d) Assurances Applicable to Both Planning and Operation Grants.—

(1) General.—The Secretary may award a grant under this section to an entity only if the entity demonstrates to the Secretary’s satisfaction that—

(2) (2) The following:

(3) (c) The Secretary shall submit to the Congress an annual report on the program under this section.
"(E) Provide services, within the limits of the capacities of the center, to any individual residing or employed in the service area of the center.

(2) The center directly or through contract, to the extent covered for adults in the State Medicaid plan and for children in accordance with section 1905(c) of the Social Security Act, provide equally and periodically screening, diagnosis, and treatment, each of the following services:

(i) Screening, assessment, and diagnosis, including case management.

(ii) Person-centered treatment planning or similar processes, including risk assessment and crisis planning.

(iii) Person-centered services provided by mental health services, including screening, assessment, diagnosis, psychotherapy, substance abuse counseling, medical management, and integrated treatment for mental illness and substance abuse which shall be evidence-based (including cognitive behavioral therapy, dialectical behavioral therapy, motivational interviewing, and other such therapies which are evidence-based).

(iv) Outpatient clinic primary care services, including screening and monitoring of key health and health risk (including screening for diabetes, hypertension, and cardiovascular disease and monitoring of weight, height, body mass index (BMI), blood pressure, blood glucose or HbA1c, and lipid profile).

(v) Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization.

(vi) Targeted case management (services to assist individuals gaining access to needed medical, mental health, and other services and applying for income security and other benefits to which they may be entitled).

(vii) Psychiatric rehabilitation services including skills training, assertive community treatment, family psychoeducation, disability self-management, supported employment, supported housing services, therapeutic foster care services, multisystemic therapy, and other such evidence-based practices as the Secretary may require.

(viii) Perinatal/postpartum and counselor services and family supports.

(G) Maintain linkages, and where possible enter into formal contracts with, inpatient psychiatric facilities and substance abuse detoxification and residential programs.

(H) Make available to individuals served by the center, directly, through contract, or through activities using labor-management training funds as provided for under section 302(c)(6) of the Labor Management Relations Act, 1947 (29 U.S.C. 185(c)(6)), the following services:

(1) To carry out programs that provide, directly or through contract, one or more of the following:
   (A) The provision of paid leave time and the payment of tuition assistance with preferences to incumbent ancillary health care workers to allow their participation in nursing education programs or specialty training or certification programs or to incumbent ancillary health care workers who wish to advance their education in any way that otherwise carry out the purposes of this section.
   (B) Maintaining linkages, and where possible enter into formal contracts with, inpatient psychiatric facilities and substance abuse detoxification and residential programs.
   (C) Providing assistance in preparing for direct care health care workers or staff nurses that are competitive for its market or to incumbent ancillary health care workers to allow their participation in nursing education programs or specialty training or certification programs.
   (D) Providing assistance in preparing for and meeting all nursing licensure tests and requirements.
   (E) Providing stipends for release time and continued health care coverage to incumbent health care workers to allow their participation in nursing education programs, including certified nurse assistants, licensed practical nurses, licensed vocational nurses, and registered nurses.
   (F) Providing assistance in preparing for and meeting all nursing licensure tests and requirements.

(2) To carry out programs that assist nurses in obtaining advanced degrees and certified nurse assistants, licensed practical nurses, licensed vocational nurses, and registered nurses) for incumbent ancillary health care workers.

(3) Supports programs funded under this section to incumbent health care workers to become nurses (including registered nurses) for incumbent ancillary health care workers.

(4) To carry out programs that provide, directly or through contract, the following:
   (A) The provision of paid leave time and continued health care coverage to incumbent health care workers to allow their participation in nursing education programs, including certified nurse assistants, licensed practical nurses, licensed vocational nurses, and registered nurses.
   (B) Continue a joint labor-management training fund which administers the program involved.

(C) The provision of paid release time, incentive compensation, or continued health coverage to staff nurses who desire to work part-time or on a part-time basis.

(3) An exercise of the authority granted in this section for staff nurses to enable them to obtain a bachelor of science in nursing degree, other advanced nursing degrees, specialty training, or career ladder to nursing (including certificate.

(E) The payment of tuition assistance which is managed by a joint labor-management training fund or other jointly administered program.

(1) Matching requirement.

(A) In general.—The Secretary may not make a grant under this section unless the applicant involved agrees, with respect to the costs to be incurred by the applicant in carrying out the programs, to make available non-Federal contributions (in cash or in kind under subparagraph (B)) toward such costs in an amount equal to not less than $1 for each $1 of Federal funds provided in the grant. Such contributions may be made directly or through donations from public or private entities, or may be provided through the cash equivalent of paid release time provided to incumbent worker students.

(B) Determination of amount of non-Federal contributions required in subparagraph (A) may be in cash or in kind (including paid release time, fairly evaluated, including equipment or services and excluded overhead costs). Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

(2) Required collaboration.

(A) Entities carrying out or overseeing programs carried out with assistance provided under this section shall demonstrate collaboration with accredited schools of nursing which may include community colleges and other academic institutions providing associate’s, bachelor’s, or advanced nursing degree programs or specialty training or certification programs.

(f) Use of funds.

(1) Amounts awarded to an entity under a grant under this section shall be used for the following:

(2) To carry out programs that provide education and training to establish nursing career ladders to educate incumbent health care workers to become nurses (including certified nurse assistants, licensed practical nurses, licensed vocational nurses, and registered nurses). Such programs shall include one or more of the following:

(A) Preparing incumbent workers to return to the classroom through English-as-a-second-language education, GED education, college counseling, college classes, and support with entry level college classes that are a prerequisite to nursing.

(B) Providing tuition assistance with preferences to dedicated career nurses to attend community colleges, universities, and accredited schools of nursing with supportive services including tutoring and counseling.

(C) Providing assistance in preparing for and meeting all nursing licensure tests and requirements.

(D) Carrying out orientation and mentorship programs for recently graduated nurses in adjusting to working at the bedside to ensure their retention and postgraduation, and ongoing programs to support nurse retention.

(E) Providing stipends for release time and continued health care coverage to enable incumbent health care workers to participate in education programs.

(2) To carry out programs that assist nurses in obtaining advanced degrees and...
completed specialty training or certification programs and to establish incentives for nurses to assume nurse faculty positions on a part-time or full-time basis. Such programs shall include one or more of the following:

(A) Increasing the pool of nurses with advanced degrees who are interested in teaching by funding programs that enable incumbent nurses to return to school.

(B) Establishing incentives for advanced degree bedside nurses who wish to teach in nursing programs so they can obtain a leave from their bedside position to assume a full- or part-time position as adjunct or full-time faculty without the loss of salary or benefits.

(C) Collaboration with accredited schools of nursing that will allow students at community colleges and other academic institutions providing associate's, bachelor's, or advanced nursing degree programs, or specialty training or certification programs, for nurses to carry out innovative nursing programs which meet the needs of bedside nursing and health care providers.

(g) PREFERENCE.—In awarding grants under this section the Secretary shall give preference to programs that:

(1) provide for improving nurse retention;

(2) provide for improving the diversity of the new nurse graduates to reflect changes in the demographics of the patient population;

(3) provide for improving the quality of nursing education to improve patient care and safety;

(4) have demonstrated success in upgrading incumbent health care workers to become nurses or which have established effective programs or pilots to increase nurse faculty; or

(5) are modeled after or affiliated with such programs described in paragraph (4).

(h) EVALUATION.—

(1) PROGRAM EVALUATIONS.—An entity that receives a grant under this section shall annually report to the Congress an annual report on the activities carried out under the grant and the outcomes of such activities. Such outcomes may include:

(A) an increased number of incumbent workers entering an accredited school of nursing and in the pipeline for nursing programs;

(B) an increased number of graduating nurses and improved nurse graduation and licensure rates;

(C) improved nurse retention;

(D) an increase in the number of staff nurses at the health care facility involved;

(E) an increase in the number of nurses with advanced degrees in nursing;

(F) an increase in the number of faculty;

(G) improved measures of patient quality (which may include staffing ratios of nurses, patient satisfaction rates, and patient safety measures); and

(H) an increase in the diversity of new nurse graduates relative to the patient population.

(2) GENERAL REPORT.—Not later than 2 years after the date of the enactment of this Act, and annually thereafter, the Secretary of Labor shall, using data and information from the reports received under paragraph (1), submit to the Congress a report concerning the overall effectiveness of the grant program carried out under this section.

(i) 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 2011 through 2015.

SEC. 2522. MENTAL AND BEHAVIORAL HEALTH TRAINING.

Part E of title VII (42 U.S.C. 294n et seq.) is amended by adding at the end the following:

``Subpart 3—Mental and Behavioral Health Training''

SEC. 775. MENTAL AND BEHAVIORAL HEALTH TRAINING PROGRAM.

(a) PROGRAM.—The Secretary, acting through the Administrator of the Health Resources and Services Administration and in consultation with the Administrator of the Department of Health and Human Services, shall establish an interdisciplinary mental and behavioral health training program consisting of awarding grants and contracts under subsection (b).

(b) SUPPORT AND DEVELOPMENT OF MENTAL AND BEHAVIORAL HEALTH TRAINING PROGRAMS.—The Secretary shall make grants to, or enter into contracts with, eligible entities—

(1) to plan, develop, operate, or participate in an accredited professional training program for mental and behavioral health professionals to promote—

(A) interdisciplinary training; and

(B) coordination of the delivery of health care within agencies, including health care institutions, community-based settings, and the patient's home;

(2) to provide financial assistance to mental and behavioral health professionals who are participants in any such program, and who plan to work in the field of mental and behavioral health;

(3) to provide development, operate, or participate in an accredited program for the training of mental and behavioral health professionals who plan to teach in the field of mental and behavioral health; and

(4) to provide financial assistance in the form of traineeships and fellowships to mental and behavioral health professionals who are participants in any such program and who plan to teach in the field of mental and behavioral health.

(c) ELIGIBILITY.—To be eligible for a grant or contract under subsection (b), an entity shall be—

(1) an accredited health professions school or training program of psychology, psychiatry, social work, marriage and family therapy, professional mental health or substance abuse counseling, or addiction medicine;

(2) an accredited public or nonprofit private hospital;

(3) a public or private nonprofit entity; or

(4) a consortium of 2 or more entities described in paragraphs (1) through (3).

(d) PREFERENCE.—In awarding grants or contracts under this section, the Secretary shall give preference to eligible entities that have a demonstrated record of at least one of the following:

(1) Training a high or significantly improved percentage of health professionals who serve in underserved communities.

(2) Supporting teaching programs that address the health care needs of vulnerable populations.

(3) Training individuals who are from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among mental and behavioral health professionals).

(4) Training individuals who serve geriatric populations with an emphasis on underserved elderly populations.

(5) Training individuals who serve pediatric populations with an emphasis on under served children.

(e) REPORT.—The Secretary shall submit to the Congress an annual report on the program under this section.

(f) DEFINITION.—In this section:

(1) the term 'interdisciplinary' means collaboration across health professions, specialties, and sub-specialties, which may include, public health, nursing, allied health, dietetics or nutrition, and appropriate health specialties.

(2) the term 'mental and behavioral health professionals' means an individual training or practicing—

(A) in psychology; general, geriatric, child or adolescent psychiatry; social work; marriage and family therapy; professional mental health or substance abuse counseling; or addiction medicine; or

(B) another mental and behavioral health specialty, as deemed appropriate by the Secretary.

(g) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $60,000,000 for each of fiscal years 2011 through 2015. Of the amounts appropriated to carry out this section for a fiscal year, not less than 15 percent shall be used for training programs in psychology.

SEC. 2523. REAUTHORIZATION OF TELEHEALTH AND TELEMEDICINE GRANT PROGRAMS.

(a) TELEHEALTH NETWORK AND TELEHEALTH RESOURCE CENTERS GRANT PROGRAMS.—Section 3303 (42 U.S.C. 254c–14) is amended—

(1) in subsection (a)—

(A) by striking paragraph (3) (relating to frontier communities); and

(B) by inserting after paragraph (2) the following:

(C) BROAD GEOGRAPHIC COVERAGE.—The term 'frontier communities' has the meaning given such term in section 3301.

(2) in subsection (d)(1)—

(A) in subparagraph (B), by striking ''and'' and inserting ';' before the period at the end;

(B) in subparagraph (C), by striking the period at the end and inserting ';' and''; and

(C) by adding at the end the following:

(D) reduce health disparities.''

(3) in subsection (f)(5)(B)(iii)—

(A) in subclause (VII), by inserting ',', including skilled nursing facilities' before the period at the end;

(B) in subclause (IX), by inserting ', including county mental health and public mental health facilities' before the period at the end; and

(C) by adding at the end the following:

(XIII) Renal dialysis facilities.''

(4) by amending subsection (i) to read as follows:

(i) PREFERENCES.—

(1) TELEHEALTH NETWORKS.—In awarding grants under subsection (d), the Secretary shall give preference to eligible entities meeting at least one of the following:

(A) NETWORK.—The eligible entity is a health care provider in, or proposing to form, a health care network that furnishes services in a medically underserved area or a health professional shortage area.

(B) BROAD GEOGRAPHIC COVERAGE.—The eligible entity demonstrates broad geographic coverage in the rural or medically underserved areas of the State or States in which the entity is located.

(C) HEALTH DISPARITIES.—The eligible entity demonstrates how the project to be funded through the grant will address health disparities.

(D) LINKAGES.—The eligible entity agrees to use the grant to establish or develop plans or other strategies that will link rural hospitals and rural health care providers to other hospitals, health care providers, and patients.

(E) EFFICIENCY.—The eligible entity agrees to use the grant to promote greater efficiency in the use of health care resources.
SEC. 2524. NO CHILD LEFT UNIMMUNIZED AGAINST INFLUENZA: DEMONSTRATION PROGRAM USING ELEMENTARY AND SECONDARY SCHOOLS AS INFLUENZA VACCINATION CENTERS.

(a) PURPOSE.—The Secretary of Health and Human Services in consultation with the Secretary of Education, shall award grants to eligible partnerships to carry out demonstration programs designed to test the feasibility of using the Nation’s elementary schools and secondary schools as influenza vaccination centers.

(b) IN GENERAL.—The Secretary shall coordinate with the Secretary of Labor, the Secretary of Education, State Medicaid agencies, State insurance agencies, and private insurers to carry out a program consistent with subsection (c) to ensure that children have coverage for all reasonable and customary expenses related to influenza vaccinations, including the costs of purchasing and administering the vaccine incurred when influenza vaccine is administered outside of the physician’s office in a school or other related setting.

(c) PROGRAM DESCRIPTION.—(1) GRANTS.—From amounts appropriated pursuant to subsection (1), the Secretary shall award grants to eligible partnerships to be used to provide influenza vaccinations to children in elementary and secondary schools, in coordination with school nurses, school health care programs, community health care providers, State insurance agencies, or private insurers.

(2) ACIP RECOMMENDATIONS.—The program under this section shall be designed to administer vaccinations consistent with the recommendations of the Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices (ACIP) for the annual vaccination of all children 5 through 19 years of age.

(3) PARTICIPATION VOLUNTARY.—Participation by a school or an individual shall be voluntary.

(d) USE OF FUNDS.—Eligible partnerships receiving a grant under this section shall ensure the maximum number of children access influenza vaccinations as follows:

(1) COVERED CHILDREN.—To the extent to which payment of the costs of purchasing or administering the influenza vaccine for children is consistent with other federally funded programs or through private insurance, eligible partnerships receiving a grant shall use funds to purchase and administer influenza vaccinations.

(2) CHILDREN COVERED BY OTHER FEDERAL PROGRAMS.—For children who are eligible under other federally funded programs for payment of the costs of purchasing or administering the influenza vaccine, eligible partnerships receiving a grant shall not use funds provided under this section for such costs.

(3) CHILDREN COVERED BY PRIVATE HEALTH INSURANCE.—For children who have private insurance, the Secretary in consultation shall ensure that the program under this section adheres to confidentiality and privacy requirements of section 264 of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note) and section 444 of the General Education Provisions Act (20 U.S.C. 1232g; commonly referred to as the “Family Educational Rights and Privacy Act of 1974”).

(f) APPLICATION.—An eligible partnership desiring a grant under this section shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.
(5) SECRETARY.—Except as otherwise specified, the term “Secretary” means the Secretary of Health and Human Services.

(1) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, and to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2015.

SEC. 2325. EXTENSION OF WISEWOMAN PROGRAM.

Section 1509 of the Public Health Service Act (42 U.S.C. 300n-6a) is amended—

(1) in subsection (A) by striking the heading and inserting “In General.”; and

(B) in the matter preceding paragraph (1), by striking “grants” and “the Secretary” and all that follows through “purpose” and inserting the following: “may make grants to such States for the purpose”; and

(2) in subsection (B)(1), by striking “there are authorized” and all that follows through the period and inserting “there are authorized to be appropriated $70,000,000 for fiscal year 2011, $73,500,000 for fiscal year 2012, $77,000,000 for fiscal year 2013, $81,000,000 for fiscal year 2014, and $85,000,000 for fiscal year 2015.”.

SEC. 2326. HEALTHY TEEN INITIATIVE TO PREVENT TEEN PREGNANCY.

Part B of title III (42 U.S.C. 243 et seq.) is amended by inserting after section 317 the following:

“SEC. 317U. HEALTHY TEEN INITIATIVE TO PREVENT TEEN PREGNANCY.

“(a) PROGRAM.—To the extent and in the amount of appropriations made in advance in appropriations Acts, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a program consisting of making grants, in amounts determined under subsection (c), to each State that submits an application in accordance with subsection (d) for a evidence-based prevention program described in subsection (b).

“(b) USE OF FUNDS.—Amounts received by a State under this section shall be used to conduct or support evidence-based education programs (directly or through grants or contracts) to public or private nonprofit entities, including schools and community-based and faith-based organizations, to reduce teen pregnancy or sexually transmitted diseases.

“(c) DISTRIBUTION OF FUNDS.—The Director shall, for fiscal year 2011 and each subsequent fiscal year, make grants to each State described in subsection (a) in an amount equal to the product of—

“(1) the amount appropriated to carry out this section for the fiscal year; and

“(2) the percentage determined for the State under section 502(c)(1)(B)(ii) of the Social Security Act.

“(d) APPLICATION.—To seek a grant under this section, a State shall submit an application at such time, in such manner, and containing such information and assurance of compliance as the Secretary may require. At a minimum, an application shall to the satisfaction of the Secretary—

“(1) describe the State’s proposal to address the needs of at-risk teens in the State;

“(2) identify the evidence-based education program or programs selected from the evidence-based model that will be made; or

“(3) list any public and private entities with whom the State will collaborate to work, including schools and community-based and faith-based organizations, and demonstrate their capacity to implement the proposed program or programs; and

“(4) identify an independent entity that will evaluate the impact of the program or programs; and

“(5) identify an independent entity that will evaluate the impact of the program or programs.

“(e) EVALUATION.—

“(1) REQUIREMENT.—As a condition on receipt of a grant under this section, a State shall agree—

“(A) to arrange for an independent evaluation of the impact of the programs to be conducted or supported through the grant; and

“(B) to submit reports to the Secretary on such programs and the results of evaluation of such programs.

“(2) FUNDING LIMITATION.—Of the amounts determined under subsection (c), to provide, from non-Federal sources, an amount equal to $1 (in cash or in kind) for each $4 provided through the grant to carry out the activities supported by the grant.

“(f) RULE OF CONSTRUCTION.—This section shall not be construed to preempt or limit any State law regarding parental involvement and decisionmaking in children’s education.

“(g) REGISTRY OF ELIGIBLE PROGRAMS.—The Secretary shall develop not later than 180 days after the date of the enactment of this Act, a publically available registry of programs described in subsection (b), that, as determined by the Secretary—

“(1) meet the definition of the term ‘evidence-based’ in—

“(2) are medically and scientifically accurate;

“(3) provide age-appropriate information.

“(h) USE OF FUNDS.—A grant received by a State under this section shall provide—

“(1) training, technical assistance, and information for the purpose of—

“(2) the percentage determined for the State agrees to provide, from non-Federal sources, an amount equal to $1 (in cash or in kind) for each $4 provided through the grant to carry out the activities supported by the grant.

“(i) DEFINITION.—In this section, the term ‘evidence-based’ means based on a model that has been found, in methodologically sound research—

“(1) to delay initiation of sex;

“(2) to decrease number of partners;

“(3) to reduce teen pregnancy;

“(4) to reduce sexually transmitted infecition rates;

“(5) to improve rates of contraceptive use.

“(j) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there is authorized to be appropriated $50,000,000 for each of fiscal years 2011 through 2015.”.

SEC. 2327. NATIONAL TRAINING INITIATIVES ON AUTISM SPECTRUM DISORDERS.

Title I of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) is amended by adding at the end the following:

“Subtitle F—National Training Initiative on Autism Spectrum Disorders

“SEC. 171. NATIONAL TRAINING INITIATIVE.

“(a) GRANTS AND TECHNICAL ASSISTANCE.—

“(1) GRANTS.—

“(A) IN GENERAL.—The Secretary, in consultation with the Interagency Autism Coordinating Committee, shall award multiple grants to eligible entities to provide individuals (including parents and health, allied health, vocational, and educational professionals) with interdisciplinary training and technical assistance, and information for the purpose of improving services rendered to children and adults with autism, and their families, to address unmet needs related to autism. Such training, education, assistance, and information shall include each of the following:

“(i) Training health, allied health, vocational, and educational professionals to identify, evaluate the needs of, and develop interventions, services, treatments, and supports for children and adults with autism.

“(ii) Developing model services and supports that demonstrate evidence-based practices.

“(iii) Developing programs that allow for the interventions, services, treatments, and supports to be evaluated for fidelity of implementation.

“(iv) Working to expand the availability of evidence-based, lifelong interventions; educational, employment, and transition services; and community supports.

“(v) Providing statewide technical assistance in collaboration with relevant State agencies, institutions of higher education, and service providers; and

“(v) containing such other information and assurances as the Secretary may require.

“(B) ELIGIBLE ENTITY.—To be eligible to receive a grant under this subsection, an entity shall be—

“(i) a University Center for Excellence in Developmental Disabilities Education, Research, and Service; or

“(ii) a comparable interdiscipliary education, research, and service entity.

“(C) APPLICATION REQUIREMENTS.—An entity that desires to receive a grant for a program under this subsection shall submit to the Secretary an application—

“(i) demonstrating that the entity has capacity to—

“(ii) provide technical and clinical assistance to evidence-based practices to evaluate, and provide effective interventions, services, treatments, and supports to, children and adults with autism and their families;

“(II) include individuals with autism and their families as part of the program to ensure that an individual- and family-centered approach is used;

“(III) share and disseminate materials and practices as they are developed, and evaluated to be effective in, the provision of training and clinical assistance; and

“(IV) provide training, technical assistance, interventions, services, treatments, and supports under this subsection state-wide;

“(II) providing assurances that the entity will—

“(i) trainees under this subsection with an appropriate balance of interdisciplinary academic and community-based experiences; and

“(II) to the Secretary, in the manner prescribed by the appropriate grants and contracts law, regarding the number of individuals who have benefitted from, and outcomes of, the provision of training and technical assistance under this subsection;

“(III) providing assurances that training, technical assistance, dissemination of information, and services under this subsection will be—

“(i) consistent with the goals of this Act, the Americans with Disabilities Act of 1990, the Individuals with Disabilities Education Act, and the Elementary and Secondary Education Act of 1965; and

“(ii) conducted in coordination with relevant State agencies, institutions of higher education, and service providers; and

“(IV) containing such other information and assurances as the Secretary may require.

“(D) USE OF FUNDS.—A grant received under this subsection shall be used to provide individuals (including parents and health, allied health, vocational, and educational professionals) with interdisciplinary training and technical assistance, and information for the purpose of improving services rendered to children and adults with autism, and their families, to address unmet needs related to autism. Such training, education, assistance, and information shall include each of the following:

“(i) Training health, allied health, vocational, and educational professionals to identify, evaluate the needs of, and develop interventions, services, treatments, and supports for children and adults with autism.

“(ii) Developing model services and supports that demonstrate evidence-based practices.

“(III) Developing systems and products that allow for the interventions, services, treatments, and supports to be evaluated for fidelity of implementation.

“(IV) Working to expand the availability of evidence-based, lifelong interventions; educational, employment, and transition services; and community supports.

“(V) Providing statewide technical assistance in collaboration with relevant State agencies, institutions of higher education, autism advocacy groups, and community-based service providers.
‘(vi) Working to develop comprehensive systems of supports and services for individuals with autism and their families, including seamless transitions between education and health care for the life course.

‘(vii) Promoting training, technical assistance, dissemination of information, supports, and services.

‘(viii) Developing mechanisms to provide training and technical assistance, including for-credit courses, intensive summer institutes, continuing education programs, distance-based programs, and Web-based information dissemination strategies.

‘(ix) Promoting activities that support community based and individual services and enable individuals with autism and related developmental disabilities to fully participate in society and achieve good quality of life for the life course.

‘(x) Collecting data on the outcomes of training and technical assistance programs to meet statewide needs for the expansion of services to children and adults with autism.

‘(E) AMOUNT OF GRANTS.—The amount of a grant to any entity for a fiscal year under this section shall be not less than $250,000.

‘(2) GRANTS.—(i) AUTHORIZATION.—The Secretary shall reserve 2 percent of the amount appropriated to carry out this subsection for a fiscal year to make a grant to a national organization with demonstrated capacity for providing training and technical assistance to—

‘(A) assist in national dissemination of specific information, including evidence-based research, from interdisciplinary training programs, and when appropriate, other entities whose findings would inform the work performed by entities awarded grants;

‘(B) compile and disseminate strategies and materials that prove to be effective in the provision of training and technical assistance so that the entire network can benefit from the models, materials, and practices developed in individual centers;

‘(C) assist in the coordination of activities of grantees under this subsection;

‘(D) develop a Web portal that will provide linkages to each of the individual training initiatives and provide access to training modules, promising training, and technical assistance practices and other materials developed by grantees;

‘(E) establish a research-based resource for Federal and State policymakers on information concerning the provision of training and technical assistance for the assessment, and provision of services for children and adults with autism;

‘(F) convene experts from multiple interdisciplinary training programs, individuals with autism, and the families of such individuals to discuss and make recommendations with regard to training issues related to assessment, interventions, services, treatment, and supports for children and adults with autism; and

‘(G) undertake any other functions that the Secretary determines to be appropriate.

‘(3) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, there are authorized to be appropriated $8,000,000 for each of fiscal years 2011 through 2015.

‘(4) AUTHORIZATION OF APPROPRIATIONS.—To carry out this subsection, there are authorized to be appropriated $8,000,000 for each of fiscal years 2011 through 2015.

‘(5) PERFORMANCE OF GRANTS.—(a) The term ‘autism’ means an autism spectrum disorder or a related development disability.

‘(b) The term ‘interventions’ means educational methods and positive behavioral support strategies designed to improve or ameliorate symptoms associated with autism.

‘(c) The term ‘minority institution’ has the meaning given to such term in section 365 of the Higher Education Act of 1965.

‘(d) The term ‘services’ means services to assist individuals to live more independently in their communities.

‘(e) The term ‘treatments’ means health services, including mental health services, and support strategies designed to improve or ameliorate symptoms associated with autism.

‘(f) The term ‘University Center for Excellence in Developmental Disabilities Education, Research, and Service’ means a University Center for Excellence in Developmental Disabilities Education, Research, and Service that has been or is funded through the substance D or substance E of section 2528.

‘(g) ‘Other academic institutions’ means a University Center for Excellence in Developmental Disabilities Education, Research, and Service that has been or is funded through the substance D or substance E of section 2528.

‘(h) ‘State’ means a State law (includ”
(1) assess the clinical effectiveness of pharmacist-provided services under the MTM services program, as compared to usual care, including an evaluation of whether enrollees maintain or improve health with fewer hospitalizations and emergency room visits than similar patients not enrolled in the program; 

(2) assess changes in overall health care resource of targeted individuals; 

(3) assess patient and prescriber satisfaction with MTM services; 

(4) analyze the impact of patient-cost-sharing requirements on medication adherence and recommendations for modifications; 

(5) identify and evaluate other factors that may influence medication adherence, including demographic characteristics, clinical characteristics, and health services use of the patient, as well as characteristics of the regimen, pharmacy benefit, and MTM services provided; and 

(6) evaluate the extent to which participating pharmacists who maintain a dispensing role have a conflict of interest in the provision of MTM services, and if such conflict is found, provide recommendations on how such a conflict might be appropriately addressed.

(b) Grant to Development of Performance Measures.—The Secretary may award grants or contracts to eligible entities for the purpose of supporting the development of performance measures that assess the use and effectiveness of medication therapy management services.

SEC. 2520. POSTPARTUM DEPRESSION.

(a) Expansion and Intensification of Activities.—(1) Continuation of Activities.—The Secretary shall expand and intensify activities on postpartum conditions.

(2) Programs for Postpartum Conditions.—In carrying out paragraph (1), the Secretary may continue to conduct research to expand the understanding of the causes of, and treatments for, postpartum conditions, including conducting and supporting the following:

(A) Basic research concerning the etiology and causes of the conditions.

(B) Epidemiological studies to address the frequency of postpartum conditions and the differences among racial and ethnic groups with respect to the conditions.

(C) The development of improved screening and diagnostic technologies.

(D) Clinical research for the development and evaluation of new treatments.

(E) Information and education programs for health professionals and the public, which may include a coordinated national campaign that—

(i) is designed to increase the awareness and knowledge of postpartum conditions;

(ii) may include public service announcements through television, radio, and other media; and

(iii) may focus on—

(I) raising awareness about screening;

(II) educating new mothers and their families about postpartum conditions to promote earlier diagnosis and treatment; and

(III) ensuring that such education includes complete information concerning postpartum conditions, including its symptoms, methods of coping with the illness, and treatment resources.

(b) Report by the Secretary.

(1) Study.—The Secretary shall conduct a study on the effectiveness of screening for postpartum conditions.

(2) Report.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to the Congress a report on the study conducted by paragraph (1) and submit a report to the Congress on the results of such study.

(c) Sense of Congress Regarding Longitudinal Study of Relative Mental Health Consequences for Women of Resolving a Pregnancy.

(1) Service of Congress.—It is the sense of the Congress that the Director of the National Institute of Mental Health may conduct a nationally representative longitudinal study of the period of fiscal years 2011 through 2020 on the relative mental health consequences for women of resolving a pregnancy through adoption, miscarriage, and having an abortion. This study may assess the incidence, timing, magnitude, and duration of the immediate and long-term mental health consequences (positive or negative) of these pregnancy outcomes.

(2) Report.—Beginning not later than 3 years after the date of the enactment of this Act, and periodically thereafter for the duration of the study, such Director may prepare and submit to the Congress reports on the findings of the study.

(d) Definitions for this section:

(1) The term “postpartum condition” means postpartum depression or postpartum psychosis.

(2) The term “Secretary” means the Secretary of Health and Human Services.

(e) Authorization of Appropriations. —For the purpose of carrying out this section, in addition to any other amounts authorized to be appropriated for this purpose, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2013.

SEC. 2530. Grants to Promote Positive Health Behaviors and Outcomes.

Part P of title III (42 U.S.C. 250 et seq.) is amended by adding at the end the following:

“SEC. 2501. Grants to promote positive health behaviors and outcomes.

(a) Grants Authorized.—The Secretary, in collaboration with the Director of the Centers for Disease Control and Prevention and other Federal officials determined appropriate by the Secretary, is authorized to award grants to eligible entities to promote positive health behaviors for populations in medically underserved communities, especially racial and ethnic minority populations:

(1) to educate, guide, and provide outreach in a community setting regarding health behaviors prevalent in medically underserved communities, especially racial and ethnic minority populations;

(2) to educate, guide, and provide experiential learning opportunities that target behavioral risk factors including—

(A) poor nutrition;

(B) physical inactivity;

(C) being overweight or obese;

(D) tobacco use;

(E) alcohol and substance use;

(F) injury and violence;

(G) risky sexual behavior;

(H) untreated mental health problems;

(1) untreated dental and oral health problems; and

(J) understanding informed consent;

(2) to educate and provide guidance regarding effective strategies to promote positive health behaviors within the family;

(3) to provide training and provide outreach regarding enrollment in health insurance including the State Children’s Health Insurance Program under title XXI of the Social Security Act, the Medicaid program under title XVIII of such Act, and Medicaid under title XIX of such Act; and

(4) to educate and refer underserved populations to appropriate health care agencies and community-based programs and organizations in order to increase access to quality health-related services, including preventive health services, and to eliminate duplicative care; or

(5) to educate, guide, and provide home visits to the services regarding maternal health and prenatal care.

(b) Application.—(1) In General.—Each eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary, at such time, in such manner, and accompanied by such information as the Secretary requires.

(2) Contents.—Each application submitted pursuant to paragraph (1) shall—

(A) describe the activities for which assistance is sought under this section;

(B) contain an assurance that, with respect to each community health worker program receiving funds under the grant, such program will provide training and supervision to community health workers to enable such workers to provide authorized program services;

(C) contain an assurance that the applicant will evaluate the effectiveness of community health worker programs receiving funds under the grant; and

(D) contain an assurance that each community health worker program receiving funds under the grant will provide services in the cultural context in which they are primarily intended for the individuals served by the program.

(c) Evidence-Based Interventions.—The Secretary may require that recipient programs provide evidence-based interventions.

(b) Evidence-Based Interventions.—The Secretary may require that recipient programs provide evidence-based interventions.

(c) Collaboration With Academic Institutions.—The Secretary shall encourage community health worker programs receiving funds under this section to collaborate with academic institutions, especially those that graduate a disproportionate number of minority health professionals, regarding the development of comprehensive programs to deliver services under the grant.

(d) Priority.—In awarding grants under subsection (a), the Secretary shall give priority to applicants that—

(1) propose to target geographic areas—

(A) with a high percentage of residents who are eligible for health insurance but are uninsured or underinsured; and

(B) with a high percentage of residents who suffer from chronic diseases including pulmonary conditions, hypertension, heart disease, mental disorders, diabetes, and asthma; and

(C) with a high infant mortality rate;

(2) have experience in providing health-related social services to individuals who are underserved with respect to such services; and

(3) have demonstrated capacity to implement outcome-based payment systems that reward community health worker programs.
health workers for connecting underserved populations with the most appropriate services at the most appropriate time. Nothing in this section shall be construed to require such programs or activities to be developed or assisted under this section.

"(g) QUALITY ASSURANCE AND COST EFFECTIVENESS.—The Secretary shall establish guidelines for assuring the quality of the training and supervision of community health workers under the programs funded under this section and for assuring the cost-effectiveness of such programs.

"(h) MONITORING.—The Secretary shall monitor community health worker programs identified in approved applications under this section and determine whether such programs are in compliance with the guidelines established under subsection (g).

"(i) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to community health worker programs identified in approved applications under this section with respect to planning, developing, and operating programs under the grant.

"

''(j) REPORT TO CONGRESS.—

''(1) IN GENERAL.—Not later than 4 years after the date on which the Secretary first awards grants under subsection (a), the Secretary shall submit to Congress a report regarding the grant project.

''(2) CONTENTS.—The report required under paragraph (1) shall include the following:

(A) A description of the programs for which grant funds were used.

(B) The number of individuals served under such programs.

(C) An evaluation of—

(i) the effectiveness of such programs;

(ii) the cost of such programs; and

(iii) the impact of the programs on the health outcomes of the community residents.

(D) Recommendations for sustaining the community health worker programs developed or assisted under this section.

(E) Recommendations regarding training to enhance career opportunities for community health workers.

''(k) DEFINITIONS.—In this section:

''(1) COMMUNITY HEALTH WORKER.—The term ‘community health worker’ means an individual who promotes health or nutrition within the community in which the individual resides.

(A) by serving as a liaison between communities and health care agencies;

(B) by providing guidance and social assistance to community residents;

(C) by enhancing community residents’ ability to effectively communicate with health care providers;

(D) by providing culturally and linguistically appropriate health or nutrition education;

(E) by advocating for individual and community needs, including oral and mental, or nutrition needs; and

(F) by providing referral and followup services or otherwise coordinating care.

''(2) COMMUNITY.—The term ‘community setting’ means a home or a community organization located in the neighborhood in which a participant resides.

''(3) MEDICALLY UNDERSERVED COMMUNITY.—The term ‘medically underserved community’ means a community identified by a State, United States territory or possession, or zone of the Commonwealth of the Northern Mariana Islands, or the Virgin Islands, as being a medically underserved community that has been designated under section 333.

''(4) MEDICALLY UNDERSERVED.—The term ‘medical need’ means the provision of training, supervision, and materials needed to effectively deliver the services described in subsection (b), reimbursement for services, and other benefits.

''(5) ELIGIBLE ENTITY.—The term ‘eligible entity’ means a public or private nonprofit entity that has experience in the public or private subvention of a State, a public health department, or a federally qualified health center, or is a consortium of any of such entities, located in the United States or territories.

''(6) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $30,000,000 for each of fiscal years 2011 through 2015.

SEC. 2531. MEDICAL LIABILITY ALTERNATIVES.

(a) INCENTIVE PAYMENTS FOR MEDICAL LIABILITY REFORM.

(1) IN GENERAL.—To the extent and in the amounts made available in advance in appropriations Acts, the Secretary shall make an incentive payment, in an amount determined by the Secretary, to each State that has an alternative medical liability law in compliance with this section.

(2) DETERMINATION BY SECRETARY.—The Secretary shall determine that a State has an alternative medical liability law in compliance with this section if the Secretary is satisfied that—

(A) the State enacted the law after the date of the enactment of this Act and is implementing the law;

(B) the law is effective; and

(C) the contents of the law are in accordance with paragraph (4).

(3) CONSIDERATIONS FOR DETERMINING EFFECTIVENESS.—In determining whether an alternative medical liability law is effective under paragraph (2)(B), the Secretary shall consider whether the law—

(A) makes the medical liability system more reliable by reducing the risk of uninsured, or prompt and fair resolution of, disputes;

(B) encourages the discouragement of health care errors; and

(C) maintains access to affordable liability insurance.

(4) CONTENTS OF ALTERNATIVE MEDICAL LIABILITY LAW.—The contents of an alternative medical liability law are in accordance with this paragraph if—

(A) the litigation alternatives contained in the law consist of certificate of merit, early offer, or both;

(B) the law does not limit attorneys’ fees or impose caps on damages;

(C) no limitation on other state laws;

(D) nothing in this section shall be construed to—

(i) preempt or modify the application of any existing State law that limits attorneys’ fees or imposes caps on damages;

(ii) the cost of such programs; and

(iii) the impact of the programs on the health outcomes of the community residents.

(D) Recommendations for sustaining the community health worker programs developed or assisted under this section.

(E) Recommendations regarding training to enhance career opportunities for community health workers.

(F) By providing culturally and linguistically appropriate health or nutrition education;

(G) By advocating for individual and community needs, including oral and mental, or nutrition needs; and

(H) By providing referral and followup services or otherwise coordinating care.

(2) COMMUNITY.—The term ‘community setting’ means a home or a community organization located in the neighborhood in which a participant resides.

(3) MEDICALLY UNDERSERVED COMMUNITY.—The term ‘medically underserved community’ means a community identified by a State, United States territory or possession, or zone of the Commonwealth of the Northern Mariana Islands, or the Virgin Islands, as being a medically underserved community that has been designated under section 333.

(4) MEDICALLY UNDERSERVED.—The term ‘medical need’ means the provision of training, supervision, and materials needed to effectively deliver the services described in subsection (b), reimbursement for services, and other benefits.

(5) ELIGIBLE ENTITY.—The term ‘eligible entity’ means a public or private nonprofit entity that has experience in the public or private subvention of a State, a public health department, or a federally qualified health center, or is a consortium of any of such entities, located in the United States or territories.

(6) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $30,000,000 for each of fiscal years 2011 through 2015.

SEC. 2532. INFANT MORTALITY PILOT PROGRAMS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ‘Secretary’), acting through the Director, shall award grants to eligible entities proposing to serve any of the 15 counties or groups of counties with the highest rates of infant mortality in the United States in the past 3 years.

(b) FUNDING.—Of the funds received under this section, the Secretary shall use such sums as may be necessary to remain available until expended.

(c) PREFERENCE.—In awarding grants under this section, the Secretary shall give preference to eligible entities proposing to serve any of the 15 counties or groups of counties with the highest rates of infant mortality in the United States in the past 3 years.

(d) REPORTS.—Beginning not later than one year after receiving a grant, and annually thereafter for the duration of the grant, the entity that receives a grant under subsection (a) shall submit a report to the Secretary detailing its infant mortality pilot program.

(e) CONTENTS OF REPORT.—The reports required under paragraph (1) shall include information such as the methodology of, and outcomes and statistics from, the grantee’s infant mortality pilot program.

(f) EVALUATION.—The Secretary shall—

(1) in general.—Not later than 1 year after receiving a grant, and annually thereafter for the duration of the grant, the entity that receives a grant under subsection (a) shall submit a report to the Secretary detailing its infant mortality pilot program.

(2) CONTENTS OF REPORT.—The reports required under paragraph (1) shall include information such as the methodology of, and outcomes and statistics from, the grantee’s infant mortality pilot program.

(3) EVALUATION.—The Secretary shall use the reports required under paragraph (1) to...
(e) REPORT.—The Secretary shall submit to the Congress an annual report on the program carried out under this section.

(f) DEFINITIONS.—In this section:

(1) THE TERM "SECONDARY SCHOOL" means the profession of any member of the health workforce, as defined in section 764(i) of the Public Health Service Act, as added by section 2261.

(2) The term "local educational agency" has the meaning given to the term in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 791).

(3) The term "secondary school"—(A) means a secondary school, as defined in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 791); and

(B) includes any such school that is a middle school.

SEC. 2533. SECONDARY SCHOOL HEALTH SCIENCES TRAINING PROGRAM. (a) PROGRAM.—The Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration, and in consultation with the Secretary of Education, may establish a health sciences training program consisting of awarding grants and contracts under this section to provide secondary school students for careers in health professions.

(b) DEVELOPMENT AND IMPLEMENTATION OF HEALTH SCIENCES CURRICULA.—The Secretary may make grants to, or enter into contracts with, eligible entities—

(1) to plan, develop, or implement secondary school health sciences curricula, including curricula in biology, chemistry, physiology, mathematics, nutrition, and other sciences deemed appropriate by the Secretary to prepare students for associate’s or bachelor’s degree programs in health professions or bachelor’s degree programs in health professions-related majors; and

(2) to increase the interest of secondary school students in applying to, and enrolling in, accredited associate’s or bachelor’s degree programs in health professions or bachelor’s degree programs in health professions-related majors, including through—

(A) work-study programs;

(B) provide increased awareness of careers in health professions; and

(C) other activities to increase such interest.

(1) ELIGIBILITY.—To be eligible for a grant or contract under subsection (b), an entity shall—

(i) be a local educational agency; and

(ii) provide assurances that activities under the grant or contract will be carried out in partnership with an accredited health professions school or program, public or private non-profit, or public or private non-profit entity.

(d) PREFERENCE.—In awarding grants and contracts under subsection (b), the Secretary shall give preference to entities that have a demonstrated record of at least one of the following:

(1) Graduating a high or significantly improved percentage of students who have achieved mastery in secondary school State science standards.

(2) Graduating students from disadvantaged backgrounds, including racial and ethnic minorities who are underrepresented in—

(A) associate’s or bachelor’s degree programs in health professions or bachelor’s degree programs in health professions-related majors; or

(B) health professions.

SEC. 3400. COMMUNITY-BASED COLLABORATIVE CARE NETWORK PROGRAM. (a) In general.—The Secretary shall provide grants or contracts for the purpose of establishing model projects to accomplish the following goals:

(1) To reduce unnecessary use of items and services furnished in emergency departments of hospitals (especially to ensure that individuals without health insurance coverage or with inadequate health insurance coverage are provided with services of a primary care provider instead of the services of a primary care provider) through methods such as—

(A) screening individuals who seek emergency department services for possible eligibility under relevant governmental health programs or for subsidies under such programs; and

(B) providing such individuals referrals for followup care and chronic condition care.

(2) To manage chronic conditions to reduce their severity, negative health outcomes, and costs.

(3) To encourage health care providers to coordinate their efforts so that the most vulnerable patient populations seek and obtain primary care.

(4) To provide more comprehensive and coordinated care to vulnerable low-income individuals and individuals without health insurance coverage or with inadequate coverage.

(5) To provide mechanisms for improving both quality and efficiency of care for low-income individuals and families, with an emphasis on those most likely to remain uninsured despite the existence of government programs to make health insurance more affordable.

(6) To increase preventive services, including screening and counseling, to those who lack such services and to improve such screening, in order to improve health status and reduce long-term complications and costs.

(7) To ensure the availability of community-wide safety net services, including emergency and trauma care.

(b) Eligibility and Grantee Selection.—

(1) Application.—A community-based collaborative care network described in subsection (d) shall submit to the Secretary an application in such form and manner and containing such information as specified by the Secretary. Such information shall at a minimum include—

(A) identify the health care providers participating in the community-based collaborative care network proposed by the applicant; and

(B) if a proposal submitted in paragraph (d)(1)(B) is not included, the reason such provider is not so included;

(2) include a description of how the proposal plan to collaborate to provide comprehensive and integrated care for low-income individuals, including uninsured and underinsured individuals;

(3) include a description of the organizational and joint governance structure of the community-based collaborative care network in a manner so that it is clear how decisions will be made and how the decision-making process of the network will include appropriate representation of the participating entities;

(4) define the geographic areas and populations that the network intends to serve;

(5) define the scope of services that the network intends to provide and identify any reasons why such services would not include a suggested core service identified by the Secretary under paragraph (3);

(6) demonstrate the network’s ability to meet the requirements of this section; and

(7) provide assurances that funds received shall be used to support the entire community-based collaborative care network.

(c) Selection of grantees.—

(1) In general.—The Secretary shall select community-based collaborative care networks to receive grants from applications submitted under paragraph (1) on the basis of the quality of the proposal submitted, geographic diversity (including different States and regions served and urban and rural diversity), the number of low-income and uninsured individuals that the proposal intends to serve.

(2) Granting Entity.—The Secretary shall give priority to proposals from community-based collaborative care networks that—

(i) include the capability to provide the broadest range of services to low-income individuals and families;

(ii) include providers that currently serve a high volume of low-income individuals.

(d) Completion of grant or contract.—

(C) RENEWAL.—In subsequent years, based on the grantee’s performance, the Secretary may provide renewal grants to prior year grant recipients.

(2) SUGGESTED CORE SERVICES.—For purposes of paragraph (1)(E), the Secretary shall develop a list of suggested core patient and core network services to be provided by a
community-based collaborative care network. The Secretary may select a community-based collaborative care network under paragraph (2), the application of which does not include all such services. If such application provides a reasonable explanation why such services are not proposed to be included, and the Secretary determines that the application is otherwise high quality.

"(4) TERMINATION AUTHORITY.—The Secretary may terminate selection of a community-based collaborative care network under this subsection if the collaborative care network fails to meet the Secretary's governing standard, and the Secretary shall include a determination that the network fails to meet a comprehensive range of coordinated and integrated health care services as required under subsection (d)(2).

"(B) has failed to meet reasonable quality standards;

"(C) has misappropriated funds provided under this section; or

"(D) has failed to provide a comprehensive range of coordinated and integrated health care services as required under subsection (d)(2);

"(E) has failed to make progress toward accomplishing goals set out in subsection (a).

"(e) USE OF FUNDS.—

"(1) USE BY GRANTEES.—Grant funds are provided to community-based collaborative care networks to carry out the following activities:

"(A) Assist low-income individuals without adequate health care coverage to—

"(i) access and appropriately use health services;

"(ii) enroll in applicable public or private health insurance programs;

"(iii) obtain referrals to and see a primary care provider in case such an individual does not have a primary care provider; and

"(iv) obtain appropriate care for chronic conditions.

"(B) Improve health care by providing case management, application assistance, and appropriate referrals such as through methods to—

"(i) create and meaningfully use a health information technology network to track patients across collaborative providers;

"(ii) improve health outreach, such as by using neighborhood health workers who may inform individuals about the availability of safety net and primary care providers available through the community-based collaborative care network;

"(iii) provide for followup outreach to re- mind patients of appointments or follow-up care needed; and, otherwise providing an urgent care alternative to an emergency department; and

"(iv) provide transportation to individuals to and from the site of care;

"(v) expand the capacity to provide care at any provider participating in the community-based collaborative care network, including telehealth, hiring new clinical or administrative staff, providing access to services and other services not specified in the community-based collaborative care network.

"(C) ADDITIONAL INCLUSIONS.—Each such network may include any of the following additional providers:

"(1) A hospital, including a critical access hospital (as defined in section 1862(o)(2) of the Social Security Act (42 U.S.C. 1395i–4(o)(2))).

"(2) A county or municipal department of health.

"(3) A rural health clinic or a rural health network (as defined in sections 1861(aa) and 1820(d) of the Social Security Act, respectively (42 U.S.C. 1395x(aa) located in the geographic area served by the Coordinated Care Network);

"(D) REQUIRED INCLUSION.—Each such network shall include—

"(1) a primary care provider or medication management provider in the network and the health professional providing care to and from the site of care;

"(2) a rural health clinic or a rural health network that is otherwise eligible for funding that may be spent on direct care services after hours, on weekends, or otherwise provided to community-based collaborative care networks to include at least the services described in their application and approved by the Secretary.

"(A) the number of people served;

"(B) any other type of provider specified by the Secretary, which has a desire to serve low-income and uninsured patients.

"(D) Community-based collaborative care networks shall not affect federally qualified health centers' eligibility for program participation.

"(E) Providing for the approval by the Secretary of the scope of community-based collaborative care network services for each network that addresses an appropriate minimum scope of work consistent with the setting of the network and the health professionals and public for each network.

"(F) Providing for the approval by the Secretary of the scope of community-based collaborative care network services for each network that addresses an appropriate minimum scope of work consistent with the setting of the network and the health professionals and public for each network.

"(3) CLARIFICATION.—Participation in a community-based collaborative care network shall not disqualify the network provider from reimbursement under title XVIII, XIX, or XXI of the Social Security Act with respect to any other eligible patient. Nothing in this section shall prevent a community-based collaborative care network that is otherwise eligible for participation in a contract with Medicare, a private health insurer, or any other appropriate entity to provide care under Medicare, under health insurance coverage offered by the insurer, or otherwise.

"(e) EVALUATIONS.—

"(1) GRANTEE REPORTS.—Beginning in the third year following an initial grant, each community-based collaborative care network shall submit to the Secretary, with respect to each year the grantee has received a grant, an evaluation of the activities carried out by the community-based collaborative care network under the community-based collaborative care network program and shall include—

"(A) the number of people served;

"(B) any common health problems treated;

"(C) any reductions in emergency department use; and

"(D) any improvements in access to primary care.

"(2) AN ACCOUNTING OF HOW MUCH FUNDS ARE USED; INCLUD INDICATION OF THE AMOUNTS USED FOR EACH PROVIDER. Any other type of provider specified by the Secretary, which has a desire to serve low-income and uninsured patients.

"(D) Community-based collaborative care networks shall not affect federally qualified health centers' eligibility for program participation.

"(E) Providing for the approval by the Secretary of the scope of community-based collaborative care network services for each network that addresses an appropriate minimum scope of work consistent with the setting of the network and the health professionals and public for each network.

"(F) Providing for the approval by the Secretary of the scope of community-based collaborative care network services for each network that addresses an appropriate minimum scope of work consistent with the setting of the network and the health professionals and public for each network.

"(3) CLARIFICATION.—Participation in a community-based collaborative care network shall not disqualify the network provider from reimbursement under title XVIII, XIX, or XXI of the Social Security Act with respect to any other eligible patient. Nothing in this section shall prevent a community-based collaborative care network that is otherwise eligible for participation in a contract with Medicare, a private health insurer, or any other appropriate entity to provide care under Medicare, under health insurance coverage offered by the insurer, or otherwise.

"(4) EVALUATIONS.—

"(1) GRANTEE REPORTS.—Beginning in the third year following an initial grant, each community-based collaborative care network shall submit to the Secretary, with respect to each year the grantee has received a grant, an evaluation of the activities carried out by the community-based collaborative care network under the community-based collaborative care network program and shall include—

"(A) the number of people served;

"(B) any common health problems treated;

"(C) any reductions in emergency department use;

"(D) any improvements in access to primary care.

"(2) AN ACCOUNTING OF HOW MUCH FUNDS ARE USED; INCLUD INDICATION OF THE AMOUNTS USED FOR EACH PROVIDER. Any other type of provider specified by the Secretary, which has a desire to serve low-income and uninsured patients.

"(D) Community-based collaborative care networks shall not affect federally qualified health centers' eligibility for program participation.

"(E) Providing for the approval by the Secretary of the scope of community-based collaborative care network services for each network that addresses an appropriate minimum scope of work consistent with the setting of the network and the health professionals and public for each network.

"(F) Providing for the approval by the Secretary of the scope of community-based collaborative care network services for each network that addresses an appropriate minimum scope of work consistent with the setting of the network and the health professionals and public for each network.

"(3) CLARIFICATION.—Participation in a community-based collaborative care network shall not disqualify the network provider from reimbursement under title XVIII, XIX, or XXI of the Social Security Act with respect to any other eligible patient. Nothing in this section shall prevent a community-based collaborative care network that is otherwise eligible for participation in a contract with Medicare, a private health insurer, or any other appropriate entity to provide care under Medicare, under health insurance coverage offered by the insurer, or otherwise.

"(4) EVALUATIONS.—

"(1) GRANTEE REPORTS.—Beginning in the third year following an initial grant, each community-based collaborative care network shall submit to the Secretary, with respect to each year the grantee has received a grant, an evaluation of the activities carried out by the community-based collaborative care network under the community-based collaborative care network program and shall include—

"(A) the number of people served;

"(B) any common health problems treated;

"(C) any reductions in emergency department use;

"(D) any improvements in access to primary care.

"(2) AN ACCOUNTING OF HOW MUCH FUNDS ARE USED; INCLUD INDICATION OF THE AMOUNTS USED FOR EACH PROVIDER. Any other type of provider specified by the Secretary, which has a desire to serve low-income and uninsured patients.

"(D) Community-based collaborative care networks shall not affect federally qualified health centers' eligibility for program participation.

"(E) Providing for the approval by the Secretary of the scope of community-based collaborative care network services for each network that addresses an appropriate minimum scope of work consistent with the setting of the network and the health professionals and public for each network.

"(F) Providing for the approval by the Secretary of the scope of community-based collaborative care network services for each network that addresses an appropriate minimum scope of work consistent with the setting of the network and the health professionals and public for each network.
“(F) to the extent requested by the Secretary, any quality measures or any other measures specified by the Secretary.

(2) PROGRAM REPORTS.—The Secretary shall establish a nationwide evaluation of the program, including an evaluation of the impact of any grants under this section, the Secretary shall submit to Congress an annual evaluation report regarding the program, including an evaluation of the impact of any grants under this section.

(3) AUDIT AUTHORITY.—The Secretary may conduct periodic audits and request periodic spending reports of community-based collaborative care networks under the community-based collaborative care network program.

(4) CLARIFICATION.—Nothing in this section requires a provider to report individually the information of an individual to government agencies, unless the individual consents, consistent with HIPAA privacy and security law, as defined in section 3801(a).

(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $10,000,000 for fiscal year 2011 and such sums as may be necessary for each of fiscal years 2012 through 2015.

SEC. 2535. COMMUNITY-BASED OVERWEIGHT AND OBESITY PREVENTION PROGRAM.

Part Q of title III (42 U.S.C. 200h et seq.) is amended by inserting after section 399W the following:

SEC. 399W.1. COMMUNITY-BASED OVERWEIGHT AND OBESITY PREVENTION PROGRAM.

(a) PROGRAM.—The Secretary shall establish and administer a demonstration program to prevent the overweight and obesity prevention program consisting of awarding grants and contracts under subsection (b).

(b) GRANTS.—The Secretary shall award grants to, or enter into contracts with, eligible entities:

(1) to plan evidence-based programs for the prevention of overweight and obesity among children and their families through improved nutrition and increased physical activity;

(2) to implement such programs.

(c) ELIGIBILITY.—To be eligible for a grant or contract under subsection (b), an entity shall demonstrate community support and includes—

(1) a broad cross section of stakeholders, such as—

(A) hospitals, health care systems, community health centers, or other health care providers;

(B) universities, local educational agencies, or childcare providers;

(C) State, local, and tribal health departments;

(D) State, local, and tribal park and recreation departments;

(E) employers; and

(F) health insurance companies;

(2) residents of the community; and

(3) providers of public and private entities that have a history of working with within and serving the community.

(d) PERIOD OF AWARDS.—

(1) IN GENERAL.—The period of a grant or contract under this section shall be 5 years, subject to renewal under paragraph (2).

(2) RENEWAL.—At the end of each fiscal year, the Secretary may renew a grant or contract award under this section only if the grant or contract recipient demonstrates to the Secretary that the recipient has made appropriate, measurable progress in preventing overweight and obesity.

(e) REQUIREMENTS.—

(1) IN GENERAL.—The Secretary may award a grant or contract under this section to an entity that demonstrates to the Secretary's satisfaction that—

(A) not later than 90 days after receiving the grant or contract, the entity will establish a steering committee to provide input on the assessment of, and recommendations on improvements to, the entity's program funded through the grant or contract; and

(B) the entity has conducted or will conduct an assessment of the overweight and obesity problem in its community, including the extent of the problem and factors contributing to the problem.

(2) MATCHING REQUIREMENT.—The Secretary may award a grant or contract to an eligible entity under this section only if the entity demonstrates to the Secretary that funds received through the grant or contract will be expended for any activity to the extent that payment has been made, or can reasonably be expected to be made—

(1) under any insurance policy;

(2) under Federal or State health benefits programs (including titles XIX and XXI of the Social Security Act); or

(3) by an entity which provides health services on a prepaid basis.

(f) MAINTENANCE OF EFFORT.—The Secretary may award a grant or contract under this section to an entity only if the entity demonstrates to the satisfaction of the Secretary that—

(1) funds received through the grant or contract will be expended only to supplement, and not supplant, Federal and non-Federal funds otherwise available to the entity for the activities to be funded through the grant or contract; and

(2) with respect to such activities, the entity will maintain expenditures of non-Federal amounts for such activities at a level not less than the lesser of such expenditures maintained by the entity for the fiscal year preceding the fiscal year in which the entity receives the grant or contract.

(g) PREFERENCES.—In awarding grants and contracts under this section, the Secretary shall give preference to eligible entities that—

(1) will serve communities with high levels of overweight and obesity and related chronic diseases; or

(2) will plan or implement activities for the prevention of overweight and obesity in school or other settings.

(h) REPORT.—The Secretary shall submit to the Congress an annual report on the program of grants and contracts awarded under this section.

(i) DEFINITIONS.—In this section:

(1) ‘‘Evidence-based’’ means that methodology, research that has demonstrated a beneficial health effect in the judgment of the Secretary and includes the Ways to Enhance Children’s Activity and Nutrition (We Can) program and curriculum of the National Institutes of Health.

(2) ‘‘The term ‘local educational agency’ has the meaning given to that term in section 9101 of the Elementary and Secondary Education Act of 1965.

(3) ‘‘Authorization of Appropriations.—The term ‘grant or contract’ means such sums as may be appropriated $10,000,000 for fiscal year 2011 and such sums as may be necessary for each of fiscal years 2012 through 2015.

SEC. 2536. REDUCING STUDENT-TO-SCHOOL NURSE RATIOS.

(a) DEMONSTRATION GRANTS.—

(1) IN GENERAL.—The Secretary of Education shall, in consultation with the Secretary of Health and Human Services and the Director of the Centers for Disease Control and Prevention, make demonstration grants to eligible local educational agencies for the purpose of reducing the student-to-school nurse ratio in public elementary and secondary schools.

(2) SPECIAL CONSIDERATION.—In awarding grants under this section, the Secretary of Education shall give special consideration to applications submitted by high-need local educational agencies to demonstrate the greatest need for new or additional nursing services among children in the public elementary and secondary schools served by the entity.

(b) PROGRAM.—The Secretary shall submit to the Congress a report on the results of the demonstration grant program carried out under this section, including an evaluation of the effectiveness of the program in improving the student-to-school nurse ratios described in subsection (a) and an evaluation of the impact of any resulting enhanced health of students on learning.

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

(1) ‘‘Eligible local educational agency’’ means a local educational agency in which the student-to-school nurse ratio in the public elementary and secondary schools served by the agency is 750 or more students to every school nurse.

(2) The term ‘‘high-need local educational agency’’ means a local educational agency that meets the following:

(A) that serves not fewer than 10,000 children from families with incomes below the poverty line; or

(B) which for not less than 20 percent of the children served by the agency are from families with incomes below the poverty line.

(3) The term ‘‘nurse’’ means a licensed nurse, as defined under State law.

SEC. 2537. MEDICAL-LEGAL PARTNERSHIPS.

(a) IN GENERAL.—The Secretary shall establish and administer a demonstration project consisting of—
(1) awarding grants to, and entering into contracts with, medical-legal partnerships to assist patients and their families to navigate health-related programs and activities; and
(2) evaluating the effectiveness of such partnerships.

(b) Use of Funds.—Amounts received as a grant or contract under this section shall be used to develop and build their families to navigate health care-related programs and activities and thereby achieve one or more of the following goals:

(1) Enhancing access to health care services.
(2) Improving health outcomes for low-income individuals.
(3) Reducing health disparities.
(4) Enhancing wellness and prevention of chronic conditions.

(c) Prohibition.—No funds under this section may be used—

(1) for any medical malpractice or other civil action or proceeding; or
(2) to assist individuals who are not lawfully present in the United States.

(d) Report.—Not later than 5 years after the date of the enactment of this Act, the Secretary shall submit to the Congress a report on the results of the demonstration project under this section. Such report shall include the following:

(1) Information on the extent to which medical-legal partnerships funded through this section achieved the goals described in subsection (b).
(2) Recommendations on the possibility of extending or expanding the demonstration project.

(e) Definitions.—In this section:

(1) the term "medical-legal partnership" has the meaning given to the term in section 3171 of the Public Health Service Act, as added by section 201.
(2) The term "medical-legal partnership" means an entity—

(A) that is a collaboration between—

(i) a community health center, public hospital, children’s hospital, or other provider of health care services to a significant number of low-income beneficiaries; and
(ii) one or more attorneys; and

(B) whose primary mission is to assist patients and their families navigate health care-related programs and activities.

(3) The term "Secretary" means the Secretary of Health and Human Services.

(f) Authorization of Appropriations.—To carry out this section, there are authorized to be appropriated—

SEC. 2538. SCREENING, BRIEF INTERVENTION, REFERRAL, AND TREATMENT FOR MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS.

Part D of title V (42 U.S.C. 290dd et seq.) is amended by adding at the end the following:

"SEC. 544. SCREENING, BRIEF INTERVENTION, REFERRAL, AND TREATMENT FOR MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS.

(a) Program.—The Secretary, acting through the Administrator, shall establish a program of awarding grants, contracts, and cooperative agreements under subsection (b) on mental health and substance abuse screening, brief intervention, referral, and recovery services for individuals in primary health care settings.

(b) Use of Funds.—The Secretary may award grants to, or enter into contracts or cooperative agreements with, entities—

(1) to provide mental health and substance abuse screening, brief interventions, referral, and recovery services; and
(2) to coordinate these services with primary health care services in the same program and setting.

(3) to develop a network of facilities to which patients may be referred if needed;
(4) to purchase needed screening and other tools that are—

(A) necessary for providing these services; and
(5) supported by evidence-based research;

(b) Screening.—To be eligible for a grant or contract, or cooperative agreement under this section, an entity shall be a public or private nonprofit entity that—

(1) provides primary care services;
(2) seeks to integrate mental health and substance abuse services into its service system;
(3) has developed a working relationship with providers of mental health and substance abuse services;
(4) demonstrates a need for the inclusion of mental health and substance abuse services in its service system; and

(5) agrees—

(A) to prepare and submit to the Secretary an evaluation of all activities funded through the grant, contract, or cooperative agreement; and

(B) to use funds and performance measures as may be stipulated by the Secretary for purposes of such evaluation.

(c) Preference.—In awarding grants, contracts, and cooperative agreements under this section, the Secretary shall give preference to entities that—

(1) provide services in rural or frontier areas of the Nation;
(2) provide services to special needs populations, including American Indian or Alaska Native populations;
(3) provide services in school-based health clinics or on university and college campuses;

(d) Duration.—The period of a grant, contract, or cooperative agreement under this section may not exceed 5 years.

(e) Report.—Not later than 4 years after the first appropriation of funds to carry out this section, the Secretary shall submit a report to the Congress on the program under this section—

(1) including an evaluation of the benefits of integrating mental health and substance abuse care within primary health care; and

(2) focusing on the performance measures stipulated by the Secretary under subsection (c)(6).

(f) Authorization of Appropriations.—

(1) In general.—To carry out this section, there are authorized to be appropriated $30,000,000 for fiscal year 2011 and such sums as may be necessary for each of fiscal years 2012 through 2015.

(2) Program Management.—Of the funds appropriated to carry out this section for a fiscal year, the Secretary may use not more than 5 percent to manage the program under this section.

SEC. 2539. GRANTS TO ASSIST IN DEVELOPING MEDICAL SCHOOLS IN FEDERALLY IDENTIFIED HEALTH PROFESSIONAL SHORTAGE AREAS.

(a) Grants Authorized.—The Secretary of Health and Human Services may make grants to nonprofit organizations or institutions of higher education for the purpose of assisting the organization or institution involved to develop a medical school if—

(1) the medical school will be located in an area that is designated (under section 332 of the Public Health Service Act (42 U.S.C. 258(e) as a health professional shortage area;

(2) the institution provides services that are necessary for the Secretary to meet the needs of substantially private or public funding from non-Federal sources for the development of the medical school; and

(3) the organization or institution provides assurances satisfactory to the Secretary that accreditation will be achieved for the medical school.

(b) Use of Grant Funds.—Grants awarded under this section may be used for the acquisition and building of the medical school campus in a health professional shortage area and the purchase of equipment, curriculum and faculty development, and general operations related to the operation and establishment of the medical school.

(c) Authorization of Appropriations.—For the purpose of carrying out this section, there is authorized to be appropriated $100,000,000 for each of fiscal years 2011 through 2015.

Page 1523, strike lines 5 through 17 and insert the following:

(1) In General.—A violation of subparagraph (A) shall be subject to enforcement by the Federal Trade Commission in the same manner, by the same means, and with the same jurisdiction as would an unfair and deceptive act or practice in or affecting interstate commerce or an unfair method of competition in or affecting interstate commerce prohibited under section 5 of the Federal Trade Commission Act, as though all applicable Federal Trade Commission Act were incorporated into and made a part of this subsection.

PART 3—EMERGENCY CARE-RELATED PROGRAMS

SEC. 2551. TRAUMA CARE CENTERS.

(a) Grants for Trauma Care Centers.—

(1) In general.—The Secretary shall establish a trauma center program consisting of awarding grants under section (b).

(2) Grants.—The Secretary shall award grants as follows:

(1) Existing centers.—Grants to public, private nonprofit, Indian Health Service, Indian tribal, and urban Indian trauma centers—

(A) to further the core missions of such centers; or

(B) to provide emergency relief to ensure the continued and future availability of trauma services by trauma centers—

(i) at risk of closing or operating in an area where a closing has occurred within their primary service area; or

(ii) in need of financial assistance following a natural disaster or other catastrophic event, such as a terrorist attack.

(2) New centers.—Grants to local governments and public or private nonprofit entities to establish new trauma centers in urban areas with a substantial degree of trauma resulting from violent crimes.

(c) Minimum Qualifications of Trauma Centers.

(1) Participation in Trauma Care System Operating Under Certain Professional Guidelines. —

(A) Limitation.—Subject to subparagraph (B), the Secretary may not award a grant to an existing trauma center under this section unless the center is a participant in a trauma care system that substantially complies with section 1213.

(B) Exemption.—Subparagraph (A) shall not apply to trauma centers that are located in states with no existing trauma care system.

(2) Designation.—The Secretary may not award a grant under this section to an existing trauma center unless the center—

(A) verified as a trauma center by the American College of Surgeons; or

(B) is a designated urban Indian trauma center.
“(B) designated as a trauma center by the applicable State health or emergency medical services authority.”.

(b) CONSIDERATIONS IN MAKING GRANTS.—Section 1241(b) (42 U.S.C. 300d–42) is amended to read as follows:

“SEC. 1242. CONSIDERATIONS IN MAKING GRANTS.

“(a) CORE MISSION AWARDS.—

“(1) IN GENERAL.—In awarding grants under section 1241(b)(1)(A), the Secretary shall—

“(A) of the amount allocated for such grants for level I and level II trauma centers in rural or underserved areas; and

“(B) reserve a minimum of 25 percent of the amount allocated for such grants for level III and level IV trauma centers in rural or underserved areas; and

“(C) give preference to any application made by a trauma center—

“(i) in a geographic area where growth in demand for trauma services exceeds capacity;

“(ii) that demonstrates the financial support of the State or political subdivision involved;

“(iii) that has at least 1 graduate medical education fellowship in trauma or trauma-related specialties, including neurological surgery, general surgery, orthopedic surgery, otolaryngology, obstetrics and gynecology, and internal medicine, for which demand is exceeding supply; or

“(iv) that demonstrates a substantial commitment to the training and development of providers;

“(2) give preference to any application made by a trauma center—

“(A) providing or will provide trauma care in an urban area with a substantial degree of trauma resulting from violence;

“(B) giving priority to the care of patients who are in a trauma center in a State which has not designated 4 levels of trauma centers, any reference in this section to a trauma center shall be deemed to be a reference to a trauma center under section 1241(b); and

“(C) giving priority to the care of patients who are in a trauma center in a State which has not designated 4 levels of trauma centers, any reference in this section to a trauma center shall be deemed to be a reference to a trauma center under section 1241(b); and

“(2) give preference to any application made by a trauma center—

“(A) providing or will provide trauma care in a geographic area in which the availability of trauma care has either significantly decreased or increased, or the result of a trauma center in the area permanently ceasing participation in a system described in section 1241(c)(1) as of a date occurring during the 3-year period preceding the fiscal year for which the center received such grants;

“(B) giving priority to the care of patients who are in a trauma center in a State which has not designated 4 levels of trauma centers, any reference in this section to a trauma center shall be deemed to be a reference to a trauma center under section 1241(b); and

“(C) giving preference to the care of patients who are in a trauma center in a State which has not designated 4 levels of trauma centers, any reference in this section to a trauma center shall be deemed to be a reference to a trauma center under section 1241(b); and

“(2) give preference to any application made by a trauma center—

“(A) providing or will provide trauma care in a geographic area where growth in demand for trauma services exceeds capacity;

“(B) will, in providing trauma care during the 1-year period beginning on the date on which the application for the grant is submitted, incur substantial uncompensated care costs in an amount that renders the center unable to continue participation in such system or significantly decrease in the availability of trauma care in the geographic area.

“(C) and (2) of section 1241(b). The Secretary may not award a grant under section 1241(b) unless the applicant agrees that, during the period in which the trauma center involved will continue participation, or in the case of a new center will participate, in the system described in section 1241(c)(1), except as provided in section 1241(c)(1)(B), throughout the grant period beginning on the date that the center first receives payments under the grant; and

“(D) give preference to any application made by a trauma center—

“(A) providing or will provide trauma care in a geographic area where growth in demand for trauma services exceeds capacity;

“(B) will, in providing trauma care during the 1-year period beginning on the date on which the application for the grant is submitted, incur substantial uncompensated care costs in an amount that renders the center unable to continue participation in such system or significantly decrease in the availability of trauma care in the geographic area.

“(C) and (2) of section 1241(b). The Secretary may not award a grant under section 1241(b) unless the applicant agrees that, during the period in which the trauma center involved will continue participation, or in the case of a new center will participate, in the system described in section 1241(c)(1), except as provided in section 1241(c)(1)(B), throughout the grant period beginning on the date that the center first receives payments under the grant; and

“(1) a level I or level II trauma center is deemed to be a reference to a trauma center within the highest 2 levels of trauma centers designated under paragraph (1)(A) and (1)(B), and

“(2) a level III or IV trauma center is deemed to be a reference to a trauma center not within such highest 2 levels.

“(c) DESIGNATIONS OF LEVELS OF TRAUMA CENTERS IN CERTAIN STATES.—In the case of a State which has not designated 4 levels of trauma centers, any reference in this section to a trauma center shall be deemed to be a reference to a trauma center under section 1241; and

“(d) REPORT.—Beginning 2 years after the date of the enactment of the Affordable Care Act, the Committee shall annually—

“(1) report on the status of the grants made pursuant to section 1241;

“(2) evaluate and report to Congress on the overall financial stability of trauma centers in the United States;

“(3) report on the populations using trauma care centers and include aggregate patient data on income, race, ethnicity, and geography; and

“(4) evaluate the effectiveness and efficiency of trauma care center activities using standard public health measures and evaluation methodologies.”.

“SEC. 1243. CERTAIN AGREEMENTS.

“(a) COMMITMENT REGARDING CONTINUED PARTICIPATION IN THE SYSTEM.—The Secretary may not award a grant to an applicant under section 1241(b) unless the applicant agrees that—

“(1) the trauma center involved will continue participation, or in the case of a new center will participate, in the system described in section 1241(c)(1), except as provided in section 1241(c)(1)(B), throughout the grant period beginning on the date that the center first receives payments under the grant; and

“(2) if the agreement made pursuant to paragraph (1) is violated by the center, the center will be liable to the United States for an amount equal to the sum of—

“(A) the amount provided to the center under section 1241; and

“(B) an amount representing interest on the amount specified in subparagraph (A).

“(b) MAINTENANCE OF FINANCIAL SUPPORT.—With respect to activities for which funds awarded through a grant under section 1241 are authorized to be expended, the Secretary may not award such a grant unless the applicant agrees that, during the period in which the trauma center involved is receiving payments under the grant, the center will continue to receive payments from other governmental funding, the amount of which is at least equal to the amount provided under section 1241(b) during the fiscal year in which the grant period expires; and

“(1) reasonable volume fluctuation that is not caused by intentional trauma boundary reduction;

“(2) downgrading of the level of services; and

“(3) whether such center diverts its incoming patients away from such center 5 percent or more of the time during which the center is in operation over the course of the year.

“(c) TRAUMA CARE REGISTRY.—The Secretary shall establish, within the Office of the Assistant Secretary for Preparedness and Response, an emergency care coordination center (in this section referred to as the ‘Center’), to be headed by a director.

“(d) EMERGENCY CARE COORDINATION CENTER.—The Center shall provide emergency care coordination in coordination with the Federal Interagency

“H12778

CONGRESSIONAL RECORD — HOUSE

November 7, 2009
Committee on Emergency Medical Services, shall—

“(A) promote and fund research in emergency medicine and trauma health care;

“(B) establish partnerships and more effective emergency medical systems in order to enhance appropriate triage, distribution, and care of routine community patients;

“(C) promote local, regional, and State emergency medical systems' preparedness for and response to public health events.

(b) COUNCIL OF EMERGENCY CARE—

“(1) ESTABLISHMENT.—The Secretary, acting through the Director of the Center, shall establish a Council of Emergency Care to provide advice and recommendations to the Director on carrying out this section.

“(2) COMPOSITION.—The Council shall be comprised of representatives of the departments and agencies of the Federal Government who are experts in emergency care and management.

“(c) REPORT.—

“(1) SUBMISSION.—Not later than 12 months after the date of the enactment of the Affordable Health Care for America Act, the Secretary shall submit to the Congress an annual report on the activities carried out under this section.

“(2) CONSIDERATIONS.—In preparing a report under paragraph (1), the Secretary shall consider factors including—

“(A) emergency department crowding and boarding; and

“(B) delays in care following presentation.

“(d) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated—

“(1) an amount for each fiscal year, the Secretary shall reserve 3 percent of such costs in an amount that is not less than 25 percent of such costs.

“SEC. 2553. PILOT PROGRAMS TO IMPROVE EMERGENCY MEDICAL CARE—

Part B of title III (42 U.S.C. 243 et seq.) is amended by inserting after section 314 the following:

“SEC. 315. REGIONALIZED COMMUNICATION SYSTEMS FOR EMERGENCY CARE RESPONSE—

“(a) In General.—The Secretary, acting through the Assistant Secretary for Preparedness and Response, shall award not fewer than 4 multiyear contracts or competitive grants to eligible entities to support demonstration programs that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care systems.

“(b) ELIGIBLE ENTITY: REGION.—

“(1) ELIGIBLE ENTITY.—In this section, the term ‘eligible entity’ means a State or a partnership of 1 or more States and 1 or more local governments.

“(2) REGION.—In this section, the term ‘region’ means an area within a State, an area that lies within multiple States, or a similar area (such as a multicounty area), as determined by the Secretary.

“(c) DEMONSTRATION PROGRAM.—The Secretary shall award a contract or grant under subsection (a) to an eligible entity that—

“(1) coordinates with public safety services, public health services, medical services, medical facilities, and other entities within a region;

“(2) coordinates an approach to emergency medical system access throughout the region, including 9–1–1 public safety answering points and emergency medical dispatch;

“(3) includes personnel, training, emergency medical services (or equivalent State office), a regional medical direction or transport command, and a regional medical training program; and

“(4) includes a categorization or designation system for special medical facilities throughout the region that is—

“(I) consistent with State laws and regulations; and

“(II) integrated with the protocols for transport and destination throughout the region;

“(v) includes a consistent regionwide patient tracking system, a patient tracking system, and a resource allocation system that—

“(A) provides for a day-to-day emergency care system operation; and

“(B) can manage surge capacity during a major event or disaster; and

“(III) is integrated with other components of the national and State emergency preparedness system;

“(B) an agreement to make available non-Federal contributions in accordance with subsection (e); and

“(C) such other information as the Secretary may require.

“(e) MATCHING FUNDS.—

“(1) IN GENERAL.—With respect to the costs of the activities to be carried out each year under a contract or grant under subsection (a), the Secretary shall make available non-Federal contributions toward such costs in an amount that is not less than 25 percent of such costs.

“(2) DETERMINATION OF AMOUNT CONTRIBUTED.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including plant, equipment, or services. Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of such non-Federal contributions.

“(f) PRIORITY.—The Secretary shall give priority for the award of the contracts or grants described in subsection (a) to any eligible entity that serves a medically underserved population (as defined in section 330(b)(3)).

“SEC. 315A. ASSISTING VETERANS WITH MILITARY EMERGENCY MEDICAL TRAINING—

(a) In General.—Part B of title III (42 U.S.C. 243 et seq.), as amended, is amended by inserting after section 315 the following:

“SEC. 315A. ASSISTING VETERANS WITH MILITARY EMERGENCY MEDICAL TRAINING TO BECOME STATE-LICENSED OR CERTIFIED EMERGENCY MEDICAL TECHNICIANS (EMTS).—

“(a) PROGRAM.—The Secretary shall establish a program consisting of awarding grants to States to assist veterans who received and completed military emergency medical training while serving in the Armed Forces of the United States to become, upon their
discharge or release from active duty service, State-licensed or certified emergency medical technicians.

“(b) Use of Funds.—Amounts received as a grant under this section may be used to assist veterans described in subsection (a) to become State-licensed or certified emergency medical technicians as follows:

(1) Providing training.

(2) Providing reimbursement for costs associated with—

(A) training; or

(B) applying for licensure or certification.

(3) Expediting the licensing or certification process.

“(c) Eligibility.—To be eligible for a grant under this section, a State shall demonstrate to the Secretary’s satisfaction that the State is in need of shortage of emergency medical technicians.

“(d) Report.—The Secretary shall submit to the Congress an annual report on the program under this section.

“(e) Authorization of Appropriations.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2015.

(b) GAO Study and Report.—The Comptroller General of the United States shall—

(1) conduct a study on the barriers experienced by veterans who received training as medical personnel while serving in the Armed Forces of the United States and, upon their discharge or release from active duty service, seek to become licensed or certified in a State as civilian health professionals; and

(2) not later than 2 years after the date of enactment of this Act, submit to the Congress a report on the results of such study, including recommendations on whether the program established under section 315A of the Public Health Service Act, as added by subsection (a), should be expanded to assist veterans seeking to become licensed or certified in a State as health providers other than emergency medical technicians.

SEC. 2554. DENTAL EMERGENCY RESPONDERS: PUBLIC HEALTH AND MEDICAL RESPONSE.

(a) National Health Security Strategy.—Section 2502(b)(3) (42 U.S.C. 300h–3(b)(3)) is amended—

(1) in the matter preceding subparagraph (A), by inserting “dental” and before “mental health facilities”;

(2) in subparagraph (B), by inserting “and dental” after “medical”;

(b) All-Hazards Public Health and Medical Response Curriculum and Training.—Section 319F(a)(5)(B) (42 U.S.C. 247d–6a(a)(5)(B)) is amended by striking “public health or medical” and inserting “public health, medical, or dental”.

SEC. 2555. DENTAL EMERGENCY RESPONDERS: HOMELAND SECURITY.


(b) National Preparedness System.—Subparagraph (B) of section 653(b)(4) of the Post-Katrina Emergency Management Reform Act of 2006 (6 U.S.C. 733(b)(4)) is amended by striking “public health and medical” and inserting “public health, medical, and dental”.

(c) Chief Medical Officer.—Paragraph (5) of section 516(c) of the Homeland Security Act of 2002 (6 U.S.C. 516(c)) is amended by striking “medical community” and inserting “medical and dental communities”.

PART IV—PAIN CARE AND MANAGEMENT PROGRAMS

SEC. 2561. INSTITUTE OF MEDICINE CONFERENCE ON PAIN.

(a) Convening.—Not later than June 30, 2011, the Institute of Medicine of the National Academies shall seek to enter into an agreement with the Institute of Medicine of the National Academies to convene a Conference on Pain in this section referred to as “the Conference”.

(b) Purpose.—The purposes of the Conference shall be—

(1) increase the recognition of pain as a significant public health problem in the United States;

(2) evaluate the adequacy of assessment, diagnosis, treatment, and management of acute and chronic pain in the general population, and in identified racial, ethnic, gender, age, and other demographic groups that may be disproportionately affected by inequities in the assessment, diagnosis, treatment, and management of pain;

(3) identify barriers to appropriate pain care, including—

(A) lack of understanding and education among employers, patients, health care providers, and third party payers; and

(B) barriers to access to care at the primary, specialty, and tertiary care levels, including barriers—

(i) specific to those populations that are disproportionately undertreated for pain;

(ii) related to physician concerns over regulatory and law enforcement policies applicable to some pain therapies; and

(iii) attributable to benefit, coverage, and payment policies in both the public and private sectors; and

(C) gaps in basic and clinical research on the symptoms and causes of pain, and potential assessment methods and new treatments to improve pain care; and

(d) Establish regulations for action in both the public and private sectors that will reduce such barriers and significantly improve the state of pain care research, education, and clinical care in the United States.

(c) Other Appropriating Entity.—If the Institute of Medicine declines to enter into an agreement under subsection (a), the Secretary of Health and Human Services may enter into such agreement with another appropriate entity.

(d) Report.—A report summarizing the Conference’s findings and recommendations shall be submitted to the Congress not later than June 30, 2012.

(e) Authorization of Appropriations.—For the purpose of carrying out this section, there is authorized to be appropriated $500,000 for each of fiscal years 2011 and 2012.

SEC. 2562. PAIN RESEARCH AT NATIONAL INSTITUTES OF HEALTH.

(a) Research Initiatives.—

(1) In General.—The Director of NIH is encouraged to continue and expand, through the Pain Consortium, an aggressive program of basic and clinical research on the causes of and potential treatments for pain.

(b) Annual Recommendations.—Not less than annually, the Pain Consortium, in consultation with the Division of Program Coordination, Planning, and Strategic Initiatives, shall develop and submit to the Director of NIH recommendations on appropriate pain research initiatives that should be undertaken with funds reserved under section 402A(c)(1) for the Common Fund or otherwise available for such initiatives.

(c) Definitions.—In this section, the term ‘Pain Consortium’ means the Pain Consortium of the National Institutes of Health or a similar trans-National Institutes of Health coordinating entity designated by the Secretary for purposes of this subsection.

(d) Interagency Pain Research Coordinating Committee.—

(1) Establishment.—The Secretary shall establish not later than 1 year after the date of enactment of this section and as necessary maintain a committee, to be known as the Interagency Pain Research Coordinating Committee (in this section referred to as the ‘Committee’), to coordinate all efforts within the Department of Health and Human Services and other Federal agencies that relate to pain research.

(2) Membership.—

(A) In General.—The Committee shall be composed of the following voting members:

(i) Not more than 7 voting Federal representatives as follows:

(1) The Director of the Centers for Disease Control and Prevention.

(2) The Director of the National Institutes of Health and the directors of such national research institutes and national centers as the Secretary determines appropriate.

(3) The heads of such other agencies of the Department of Health and Human Services as the Secretary determines appropriate.

(B) Additional Members.—The Committee shall include additional voting members appointed by the Secretary as follows:

(i) Six members shall be appointed from among scientists, physicians, and other health professionals, who—

(1) are not officers or employees of the United States; and

(ii) represent multiple disciplines, including clinical, basic, and public health sciences;

(ii) represent different geographical regions of the United States; and

(iv) are from practice settings, academia, manufacturers, or other research settings.

(d) Review of the Committee.—The Chairperson of the Committee shall select a chairperson from among such members. The selection of a chairperson shall be subject to the approval of the Director of NIH, but in no case less often than once each year.

(e) Meetings.—The Committee shall meet at the call of the chairperson of the Committee or upon the request of the Director of NIH.

(f) Duties.—The Committee shall—

(1) develop a summary of pain care research supported or conducted by the Federal agencies relevant to the diagnosis, prevention, and treatment of pain and diseases and disorders associated with pain;

(2) identify critical gaps in basic and clinical research on the symptoms and causes of pain;

(3) make recommendations to ensure that the activities of the National Institutes of Health and other Federal agencies, including the Department of Defense and the Department of Veteran Affairs, are free of unnecessary duplication of effort; and

(4) make recommendations on how best to disseminate information on pain care; and
HEALTH AND HUMAN SERVICES

PUBLIC HEALTH AND SICKNESS INSURANCE

PUBLIC AWARENESS CAMPAIGN ON PAIN MANAGEMENT.

Part B of title II (42 U.S.C. 328 et seq.) is amended by adding at the end the following:

SEC. 249. NATIONAL EDUCATION OUTREACH AND AWARENESS CAMPAIGN ON PAIN MANAGEMENT.

(a) Establishment.—Not later than 12 months after the date of the enactment of this section, the Secretary shall establish and implement a national pain care education and awareness campaign with the following.

(b) Requirements.—The Secretary shall design the public awareness campaign under this section to educate consumers, patients, their families, and other caregivers with respect to—

(1) the incidence and importance of pain as a national public health problem;
(2) the adverse physical, psychological, emotional, societal, and financial consequences that can result if pain is not adequately assessed, diagnosed, treated, or managed;
(3) the availability, benefits, and risks of all pain treatments and management options;
(4) having pain promptly assessed, appropriately diagnosed, treated, and managed, and regularly reassessed with treatment adjusted as needed;
(5) the role of credentialed pain management specialists and subspecialists, and of comprehensive interdisciplinary centers of treatment that address pain;
(6) the availability in the public, non-profit, and private sectors of pain management-related information, services, and resources for consumers, employers, third-party payors, patients, their families, and caregivers, including information on—

(A) appropriate assessment, diagnosis, treatment, and management options for all types of pain and pain-related symptoms; and
(B) conditions for which no treatment options are currently available; and
(7) other issues the Secretary deems appropriate.

(c) Consultation.—In designing and implementing the public awareness campaign required by this section, the Secretary shall consult with organizations representing patients in pain and other consumers, employers, physicians including physicians specializing in pain care, other pain management professionals, medical device manufacturers, and pharmaceutical companies.

(d) Codification.—

(1) Lead Official.—The Secretary shall designate one official in the Department of Health and Human Services to oversee the campaign established under this section.

(2) Agency Coordination.—The Secretary shall ensure the involvement in the public awareness campaign under this section of the Surgeon General of the Public Health Service, the Director of the Centers for Disease Control and Prevention, and such other representatives of offices and agencies of the Department of Health and Human Services as the Secretary determines appropriate.

(e) Underrepresented Areas and Populations.—In designing and implementing the public awareness campaign under this section, the Secretary shall—

(1) take into account the special needs of geographic areas and racial, ethnic, gender, age, and other demographic groups that are currently underserved; and
(2) provide resources that will reduce disparities in access to appropriate diagnosis, assessment, and treatment.

(f) Grants and Contracts.—The Secretary shall enter into cooperative agreements, cooperative agreements, and contracts with public agencies and private nonprofit organizations to assist with the development and implementation of the public awareness campaign under this section.

(g) Evaluation and Report.—Not later than the end of fiscal year 2012, the Secretary shall prepare and submit to the Congress a report evaluating the effectiveness of the public awareness campaign under this section in educating the general public with respect to the matters described in subsection (b).

(h) Authorization of Appropriations.—For purposes of carrying out this section, there are authorized to be appropriated $2,000,000 for fiscal year 2011 and $4,000,000 for each of fiscal years 2012 and 2013.

Subtitle C—Food and Drug Administration

PART I—IN GENERAL

SEC. 2571. NATIONAL MEDICAL DEVICE REGISTRY.

(a) Registry.—

(1) IN GENERAL.—Section 519 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360i) is amended—

(A) by redesignating subsection (g) as subsection (h); and
(B) by inserting after subsection (f) the following:

"(g) National Medical Device Registry

(1) establishment.—The Secretary shall establish a national medical device registry (in this subsection referred to as the 'registry') to facilitate the pooling and analysis of data from covered devices.

(B) In this subsection, the term 'covered device'—

(i) shall include each class III device; and
(ii) may include, as the Secretary determines appropriate and specifies in regulations, a class II device that is life-supporting or life-sustaining.

(2) In the case of covered devices that are sold on or after the date of the enactment of this subsection, the Secretary shall—

(A) obtain access to disparate sources of information to identify each covered device, the type, model, and serial number or other unique identifier;
(B) validate methods for analyzing patient safety and outcomes data obtained from covered devices, the type, model, and serial number or other unique identifier;
(C) in developing the registry, the Secretary shall, in consultation with the Commissioner of Food and Drugs, the Administrator of the Centers for Medicare & Medicaid Services, the Administrator of the Agency for Healthcare Research and Quality, the head of the Office of the National Coordinator for Health Information Technology, and the Secretary of Veterans Affairs, determine the best methods for—

(i) including in the registry, in a manner and form that protects patient privacy and is comprehensive, useful, and not misleading to patients, physicians, and scientists, information and is comprehensive, useful, and not misleading to patients, physicians, and scientists;

(ii) link data obtained under clause (i) with information in the registry.

(B) In this paragraph, the term "data" refers to information respecting a covered device, including claims data, patient survey data, standardized analytic files that allow the pooling and analysis of data from disparate data environments, electronic health records, and any other data deemed appropriate by the Secretary.

(C) The Secretary shall promulgate regulations for establishment and operation of the registry under paragraph (1). Such regulations—

(A) in the case of covered devices that are sold on or after the date of the enactment of this subsection, shall require manufacturers of such devices to submit to the registry, in the form specified by the Secretary, information concerning adverse event trends, adverse event patterns, incidence and prevalence of adverse events, and other information the Secretary determines appropriate, that may include data on comparative safety and outcomes trends; and

(B) in the case of covered devices that are sold before such date, may require manufacturers of such devices to submit such information to the registry, if deemed necessary by the Secretary to protect the public health;

(D) shall establish procedures—

(i) to permit linkage of information submitted pursuant to subparagraph (A) with patient safety and outcomes data obtained under paragraph (3); and

(ii) to permit analysis of linked data;

(E) may require covered device manufacturers to submit such other information as is necessary to facilitate postmarket assessments of device safety and effectiveness and notification of device risks;

(F) shall establish requirements for regular and timely reports to the Secretary, which shall be included in the registry, concerning adverse event trends, adverse event patterns, incidence and prevalence of adverse events, and other information the Secretary determines appropriate, that may include data on comparative safety and outcomes trends; and

(G) shall establish procedures to permit public access to the information in the registry in a manner and form that protects patient privacy and proprietary information.
and is comprehensive, useful, and not misleading to patients, physicians, and scientists.

(5)(A) The Secretary shall promulgate final regulations under paragraph (4) not later than 36 months after the date of the enactment of this subsection.

(B) Notwithstanding the notice of proposed rulemaking preceding the final regulations described in subparagraph (A), the Secretary shall hold a public hearing before an advisory committee on the issue of which class II devices to include in the definition of covered devices.

(C) The Secretary shall include in any regulations under this subsection an elaboration demonstrating that the requirements of such regulation—

(i) do not duplicate other Federal requirements; and

(ii) do not impose an undue burden on device manufacturers.

(6) With respect to any entity that submits or is required to submit a safety report or other information in connection with the safety of a device under this section (and any release by the Secretary of that report or information), such report or information shall not be construed to reflect necessarily a conclusion by the entity or the Secretary that the reports or information constitute evidence, admission, or implication that the product involved malfunctioned, caused or contributed to an adverse experience, or otherwise caused or contributed to injury, illness, or death. Such an entity need not admit, and may deny, that the report or information submitted by the entity constitutes an admission that the product involved malfunctioned, caused or contributed to an adverse experience, or caused or contributed to a death, serious injury, or serious illness.

(7) Notwithstanding this subsection, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 and 2012.

(2) EFFECTIVE DATE.—The Secretary of Health and Human Services shall establish and begin implementation of the registry under section 519(g) of the Federal Food, Drug, and Cosmetic Act, as added by paragraph (1), by not later than the date that is 36 months after the date of the enactment of this Act, without regard to whether or not final regulations are published in the Federal Register or if the registry have been promulgated by such date.

(3) CONFORMING AMENDMENT.—Section 303([c] 301(c)(1)(B)(i)) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 333 333(f)(1)(B)(ii)) is amended by striking ‘‘519(g)’’ and inserting ‘‘519(h)’’.

(b) ELECTRONIC EXCHANGE AND USE IN CERTIFIED ELECTRONIC HEALTH RECORDS OF UNIQUE DEVICE IDENTIFIERS.—

(1) RECOMMENDATIONS.—The HIT Policy Committee established under section 3002 of the Public Health Service Act (42 U.S.C. 300j-12) shall recommend to the head of the Office of the National Coordinator for Health Information Technology standards, implementation specifications, and certification criteria for the electronic exchange and use in certified electronic health records of a unique device identifier for each covered device as defined under section 519(g)(1)(B) of the Federal Food, Drug, and Cosmetic Act, as added by this subsection.

(2) STANDARDS, IMPLEMENTATION CRITERIA, AND CERTIFICATION CRITERIA.—The Secretary of Health and Human Services, acting through the Commissioner of Food and Drugs, shall establish and begin enforcement of regulations to implement section 519(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360i(f)) not later than 6 months after the date of the enactment of this Act.

(3) COMMUNITY HEALTH RECORDS.—In the case of a restaurant or similar retail food establishment, each food menu that is on display and that is visible to customers, a restaurant or similar retail food establishment shall disclose the number of calories contained in the food that is on display and that is visible to customers, a restaurant or similar retail food establishment shall disclose the number of calories per display food item or per serving.

(4) })).
name and address of such restaurant or simi-
lar retail food establishment or vending ma-
machine operator with the Secretary, as speci-
fied by the Secretary by regulation.

(2) RULE OF CONSTRUCTION.—Within 120 days of the
enactment of this clause, the Secretary shall
publish a notice in the Federal Register
specifying the terms and conditions for im-
plementation of this clause, and the Secretary
shall promulgate any other regulations as may
be necessary to carry out this clause.

(3) RULE OF CONSTRUCTION.—Nothing in this
subsection shall be construed to authorize
the Secretary to require an application,
review, or licensing process for any entity to
register with the Secretary, as described in
such item.

(a) DESCRIPTION.—In promulgating regula-
tions, the Secretary shall—

(a) consider standardization of recipes
and methods of preparation, reasonable varia-
tion in serving size and formulation of menu
items, space on menus and menu
boards, inadvertent human error, training of
food employees in ingredient,
and other factors, as the Secretary de-
termines; and

(b) specify the format and manner of the
nutritional content disclosure requirements
under this subclause.

(III) REPORTING.—The Secretary shall
submit to the Committee on Health, Educa-
tion, Labor, and Pensions of the Senate and
the Committee on Energy and Commerce
of the House of Representatives a quarterly
report that describes the Secretary's prog-
ress toward finalizing the regulations
under this subparagraph.

(xi) DEFINITION.—In this clause, the term
'menu' or 'menu board' means the primary
writing of the restaurant or other similar re-
tail food establishment from which a con-
maker makes an order selection.”

(c) NATIONAL UNIFORMITY.—Section 403A(a)(4)
of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343–1(a)(4)) is amend-
ed by striking “except a requirement for
nutrition labeling of food which is exempt
under subparagraph (A)(i) or (ii) of section
403(q)(5)(A)” and inserting “except that this
paragraph does not apply to food that is of-
fered for sale in a restaurant or similar ret-
tail food establishment that has 20 or more
locations doing business under the same
name (regardless of the type of ownership of the locations) and offer-
ing for sale nationally the same menu
items unless such restaurant or similar re-
tail food establishment complies with the
voluntary provision of nutrition information
requirements under paragraph (1)(A)(i)

(d) RULE OF CONSTRUCTION.—Nothing in the
amendments made by this section shall be con-
strued—

(1) to preempt any provision of State or
local law, unless such provision establishes
or continues in effect nutrient content dis-
closures of the type required under section
403(q)(5)(H) of the Federal Food, Drug, and
Cosmetic Act (as added by subsection (b))
and is expressly preempted under section
403A(a)(4) of such Act;

(2) to apply to any State or local require-
ment respecting a statement in the labeling
of food that provides for a warning con-
cerning the safety of the food or component
of the food;

(3) except as provided in section
403(q)(5)(H)(ix) of the Federal Food, Drug,
and Cosmetic Act (as added by subsection
(b)), to apply to any restaurant or simi-
lar retail food establishment other than a re-
taurant or similar retail food establishment
described in section 403(q)(5)(H)(i) of such
Act.

SEC. 2573. PROTECTING CONSUMER ACCESS TO
GENERIC DRUGS.

(a) FINDINGS.—

(1) FINDINGS.—The Congress finds the fol-
lowing:

(A) by 1984, the Drug Price Competition
and Patent Term Restoration Act (Pub. L. 98–
417; in this subsection referred to as the
‘1984 Act’ ) was enacted with the intent of
facilitating the development of generic drugs
while preserving incentives for innovation.

(B) Prescription drugs make up 10 percent
of national health care spending, and for the
past decade have been one of the fastest
growing segments of health care expendi-
tures.

(C) Until recently, the 1984 Act was suc-
sessful in facilitating entry into the market
by generic drug manufacturers, and the potential genetic competitors that
make reverse payments, i.e., payments by the brand and generic companies
for negotiating any agreement required to be
filed under subdivision (b) of section
702(a)(7)(B) of the Federal Trade
Commission Act and shall be
enforced by the Federal Trade
Commission in the same manner, but
with the same jurisdiction as though all
applicable terms and provisions of the Federal
Trade Commission Act were incorporated
into and made a part of this subsection.

(ii) INAPPLICABILITY.—Subchapter A of
chapter VII shall not apply with respect to
this section.

(iii) DETERMINATIONS.—In this subsection:

(C) Until recently, the intent of the 1984
Act has been subverted by certain settle-
mements between brand drug manufac-
turers and their potential generic competitors that
make reverse payments, i.e., payments by the brand
and generic companies
for negotiating any agreement required to be
filed under subdivision (b) of section
702(a)(7)(B) of the Federal Trade
Commission Act and shall be
enforced by the Federal Trade
Commission in the same manner, but
with the same jurisdiction as though all
applicable terms and provisions of the Federal
Trade Commission Act were incorporated
into and made a part of this subsection.

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702(a)(7)(B) of the Federal Trade
Commission Act and shall be
enforced by the Federal Trade
Commission in the same manner, but
with the same jurisdiction as though all
applicable terms and provisions of the Federal
Trade Commission Act were incorporated
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and generic companies
for negotiating any agreement required to be
filed under subdivision (b) of section
702(a)(7)(B) of the Federal Trade
Commission Act and shall be
enforced by the Federal Trade
Commission in the same manner, but
with the same jurisdiction as though all
applicable terms and provisions of the Federal
Trade Commission Act were incorporated
into and made a part of this subsection.
respect to the agreement referenced in this certification: (1) represent the complete, final, and exclusive agreement between the parties; (2) include any ancillary agreements that are made with respect to the referenced agreement; and (3) include written descriptions of any oral agreements, representations, warranties, and other information between the parties that are responsive to subsection (a) or (b) of such section 1112 and have not been reduced to writing.

(ii) DETERMINATION BY SECRETARY.—The Secretary may determine, in the Secretary’s discretion, that an element described in clause (i) is unnecessary in an application submitted under this subsection.

(iii) ADDITIONAL INFORMATION.—An application submitted under this subsection—

(I) shall include publicly available information regarding the Secretary’s previous determination that the reference product is safe, pure, and potent; and

(II) may include additional information in support of the application, including publicly available information with respect to the reference product or another biological product.

(b) INTERCHANGEABILITY.—An application (or a supplement to an application) submitted under this section may include information demonstrating that the biological product meets the standards described in paragraph (4).

(c) EVALUATION BY SECRETARY.—Upon review of an application (or a supplement to an application) submitted under this subsection the Secretary shall license the biological product under this subsection if—

(A) the Secretary determines that the information included in the application (or the supplement) is sufficient to show that the biological product—

(1) is biosimilar to the reference product; or

(2) meets the standards described in paragraph (4), and therefore is interchangeable with the reference product; and

(B) the applicant (or other appropriate person) has completed the inspection of the facility that is the subject of the application, in accordance with subsection (c).

(d) SAFETY STANDARDS FOR DETERMINING INTERCHANGEABILITY.—Upon review of an application submitted under this subsection or any supplement to such application, the Secretary shall determine the biological product under this subsection to be biosimilar to or interchangeable with the reference product if the Secretary determines that the information included in the application (or a supplement to such application) is sufficient to show that—

(A) the biological product—

(1) is biosimilar to the reference product; and

(2) can be taken to produce the same clinical result as the reference product in any given patient; and

(B) for a biological product that is administered more than once to an individual, the risk in terms of safety or diminished efficacy of alternating or switching between use of the biological product and the reference product is not greater than the risk of using the reference product without such alternation or switch.

(5) GENERAL RULES.—

(A)(1) ONE REFERENCE PRODUCT PER APPLICATION.—A biological product, in an application submitted under this subsection, may not be evaluated against more than 1 reference product.

(B) REVIEW.—An application submitted under this subsection shall be reviewed by the Comptroller General of the United States with such amendments that the Secretary determines are necessary to ensure the review and approval of the application under which the reference product is licensed.

(c) EVALUATION AND MITIGATION STRATEGIES.—The authority of the Secretary with respect to risk evaluation and mitigation strategies under the Federal Food, Drug, and Cosmetic Act shall apply to biological products licensed under this subsection in the same manner as such authority applies to biological products licensed under subsections (a) and (b).

(d) RESTRICTIONS ON BIOLOGICAL PRODUCTS CONTAINING DANGEROUS INGREDIENTS.—If information in an application submitted under this subsection, in a supplement to such an application, or otherwise available to the Secretary shows that a biological product—

(1) is, bears, or contains a select agent or toxin listed in section 73.3 or 73.4 of title 42, section 121.1 or 121.4 of title 9, or section 331.3 of title 7, Code of Federal Regulations (or any successor regulations); or

(2) is, bears, or contains a controlled substance schedule I or II of the Controlled Substances Act, as listed in part 1308 of title 21, Code of Federal Regulations (or any successor regulations); or

the Secretary shall not license the biological product under this subsection unless the Secretary determines, after consultation with appropriate national security and drug enforcement agencies, that there is no increased risk to the security or health of the public from licensing such biological product under this subsection.

(e) EXCLUSIVITY FOR INTERCHANGEABLE BIOLOGICAL PRODUCT.—Upon review of an application submitted under this subsection relying on the same reference product for which a prior biological product has received a determination of interchangeability for any condition of use, the Secretary shall not make a determination under paragraph (d) that the subsequent biological product is interchangeable for any condition of use until the earlier of—

(1) 1 year after the first commercial marketing of the first approved biosimilar biological product; or

(2) the time that the Secretary shows that a biosimilar biological product to be approved as interchangeable for that reference product—

(i) has been on the market for at least 1 year after the first commercial marketing of the first approved biosimilar biological product; and

(ii) the dismissal with or without prejudice of an action instituted under subsection (i)(5) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product, or

(iii) the denial of any request for judicial review of a final determination of the Secretary that the applicant that submitted the application for the first approved interchangeable biosimilar biological product has not complied with the standards in section 351(k)(1)(A)(iv)(I) of the Public Health Service Act (42 U.S.C. 262) or any successor regulations.

(f) EXCLUSIVITY FOR INTERCHANGEABLE BIOLOGICAL PRODUCT.—Upon review of an application submitted under this subsection relying on the same reference product for which a prior biological product has received a determination of interchangeability for any condition of use the Secretary shall not make a determination under paragraph (d) that the subsequent biological product is interchangeable for any condition of use until the earlier of—

(1) 18 months after the date of the final decision in an action instituted under subsection (i)(5) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

(2) the time that the Secretary shows that a biosimilar biological product to be approved as interchangeable for that reference product—

(i) has been on the market for at least 1 year after the first commercial marketing of the first approved biosimilar biological product; and

(ii) the dismissal with or without prejudice of an action instituted under subsection (i)(5) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product, or

(iii) the denial of any request for judicial review of a final determination of the Secretary that the applicant that submitted the application for the first approved interchangeable biosimilar biological product has not complied with the standards in section 351(k)(1)(A)(iv)(I) of the Public Health Service Act (42 U.S.C. 262) or any successor regulations.

For purposes of this paragraph, the term ‘final court decision’ means a final decision of a court from which no appeal (other than a petition to the United States Supreme Court for a writ of certiorari) has been or can be taken.
"(A) EFFECTIVE DATE OF BIOSIMILAR APPLICATION APPROVAL.—Approval of an application under this subsection may not be made effective by the Secretary until the date that is 12 months after the date on which the reference product was first licensed under subsection (a).

"(B) FILING PERIOD.—An application under this subsection must be submitted to the Secretary until the date that is 4 years after the date on which the reference product was first licensed under subsection (a).

"(C) APPLICATION EFFICACY.—Subparagraphs (A) and (B) shall not apply to a license or approval of—

"(i) a supplement for the biological product that is the reference product; or

"(ii) a subsequent application filed by the same sponsor or manufacturer of the biological product that is the reference product (or a licensor, predecessor in interest, or other related entity) for—

"(I) a change (not including a modification to the structure of the biological product) that results in a new indication, route of administration, dosing schedule, dosage form, delivery system, delivery device, or strength; or

"(II) a modification to the structure of the biological product that does not result in a change in safety, purity, or potency.

"(8) PEDIATRIC STUDIES.—

"(A) IN GENERAL.—Before or after licensure of the reference product under subsection (a) of this section, the Secretary determines that information relating to the use of such product in pediatric populations may produce health benefits in that population, the Secretary makes a written request for pediatric studies (which shall include adequate studies in pediatric populations) to the manufacturer of the reference product. The Secretary shall require the applicant to submit the information within any such timeframe, and the reports thereof are submitted and accepted in accordance with section 563a(c)(3) of the Federal Food, Drug, and Cosmetic Act. If no such request has been made or if the pediatric population may produce health benefits in that population, the Secretary shall establish a process through which the public may provide the Secretary with input regarding priorities for issuing guidance.

"(B) REQUIREMENT FOR PRODUCT CLASS-SPECIFIC GUIDANCE.—If the Secretary issues a product class-specific guidance under subsection (a), such guidance shall include a description of—

"(i) the criteria that the Secretary will use to determine whether a biological product is highly similar to a reference product in such product class;

"(ii) the criteria, if available, that the Secretary will use to determine whether a biological product meets the standards described in paragraph (i);

"(C) CERTAIN PRODUCT CLASSES.—

"(1) GUIDANCE.—The Secretary may indicate in a guidance document that the science and experience, as of the date of such guidance, with respect to a product or product class (not including any recombinant protein) does not allow approval of an application for a license or approval under this subsection for such product or product class.

"(2) MODIFICATION OR REVERSION.—The Secretary may issue a subsequent guidance document with respect to the use of biological products licensed under this subsection, the term—

"(i) expires after the date specified in subparagraph (A) before issuing final guidance.

"(3) PUBLIC NOTICE BY SECRETARY.—Within 30 days after the date of acceptance of an application filed under subsection (k), the Secretary shall publish a notice identifying—

"(A) the reference product identified in the application; and

"(B) the name and address of an agent designated by the applicant to receive notices pursuant to paragraph (4)(B).

"(4) EXCHANGES ON CONFIDENTIAL INFORMATION.—

"(A) EXCHANGES WITH REFERENCE PRODUCT SPONSOR.—

"(i) Within 30 days of the date of acceptance of an application by the Secretary, the applicant shall provide to the Secretary information pursuant to this subsection and information concerning the biosimilar product and its production. The information shall include a description of the biological product, its method of manufacture, and the materials used in the manufacture of the product.

"(ii) Within 60 days of the date of receipt of the information required to be provided under clause (i), the reference product sponsor shall provide to the applicant a list of relevant patents which the reference product sponsor, or its designee, owns or controls. The list required by clause (i) shall be submitted to the Secretary before the application is submitted under subsection (k).

"(B) EXCHANGES WITH INTERESTED THIRD PARTIES.—

"(i) At any time after the date on which the Secretary publishes a notice for an application under paragraph (3), any interested third party may provide notice to the designated agent of the applicant that the interested third party owns or has rights under 1 or more patents that may be relevant patents. The notice shall identify at least 1 patent and shall designate an individual who has executed an agreement in accordance with clause (ii) to receive confidential information from the applicant.

"(ii) Within 30 days of the date of receiving notice pursuant to clause (i), the applicant shall send to the individual designated by the interested third party the information specified in subparagraph (A)(i), unless the applicant and interested third party otherwise agree.

"(iii) Within 90 days of the date of receiving information pursuant to clause (ii), the interested third party shall provide to the Secretary a list of relevant patents with respect to which the interested third party owns, or in respect of which the interested third party has the right to commence or participate in an action for infringement of a relevant patent.

"(2) HANDLING OF CONFIDENTIAL INFORMATION.—An interested third party may use the information received pursuant to this subsection to commence or participate in an action for infringement of a relevant patent.

"(3) APPLICATION FOR BIOSIMILAR LICENSE.—An interested third party may apply for a license to the biological product that is the subject of the application under subsection (k).

"(4) AFFIRMATIVE ACTS.—An interested third party may take reasonable steps to maintain the confidentiality of information received pursuant to this subsection and use the information solely for purposes authorized by this subsection.

"(5) APPEALS.—The Secretary and interested third parties shall have the right to judicial review of any action of the Secretary under this section.
after the date on which the interested third party provides the list required by clause (iii), the interested third party shall identify that patent within 30 days of the date of issue of the notice of the date of acquisition of the interest in the patent, as applicable.

(C) IDENTIFICATION OF BASIS FOR INFRINGEMENT.—For any patent identified under clause (i) or clause (ii) of subparagraph (B), the reference product sponsor or the interested third party, as applicable—

(i) may specify the reasons why the patent in question is pertinent to, provides a contingent condition upon, provides a conditional precedent to, or is otherwise related to, the reference product and shall identify under clause (i) or (iv) of subparagraph (B), the reference product identified by the reference product sponsor or the reference product in a treatment that is indicated in the application; and

(ii) may specify whether the relevant patent is available for licensing; and

(iii) shall specify the number and date of expiration of the relevant patent.

(D) CERTIFICATION BY APPLICANT CONCERNING IDENTIFIED RELEVANT PATENTS.—Not later than 45 days after the date on which a patent is identified under clause (ii) or (iii) of subparagraph (A) or under clause (ii) or (iv) of subparagraph (B), the applicant shall send a written statement regarding each identified patent to the party that identified the patent. Such statement shall either—

(i) explain in writing why the sponsor or the interested third party believes the relevant patent would be infringed by the making, use, sale, or offer for sale within the United States, of the biosimilar product or by a use of the biosimilar product in a treatment that is indicated in the application; or

(ii) may specify whether the relevant patent is available for licensing; and

(iii) shall specify the number and date of expiration of the relevant patent.

(E) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant and sponsor enter into an agreement described in subparagraph (A)(i), the biosimilar product applicant shall provide the list required by clause (i) of subparagraph (A). Under such an agreement, the biosimilar product applicant shall file the agreement with the Secretary, and the Secretary shall make approval of the application effectual on the date after the date of expiration of the patent that has been found to be infringed by the biosimilar product applicant in a treatment indicated in the application, if the application is found to be infringed by the biosimilar product applicant.

(F) CERTIFICATION.—The chief executive officer or the company official responsible for negotiating any agreement required to be filed under subparagraph (A) shall certify in writing that, with respect to any agreement described in such subparagraph—

(i) is an agreement between the biosimilar product applicant under subsection (k) and the reference product sponsor; or

(ii) is an agreement between the biosimilar product applicant under subsection (k) and the reference product under subsection (k) that is contingent upon, provides a contingent condition for, or otherwise relates to, an agreement described in clause (i) or (ii) of subparagraph (D).

(G) FILING.—

(i) AGREEMENTS BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—An agreement described in this subparagraph—

(I) is an agreement between the biosimilar product applicant under subsection (k) and the reference product sponsor that is identified by the reference product in terms of safety, purity, and potency of the product.

(ii) includes any agreement between the biosimilar product applicant under subsection (k) and the reference product or between 2 or more biosimilar product applicants under subsection (k) regarding the manufacture, marketing, or sale of any product that is a biosimilar product for which an application was submitted; or

(iii) includes any agreement related to an agreement described in clause (i) or (ii) of this paragraph and shall be filed by the applicant or the reference product sponsor, as applicable, under subsection (k) regarding the biological product under subsection (k) that is identified by the reference product sponsor or the biosimilar product applicant under subsection (k), as applicable.

(H) REQUIREMENTS.—An agreement described in this subparagraph—

(i) must explain in writing why the agreement is necessary or appropriate, and the reasons why the treatment that is indicated in the application would not infringe the patent; or

(ii) must specify whether the relevant patent is available for licensing; and

(iii) must specify the number and date of expiration of the relevant patent.

(I) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant and sponsor enter into an agreement described in subparagraph (A) or under clause (ii) or (iv) of subparagraph (B), the applicant shall send a written statement regarding each agreement to the Secretary, and the Secretary shall make approval of the agreement effective on the date after the date of expiration of the notice of the patent; or

(ii) provide a detailed written explanation setting forth the reasons why the applicant believes—

(I) the making, use, sale, or offer for sale within the United States, of the biosimilar product or by a use of the biosimilar product in a treatment indicated in the application, would not infringe the patent; or

(ii) the patent is invalid or unenforceable.

(J) ACTION FOR INFRINGEMENT INVOLVING REFERENCE PRODUCT SPONSOR.—If an action for infringement concerning a relevant patent is brought by the reference product sponsor under section 351 of the Public Health Service Act, or under any other provision of law, the Secretary shall file with the Secretary of Commerce a notice of the filing of such suits, and shall make approval of the application effectual on the day after the date of expiration of the notice of infringement that has been found to be infringed by the biosimilar product applicant.

(K) NOTICE OF AGREEMENTS.—

(i) AGREEMENTS BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (A) or under clause (ii) or (iv) of paragraph (B), or by an interested third party under clause (ii) or (iv) of paragraph (B), the applicant shall certify in writing the complete, final, and exclusive contents of the agreement.

(ii) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (A) or under clause (ii) or (iv) of paragraph (B), or by an interested third party under clause (ii) or (iv) of paragraph (B), the applicant shall certify in writing the complete, final, and exclusive contents of the agreement.

(L) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (A) or under clause (ii) or (iv) of paragraph (B), the applicant shall certify in writing the complete, final, and exclusive contents of the agreement.

(M) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (A) or under clause (ii) or (iv) of paragraph (B), the applicant shall certify in writing the complete, final, and exclusive contents of the agreement.

(N) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (A) or under clause (ii) or (iv) of paragraph (B), the applicant shall certify in writing the complete, final, and exclusive contents of the agreement.

(O) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (A) or under clause (ii) or (iv) of paragraph (B), the applicant shall certify in writing the complete, final, and exclusive contents of the agreement.

(P) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (A) or under clause (ii) or (iv) of paragraph (B), the applicant shall certify in writing the complete, final, and exclusive contents of the agreement.

(Q) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (A) or under clause (ii) or (iv) of paragraph (B), the applicant shall certify in writing the complete, final, and exclusive contents of the agreement.

(R) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (A) or under clause (ii) or (iv) of paragraph (B), the applicant shall certify in writing the complete, final, and exclusive contents of the agreement.

(S) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (A) or under clause (ii) or (iv) of paragraph (B), the applicant shall certify in writing the complete, final, and exclusive contents of the agreement.

(T) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (A) or under clause (ii) or (iv) of paragraph (B), the applicant shall certify in writing the complete, final, and exclusive contents of the agreement.

(U) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (A) or under clause (ii) or (iv) of paragraph (B), the applicant shall certify in writing the complete, final, and exclusive contents of the agreement.

(V) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (A) or under clause (ii) or (iv) of paragraph (B), the applicant shall certify in writing the complete, final, and exclusive contents of the agreement.

(W) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (A) or under clause (ii) or (iv) of paragraph (B), the applicant shall certify in writing the complete, final, and exclusive contents of the agreement.

(X) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (A) or under clause (ii) or (iv) of paragraph (B), the applicant shall certify in writing the complete, final, and exclusive contents of the agreement.

(Y) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (A) or under clause (ii) or (iv) of paragraph (B), the applicant shall certify in writing the complete, final, and exclusive contents of the agreement.

(Z) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (A) or under clause (ii) or (iv) of paragraph (B), the applicant shall certify in writing the complete, final, and exclusive contents of the agreement.

(AA) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (A) or under clause (ii) or (iv) of paragraph (B), the applicant shall certify in writing the complete, final, and exclusive contents of the agreement.

(BB) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (A) or under clause (ii) or (iv) of paragraph (B), the applicant shall certify in writing the complete, final, and exclusive contents of the agreement.

(CC) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (A) or under clause (ii) or (iv) of paragraph (B), the applicant shall certify in writing the complete, final, and exclusive contents of the agreement.
Subtitle D—Community Living Assistance Services and Supports

SEC. 2581. ESTABLISHMENT OF NATIONAL VOLUNTARY INSURANCE PROGRAM FOR PURCHASING COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS (CLASS PROGRAM).

(a) ESTABLISHMENT OF CLASS PROGRAM.—The Public Health Service Act (42 U.S.C. 201 et seq.), as amended by section 2301, is amended by adding at the end the following:

"TITLE XX—COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS

SEC. 2301. PURPOSE.

The purpose of this title is to establish a national voluntary insurance program for purchasing community living assistance services and supports in order to—

(1) provide individuals with functional limitations with tools that will allow them to maintain their personal and financial independence and live in the community through a new financing strategy for community living assistance services and supports;

(2) establish an infrastructure that will help address the Nation’s community living assistance services and supports needs;

(3) alleviate burdens on family caregivers; and

(4) address institutional bias by providing a financing mechanism that supports personal choice and independence to live in the community.

SEC. 2302. DEFINITIONS.

In this title:

(1) ACTIVE ENROLLEE.—The term ‘active enrollee’ means an individual who is enrolled in the CLASS program in accordance with section 2304 and who has paid premiums due to maintain such enrollment.

(2) ACTIVELY EMPLOYED.—The term ‘actively employed’ means an individual who—

(A) is reporting for work at the individual’s usual place of employment (or in the case of an individual who is a member of the uniformed services, on active duty and is physically able to do so) at the time of application;

(B) is able to perform all the usual and customary duties of the individual’s employment on the individual’s regular work schedule;

(3) ACTIVITIES OF DAILY LIVING.—The term ‘activities of daily living’ has the meaning given the term in section 702(b)(2)(B) of the Internal Revenue Code of 1986.

(4) CLASS PROGRAM.—The term ‘CLASS program’ means the program established under this title.

(5) ELIGIBILITY ASSESSMENT SYSTEM.—The term ‘Eligibility Assessment System’ means the entity designated by the Secretary under section 3205(a)(2)(A)(i).

(6) ELIGIBLE BENEFICIARY.—

(A) The term ‘eligible beneficiary’ means any individual who is an active enrollee in the CLASS program and, as of the date described in subparagraph (B)—

(i) has paid premiums for enrollment in such program for at least 60 months;

(ii) has earned, for each calendar year that occurs during the first 60 months for which the individual has paid premiums for enrollment in the program, at least an amount equal to the amount of wages and self-employment income which an individual may be expected to earn in a quarter of coverage under section 213(d) of the Social Security Act for that year; and

(iii) has paid premiums for enrollment in such program for each individual 24 consecutive months, if a lapse in premium payments of more than 3 months has occurred during the period that begins on the date of the individual’s enrollment and ends on the date of such determination.

(B) DATE DESCRIBED.—For purposes of subparagraph (A), the date described in this subparagraph is the date on which the individual is determined to have a functional limitation described in section 3203(a)(1)(C) that is expected to last for a continuous period of more than 90 days.

(C) REGULATIONS.—The Secretary shall promulgate regulations specifying exceptions to the minimum earnings requirements under subparagraph (A)(ii) for purposes of being considered an eligible beneficiary for certain populations.

(7) HOSPITAL; NURSING FACILITY; INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED; INSTITUTION FOR MENTAL DISEASES.—The terms ‘hospital’, ‘nursing facility’, ‘intermediate care facility for the mentally retarded’, and ‘institution for mental diseases’ have the meanings given such terms for purposes of Medicaid.

(8) CLASS INDEPENDENCE ADVISORY COUNCIL.—The term ‘CLASS Independence Advisory Council’ or ‘Council’ means the Advisory Council established under section 3207 to advise the Secretary.

(9) CLASS INDEPENDENCE BENEFIT PLAN.—The term ‘CLASS Independence Benefit Plan’ means the benefit plan developed and described by the Secretary in accordance with section 3203.

(10) CLASS INDEPENDENCE FUND.—The term ‘CLASS Independence Fund’ or ‘Fund’ means the fund established under section 3206.

(11) MEDICAID.—The term ‘Medicaid’ means the program established under title XIX of the Social Security Act.

(12) PROTECTION AND ADVOCACY SYSTEM.—The term ‘Protection and Advocacy System’ means the system for each State established under section 1437 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000.

SEC. 2303. CLASS INDEPENDENCE BENEFIT PLAN

(a) PROCESS FOR DEVELOPMENT.—

(1) IN GENERAL.—The Secretary, in consultation with appropriate State and local authorities and other experts, shall develop an actuarially sound benefit plan as alternatives for consideration by designation by the Secretary as the CLASS Independence Benefit Plan for which eligible beneficiaries shall receive benefits under this title. Each of the plan alternatives developed shall be designed to provide eligible beneficiaries with the benefits described in section 3203, consistent with the following requirements:

(A) PREMIUMS.—Beginning with the first year of the CLASS program, and for each year thereafter, the Secretary shall establish all premiums to be paid by enrollees for the year based on an actuarial analysis of the 75-year costs of the program that ensures solvency throughout such 75-year period.

(B) VESTING PERIOD.—5-year vesting period for eligibility for benefits.

(2) BENEFIT TRIGGERS.—A benefit trigger for provision of benefits that requires a determination that an individual has a functional limitation, as certified by a licensed health care practitioner, described in any of the following clauses that is expected to last for a continuous period of more than 90 days:

(i) The individual is determined to be unable to perform at least the minimum number of hours in a week which may be 20 hours of daily living as are required under the plan for the provision of benefits without substantial assistance (as defined by the Secretary) for another individual.

(ii) The individual requires substantial supervision to protect the individual from
threats to health and safety due to substantial cognitive impairment.

‘‘(iii) The individual has a level of functional limitation similar (as determined based on the reasonably expected distribution of beneficiaries receiving benefits) of 2, and not more than 6, benefit level amounts.

‘‘(iii) DAILY OR WEEKLY.—The benefit is paid on a daily or weekly basis.

‘‘(iv) No Lifetime or Aggregate Limit.—The benefit is not subject to any lifetime or aggregate limit.

(2) Review and Recommendation by the CLASS Independence Advisory Council.—The CLASS Independence Advisory Council shall—

(A) evaluate the alternative benefit plans developed under paragraph (1); and

(B) recommend for designation as the CLASS Independence Benefit Plan for offering to the public the plan that the Council determines best balances price and benefits to meet enrollees’ needs in an actuarially sound manner, while optimizing the probability of the long-term sustainability of the CLASS program.

(3) Designation by the Secretary.—Not later than October 1, 2012, the Secretary, taking into consideration the recommendation of the CLASS Independence Advisory Council under paragraph (2)(B), shall designate a benefit plan as the CLASS Independence Benefit Plan. The Secretary shall publish such designation, along with details of the plan and the reasons for the selection by the Secretary, in a final rule that allows for a period of public comment.

(b) Additional Premium Requirements.—

(1) Adjustment of Premiums.—

(A) Except as provided in subparagraphs (B), (C), (D), and (E), the amount of the monthly premium determined for an individual upon such individual’s enrollment in the CLASS program shall remain the same for as long as the individual is an active enrollee in the program.

(B) Recalculated Premium if Required for Eligibility Purposes.—

(i) In General.—Subject to clause (ii), if the Secretary determines, based on the most recent report of the Board of Trustees of the CLASS Independence Fund, the advice of the CLASS Independence Advisory Council, and the annual report of the Inspector General of the Department of Health and Human Services, self-employed, and abusing, or such other information as the Secretary determines appropriate, that the monthly premiums and income to the CLASS Independence Fund for a year are projected to be insufficient with respect to the 20-year period that begins with that year, the Secretary shall adjust the monthly premiums for individual enrollees in the CLASS program as necessary.

(ii) Exemption from Increase.—Any increase in a monthly premium imposed as a result of the increase described in clause (i) shall not apply with respect to the monthly premium of any active enrollee who—

(I) has attained age 65,

(ii) the premiums for enrollment in the program for at least 20 years; and

(III) is not actively employed.

(c) Recalculated Premium if Recalculated Premium if Reenrollment After More than a 3-Month Lapse.—

(i) In General.—The reenrollment of an individual after a 90-day period during which the individual failed to pay the monthly premium required to maintain the individual’s enrollment in the CLASS program shall be treated as an initial enrollment for purposes of age-adjusted premium for each such month occurring in period.

(ii) Penalty for Premature Enrollment.—In determining the monthly premiums for the CLASS program, the Secretary may factor in the costs for administering the program, not to exceed—

(A) in the case of the first 5 years in which the program is in effect under this title, an amount equal to 3 percent of all premium paid during each such year; and

(B) in each of the subsequent years, an amount equal to 5 percent of the total amount of all expenditures (including benefits paid) under this title with respect to that year.

(d) No Underwriting Requirements.—No underwriting (other than on the basis of age in accordance with paragraph (2)) shall be used to—

(A) determine the monthly premium for enrollment in the CLASS program; or

(B) prevent an individual from enrolling in the program on the basis of which the individual described in this paragraph is—

(I) an individual—

(1) who is actively employed; and

(2) the spouse of an individual described in paragraph (1) and who would be an individual so described but for subparagraph (B) or (C) of that paragraph.

(2) Administrative Expenses.—In determining the monthly premiums for the CLASS program, the Secretary may factor in the costs for administering the program, not to exceed—

(A) in the case of the first 5 years in which the program is in effect under this title, an amount equal to 3 percent of all premium paid during each such year; and

(B) in each of the subsequent years, an amount equal to 5 percent of the total amount of all expenditures (including benefits paid) under this title with respect to that year.

SEC. 3204. ENROLLMENT AND DISENROLLMENT REQUIREMENTS.

(a) Automatic Enrollment.—

(i) In General.—Subject to paragraph (2), the Secretary shall establish procedures under which each individual described in subsection (c) shall be automatically enrolled in the CLASS program by an employer of such individual under rules similar to the rules of sections 401(k) and 414(w) of the Internal Revenue Code of 1986.

(ii) Alternative Payment Procedures.—The procedures established under paragraph (1) shall provide for an alternative enrollment process for an individual described in subsection (c) in the case of such an individual—

(A) who is self-employed;

(b) Selection to Opt-Out.—An individual described in subsection (c) may elect to waive enrollment in the CLASS program at any time in such form and manner as the Secretary shall prescribe.

(c) Individual Described.—For purposes of paragraph (1) in the CLASS program, an individual described in this paragraph is—

(I) an individual—

(1) who is actively employed; and

(2) who receives wages on which there is imposed a tax under section 3101(a) or 3201(a) of the Internal Revenue Code of 1986;

(II) who is actively employed; and

(III) is not actively employed.

(d) Rule of Construction.—Nothing in this title shall be construed as requiring an active enrollee to continue to satisfy subsection (B) or (C) of section 3201(c)(2) of the Social Security Act; or

(2) the spouse of an individual described in paragraph (1) and who would be an individual so described but for subparagraph (B) or (C) of that paragraph.

(2) Alternative Payment Mechanism.—The Secretary shall establish alternative mechanisms for the payment of the premiums by an individual enrolled in the CLASS program who does not have an employer who elects to deduct and withhold premiums on behalf of enrolled employees.

(2) Transfers Based on Estimates.—The amount deposited pursuant to paragraph (1) shall be transferred in at least monthly payments to the CLASS Independence Fund on the basis of estimates by the Secretary and certified to the Secretary of the Treasury of

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CONGRESSIONAL RECORD — HOUSE

November 7, 2009
OUTLINE

SEC. 3205. BENEFITS.

(a) DETERMINATION OF ELIGIBILITY.—

(I) APPLICABILITY FOR RECEIPT OF BENEFITS.—The Secretary shall establish procedures under which an active enrollee shall apply for benefits under the CLASS Independence Benefit Plan.

(2) ELIGIBILITY ASSESSMENTS.—

(A) IN GENERAL.—Not later than January 1, 2012, the Secretary shall—

(i) designate an entity (other than a service with which the Commissioner of Social Security has entered into an agreement, with entities to which the Secretary has delegated decision-making responsibilities under this paragraph) to serve as an Eligibility Assessment System by providing for the enrollment of active enrollees who apply for receipt of benefits;

(ii) enter into an agreement with the Protection and Advocacy System for each State to provide advocacy services in accordance with subsection (d); and

(iii) enter into an agreement with public and private entities to provide advice and assistance counseling in accordance with subsection (e).

(B) USE OF CASH BENEFITS.—Cash benefits paid into a Life Independence Account of an eligible beneficiary shall be used to purchase nonmedical services and supports that the beneficiary needs to maintain his or her independence at a level of care and quality of life comparable to that provided by institutionalized care.

(C) ELECTRONIC MANAGEMENT OF FUNDS.—The Secretary shall establish procedures for administering the provisions of section 3203(b)(2) of this title and the requirements of section 3122(b) of the Social Security Act (relating to comparability) and the State offers at a minimum a cash daily benefit, and respite care, personal care services, habilitation services, and care at such a level as necessary to support the beneficiary in the home or community.

(D) PRIMARY PAYOR RULES FOR BENEFICIARIES.—The Secretary shall establish rules to ensure that authorized representatives of eligible beneficiaries comply with standards of the Social Security Act or subsection (c) of section 1115 of the Social Security Act or subsection (c) or (d) of section 1902(a) of the Social Security Act (relating to state waivers of the requirements of section 1315 of the Social Security Act) and the State offers at a minimum a cash daily benefit, and respite care, personal care services, habilitation services, and care at such a level as necessary to support the beneficiary in the home or community.

(E) OTHER ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—The Secretary shall establish procedures under which—

(1) an individual who, in the year of the individual’s initial eligibility to enroll in the CLASS Independence Benefit Plan, is able to enroll in a hospital, facility, or institution.

(2) an individual who is deemed presumptively eligible if the enrollee—

(i) has applied for, and attests is eligible for, the maximum cash benefit available under the sliding scale established under the CLASS Independence Benefit Plan; and

(ii) is in the process of, or about to being the process of, applying to receive benefits under the CLASS Independence Benefit Plan issued by the Secretary.

(2) AUTHORIZED REPRESENTATIVES.—

(A) IN GENERAL.—The Secretary shall establish procedures under which an active enrollee shall apply for benefits under the CLASS Independence Benefit Plan.

(B) QUALITY ASSURANCE AND PROTECTION AGAINST FRAUD AND ABUSE.—The Secretary shall—

(i) designate an entity (other than a service with which the Commissioner of Social Security has entered into an agreement, with entities to which the Secretary has delegated decision-making responsibilities under this paragraph) to serve as an Eligibility Assessment System by providing for the enrollment of active enrollees who apply for receipt of benefits;

(ii) enter into an agreement with the Protection and Advocacy System for each State to provide advocacy services in accordance with subsection (d); and

(iii) enter into an agreement with public and private entities to provide advice and assistance counseling in accordance with subsection (e).

(C) REPORTING OF ABUSES.—The Secretary shall establish procedures for—

(i) crediting an account established on behalf of an eligible beneficiary with the beneficiary's cash daily benefit;

(ii) allowing the beneficiary to access such account through debit cards; and

(iii) accounting for withdrawals by the beneficiary from such account.

(D) PRIMARY PAYOR RULES FOR BENEFICIARIES.—The Secretary shall establish procedures for—

(i) crediting an account established on behalf of an eligible beneficiary with the beneficiary’s cash daily benefit;

(ii) allowing the beneficiary to access such account through debit cards; and

(iii) accounting for withdrawals by the beneficiary from such account.
conduct established by the Secretary, including standards requiring that such representatives provide quality services on behalf of such beneficiaries, do not have conflicts of interest, and do not misuse benefits paid on behalf of such beneficiaries or otherwise engage in fraud or abuse.

(3) Commencement of Benefits.—Benefits shall be paid on behalf of an eligible beneficiary beginning with the first month in which an application for such benefits is approved.

(4) Rollover Option for Lump-Sum Payment.—An eligible beneficiary may elect to—

(a) defer payment of their daily or weekly benefit and to rollover any such deferred benefits from month-to-month, but not from year-to-year; and

(b) receive a lump-sum payment of such deferred benefits in an amount that may not exceed the lesser of—

(i) the total amount of the accrued deferred benefits; or

(ii) the applicable annual benefit.

(5) Period for Determination of Annual Benefits.—

(A) In General.—The applicable period for determining with respect to an eligible beneficiary the applicable annual benefit and the amount of any accrued deferred benefits is the first month that commences with the first month in which the beneficiary began to receive such benefits, and each 12-month period thereafter.

(B) Inclusion of Increased Benefits.—The Secretary shall establish procedures under which cash benefits paid to an eligible beneficiary that increase or decrease as a result of a change in the functional status of the beneficiary before the end of a 12-month benefit period shall be included in the determination of the applicable annual benefit paid to the eligible beneficiary.

(C) Recoupment of Unpaid, Accrued Benefits.—

(i) In General.—The Secretary, in coordination with the Secretary of the Treasury, shall recoup any accrued benefits in the event of—

(1) the death of a beneficiary; or

(II) the failure of a beneficiary to elect under paragraph (4)(B) to receive such benefits as a lump-sum payment before the end of the 12-month period in which such benefits accrued.

(ii) Payment into Class Independence Fund.—Any benefits recouped in accordance with paragraph (1) shall be paid into the CLASS Independence Fund created under this title. The class independence fund may be invested and managed under subsection (c), (d), and (e) of section 1314(d) of the Social Security Act.

(6) Requirement to Recertify Eligibility for Receipt of Benefits.—An eligible beneficiary shall periodically, as determined by the Secretary—

(A) receive, by submission of medical evidence, the beneficiary’s continued eligibility for receipt of benefits; and

(B) submit records of expenditures attributable to the consolidated cash benefit received by the beneficiary starting the preceding year.

(7) Supplement, Not Supplant Other Health Care Benefits.—Subject to the Medicaid payment rules under paragraphs (1)(D), (E), and (F) of section 1396 of the Social Security Act, any funds paid to an eligible beneficiary shall supplement, but not supplant, other health care benefits for which the beneficiary is eligible under Medicare or any other Federal or State program that provides health care benefits or assistance.

(d) ADVOCACY SERVICES.—An agreement entered into under subsection (a)(2)(A)(i) shall require the Protection and Advocacy System for the State to—

(1) assign, as needed, an advocacy counselor or other beneficiary that is covered by such agreement and who shall provide an eligible beneficiary with—

(A) information regarding how to access the appeals process established for the program; and

(B) assistance with respect to the annual recertification of interest notifications required under subsection (c)(6); and

(2) ensure that the system and such counselors comply with the requirements of subsection (b).

(e) Advice and Assistance Counseling.—An agreement entered into under subsection (a)(2)(A)(ii) shall require the entity to appoint an advice and assistance counselor who shall provide an eligible beneficiary with information regarding—

(1) accessing and coordinating long-term services and supports in the most integrated setting;

(2) possible eligibility for other benefits and services;

(3) development of a service and support plan;

(4) information about programs established under the Assistance Technology Act of 1998 and the services offered under such programs;

(5) available assistance with decision-making and care coordination, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives or other written instructions recognized under State law, such as a living will or durable power of attorney for health care, in the case that an injury or illness causes the individual to be unable to make health care decisions; and

(6) such other services as the Secretary, by regulation, may require.

(f) No Effect on Eligibility for Other Benefits.—Benefits paid to an eligible beneficiary under the CLASS program shall be disregarded for purposes of determining or continuing the beneficiary’s eligibility for receipt of benefits under any other Federal, State, or locally funded assistance program.

(g) Advice and Assistance Counseling.—

(1) To pay cash benefits to eligible beneficiaries under the CLASS Independence Benefit Plan;

(2) to pay the administrative expenses related to the Fund to investment under subsection (b); and

(3) to pay cash benefits to eligible beneficiaries under the CLASS Independence Benefit Plan.

(h) Investment of Fund Balance.—The Secretary of the Treasury shall invest and manage the CLASS Independence Fund in the same manner, and to the same extent, as the Federal Supplemental Medical Insurance Trust Fund may be invested and managed under subsections (c), (d), and (e) of section 1314(d) of the Social Security Act.

(i) Board of Trustees.—

(1) In General.—With respect to the CLASS Independence Benefit Plan, the Secretary of the Treasury shall hereby create a body to be known as the Board of Trustees of the CLASS Independence Fund (hereinafter in this section referred to as the ‘Board of Trustees’). The Board of Trustees serving as a member of the public and nomintaed to serve in such position after the expiration of such term until the expiration of the time at which the member’s successor takes office or the time at which a report of the Board is first issued under paragraph (2) and the expiration of such member’s term under this paragraph (7). The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees. The Board of Trustees shall meet not less than four times per year. A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in the capacity with respect to the Trust Fund.

(2) Duties.—

(3) to pay cash benefits to eligible beneficiaries under the CLASS Independence Benefit Plan;
“(A) IN GENERAL.—It shall be the duty of the Board of Trustees to do the following:

“(i) Hold the CLASS Independence Fund.

“(ii) Report to the Congress not later than the first of each year on the operation and status of the CLASS Independence Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years.

“(iii) Report immediately to the Congress whenever the Board is of the opinion that the assets of the CLASS Independence Fund is not actuarially sound in regards to the projections under section 3233(b)(1)(B)(i).

“(iv) General policies followed in managing the CLASS Independence Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the CLASS Independence Fund is to be managed.

“(B) REPORT.—The report provided for in subparagraph (A)(i) shall—

“(i) include—

“(A) a statement of the assets and the disbursements made from, the CLASS Independence Fund during the preceding fiscal year;

“(B) an estimate of the expected income to, and disbursements to be made from, the CLASS Independence Fund during the current fiscal year and each of the next 2 fiscal years;

“(C) a statement of the actuarial status of the CLASS Independence Fund as of the first day of April of each year on the operation and status of the CLASS Independence Fund during the preceding fiscal year and each of the next 2 fiscal years, and as projected over the 75-year period beginning with the current fiscal year; and

“(D) an actuarial opinion certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable; and

“(ii) be printed as a House document of the session of the Congress to which the report is made.

“(C) RECOMMENDATIONS.—If the Board of Trustees determines that enrollment trends and expected future benefit claims on the CLASS Independence Fund are not actuarially sound in regards to the projections under section 3233(b)(1)(B)(i) and are unlikely to be resolved with reasonable premium increases or otherwise, the Board of Trustees shall include in the report provided for in subparagraph (A)(ii) recommendations for such legislative action as the Board of Trustees determines to be appropriate, including whether to adjust monthly premiums or impose a temporary moratorium on new enrollments.

*SEC. 2307. CLASS INDEPENDENCE ADVISORY COUNCIL.*

“(a) ESTABLISHMENT.—There is hereby created an Advisory Committee to be known as the ‘CLASS Independence Advisory Council’.

“(b) MEMBERSHIP.—

“(1) IN GENERAL.—The CLASS Independence Advisory Council shall be composed of—

“(A) who shall be appointed by the President without regard to the civil service laws and regulations; and

“(B) a majority of whom shall be representatives of individuals who participate or are likely to participate in the CLASS program, and shall include representatives of older and younger workers, individuals with disabilities, family caregivers of individuals who are at risk for institution and supports to maintain their independence at home or in another residential setting of their choice in the community, individuals with expertise in long-term care, and individuals with a background in actuarial science, economics, and other relevant disciplines, as determined by the Secretary.

“(2) TERMS.—

“(A) IN GENERAL.—The members of the CLASS Independence Advisory Council shall serve overlapping terms of 3 years (unless appointed as provided in subsection (A)(ii) prior to the expiration of a term, in which case the individual shall serve for the remainder of the term).

“(B) APPOINTMENT.—A member shall not be eligible to serve for more than 2 consecutive terms.

“(3) CHAIR.—The President shall, from time to time, appoint one of the members of the CLASS Independence Advisory Council to serve as the Chair.

“(C) DUTIES.—The CLASS Independence Advisory Council shall advise the Secretary on matters of general policy in the administration of the CLASS program established under this title and in the formulation of regulations under this title including with respect to—

“(1) the development of the CLASS Independence Benefit Plan under section 3233; and

“(2) the determination of monthly premiums under such plan.

“(D) APPLICATION OF FACA.—The Federal Advisory Committee Act, other than section 14 of that Act, shall apply to the CLASS Independence Advisory Council.

“(3) AUTHORIZATION OF APPROPRIATIONS.—

“(1) IN GENERAL.—There are authorized to be appropriated to the CLASS Independence Advisory Council $1,000,000 for each of the fiscal years 2011 and 2012.

“(E) AVAILABILITY.—Any sums appropriated under the authorization contained in this section shall remain available, without fiscal year limitation, until expended.

*SEC. 2308. REGULATIONS; ANNUAL REPORT.*

“(a) REGULATIONS.—The Secretary shall promulgate such regulations as are necessary to carry out the CLASS program in accordance with this title. Such regulations shall include provisions to prevent fraud and abuse under the program.

“(b) ANNUAL REPORT.—Beginning January 1, 2014, the Secretary shall submit an annual report to Congress on the CLASS program. Each report shall include the following:

“(1) The total number of enrollees in the program.

“(2) The total number of eligible beneficiaries during the fiscal year.

“(3) The total amount of cash benefits provided during the fiscal year.

“(4) A description of instances of fraud or abuse identified during the fiscal year.

“(5) Recommendations for such administrative or legislative action as the Secretary determines is necessary to improve the program or to prevent the occurrence of fraud or abuse.

*SEC. 2309. INSPECTOR GENERAL’S REPORT.*

“The Inspector General of the Department of Health and Human Services shall submit an annual report to the Secretary and Congress relating to the overall progress of the CLASS program and of the existence of waste, fraud, and abuse in the CLASS program. Each such report shall include findings in the following areas:

“(1) The eligibility determination process.

“(2) The processing of claims.

“(3) Quality assurance and protection against waste, fraud, and abuse.

“(4) Recouping of unpaid and accrued benefits.

“(b) CONFORMING AMENDMENTS TO MEDICAID.—For conforming provisions amending the Medicaid program, see section 1739.

*SEC. 2585. STATES FAILING TO ADHERE TO CERTAIN EMPLOYMENT OBLIGATIONS.*

Not later than 12 months after the date of the enactment of this Act, the Secretary of the Treasury, in consultation with the Commissioner of Social Security, shall report to Congress on the epidemiology of, impact of, and appropriate funding required to address

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neglected diseases of poverty, including neglected parasitic diseases identified as Chagas disease, cestodiase, toxocariasis, toxoplasmiosis, trichomoniasis, the soil-transmitted helminthiasis, and others. The report should provide the information necessary to enhance health policy to accurately evaluate and address the threat of these diseases.

SEC. 2588. OFFICE OF WOMEN'S HEALTH.

(a) HEALTH AND HUMAN SERVICES OFFICE ON WOMEN'S HEALTH.—

(1) ESTABLISHMENT.—Part A of title II (42 U.S.C. 202 et seq.) is amended by adding at the end the following:

"(c) Office on Women's Health.—

"(1) Establishment.—There is established within the Office of the Secretary of Health and Human Services an Office on Women's Health, which shall be headed by a Deputy Assistant Secretary for Women's Health who may report to the Secretary.

"(2) Duties.—The Secretary, acting through the Office, shall—

(a) establish short-range and long-range goals and objectives within the Department of Health and Human Services and, as relevant, coordinate with the appropriate offices on activities within the Department that relate to disease prevention, health promotion, service delivery, research and patient care, professional education, for issues of particular concern to women throughout their lifespan;

(b) provide expert advice and consultation to the Secretary concerning scientific, legal, ethical, and policy issues relating to women's health;

(c) monitor the Department of Health and Human Services' offices, agencies, and regional activities regarding women's health and identify needs regarding the coordination of activities, including intramural and extramural multidisciplinary activities;

(d) establish a Department of Health and Human Services Coordinating Committee on Women's Health, which shall be chaired by the Deputy Assistant Secretary for Women's Health and composed of senior level representatives from each of the agencies and offices of the Department of Health and Human Services;

(e) establish a National Women's Health Information Center to—

(A) facilitate the exchange of information regarding women's health issues and concerns; and

(B) establish short-range and long-range goals and objectives within the Department of Health and Human Services and, as relevant, coordinate with the appropriate offices on activities within the Department that relate to disease prevention, health promotion, preventive health services, research advances, and education in the appropriate use of health care;

(f) facilitate access to such information;

(g) assist in the analysis of issues and problems relating to the matters described in this paragraph; and

(h) provide technical assistance with respect to the exchange of information (including facilitating the development of materials for such technical assistance).

(2) Direct assistance programs.—(A) The Secretary shall make direct assistance grants and contracts to, and enter into cooperative agreements, with public and private entities, agencies, and organizations, for projects described by the Office and health professionals and the general public.

(b) OFFICE OF WOMEN'S HEALTH.—

(1) Establishment.—There is established within the Office of the Director of the Centers for Disease Control and Prevention an office to be known as the Office of Women's Health (referred to in this section as the 'Office'). The Office shall be headed by a Deputy Assistant Secretary for Women's Health who may report to the Secretary.

SEC. 2589. ACTIVITIES REGARDING WOMEN'S HEALTH.

(a) ESTABLISHMENT.—There is established within the Office of the Director, an Office of Women's Health and Gender-Based Research Quality Activities, in the Centers for Disease Control and Prevention (hereafter referred to in this section as the 'Office'). The Office shall be headed by a deputy assistant secretary appointed by the Director of the Centers for Disease Control and Prevention.

(b) Duties.—The Director of the Office shall—

(1) report to the Director on the current Agency level of activity regarding women's health, across, where appropriate, age, biological, and sociocultural contexts, in all aspects of Agency work, including the development of evidence reports and clinical practice guidelines, the conduct of research into patient outcomes, delivery of health care services, quality of care, and access to health care;

(2) establish short-range and long-range goals and objectives within the Agency for research important to women's health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Agency that relate to health services and medical effectiveness research, for issues of particular concern to women;

(3) identify projects in women's health that should be conducted or supported by the Agency;

(4) consult with health professionals, non-governmental organizations, consumer organizations, women's health professionals, and other individuals and groups, as appropriate, on the policy of the Centers with regard to women and

(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women's Health (established under section 229(b)(6)).

(c) DEFINITION.—As used in this section, the term 'women's health conditions', with respect to women of any age, means diseases, disorders, and conditions—

(1) unique to, significantly more serious for, or significantly more prevalent in women; and

(2) for which the factors of medical risk or type of medical intervention are different for women, or for which there is reasonable evidence that indicates that such factors or types may be different for women.

(d) OFFICE OF WOMEN'S HEALTH RESEARCH.—Section 486(a) (42 U.S.C. 287d(a)) is amended by inserting "and who shall report directly to the Director" before the period at the end thereof.

(e) AGENCY FOR HEALTHCARE RESEARCH AND QUALITY ACTIVITIES REGARDING WOMEN'S HEALTH.—Part C of title IX (42 U.S.C. 299c et seq.) is amended—

(1) by redesignating sections 927 and 928 as sections 928 and 929, respectively;

(2) by inserting after section 928 the following:

"SEC. 927. ACTIVITIES REGARDING WOMEN'S HEALTH.

(a) ESTABLISHMENT.—There is established within the Office of the Director, an Office of Women's Health and Gender-Based Research Quality Activities, in the Centers for Disease Control and Prevention (hereafter referred to in this section as the 'Office'). The Office shall be headed by a deputy assistant secretary appointed by the Director of the Centers for Disease Control and Prevention.

(b) PURPOSE.—The official designated under subsection (a) shall—

(1) report to the Director on the current Agency level of activity regarding women's health, across, where appropriate, age, biological, and sociocultural contexts, in all aspects of Agency work, including the development of evidence reports and clinical practice guidelines, the conduct of research into patient outcomes, delivery of health care services, quality of care, and access to health care;
other individuals and groups, as appropriate, on Agency policy with regard to women; and

(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women’s Health (established under section 229(b)(4)).

(3) by adding at the end of section 928 (as redesignated by paragraph (1)) the following:

''(e) Amending authority.—Nothing in this subsection shall be construed to require the establishment of an office or agency of the Department of Health and Human Services to carry out section 927 regarding women’s health, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years through 2015.

(f) HEALTH RESOURCES AND SERVICES ADMINISTRATION OFFICE OF WOMEN’S HEALTH.—Title VII of the Social Security Act (42 U.S.C. 300j et seq.) is amended by adding at the end the following:

``SEC. 713. OFFICE OF WOMEN’S HEALTH.

``(a) ESTABLISHMENT.—The Secretary shall establish within the Office of the Administrator of the Health Resources and Services Administration, an office to be known as the Office of Women’s Health. The Office shall be headed by a director who shall be appointed by the Administrator.

``(b) PURPOSE.—The Director of the Office shall—

``(1) report to the Administrator on the current Administration level of activity regarding women’s health across, where appropriate, age, biological, and sociocultural contexts;

``(2) establish short-range and long-range goals and objectives within the Health Resources and Services Administration for women’s health that are relevant and appropriate, coordinate with other appropriate offices on activities within the Administration that relate to health care provider training, health care and services research, and demonstration projects, for issues of particular concern to women;

``(3) identify projects in women’s health that are supported or supported by the bureaus of the Administration;

``(4) consult with health professionals, non-governmental organizations, consumer organizations, women’s health professionals, and other individuals and groups, as appropriate, on Administration policy with regard to women; and

``(5) serve as a member of the Department of Health and Human Services Coordinating Committee on Women’s Health (established under section 229(b)(4) of the Public Health Service Act).

``(c) CONTINUED ADMINISTRATION OF EXITING PROGRAMS.—The Director of the Office shall assume the authority for the development, implementation, administration, and evaluation of any projects carried out through the Health Resources and Services Administration relating to women’s health on the date of enactment of this section.

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

``(1) ADMINISTRATION.—The term ‘Administration’ means the Health Resources and Services Administration.

``(2) ADMINISTRATOR.—The term ‘Administrator’ means the Administrator of the Health Resources and Services Administration.

``(3) OFFICE.—The term ‘Office’ means the Office of Women’s Health established under this section in the Administration.

``(g) FOOD AND DRUG ADMINISTRATION OFFICE OF WOMEN’S HEALTH.—Chapter IX of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 391 et seq.) is amended by adding at the end the following:

``SEC. 911. OFFICE OF WOMEN’S HEALTH.

``(a) ESTABLISHMENT.—There is established within the Food and Drug Administration, an office to be known as the Office of Women’s Health (referred to in this section as the ‘Office’). The Office shall be headed by a director who shall be appointed by the Commissioner of Food and Drugs.

``(b) PURPOSE.—The Director of the Office shall—

``(1) report to the Commissioner of Food and Drugs on current Food and Drug Administration (referred to in this section as the ‘Administration’) regarding women’s participation in clinical trials and the analysis of data by sex in the testing of drugs, medical devices, and biological products across all ages, age, biological, and sociocultural contexts;

``(2) establish short-range and long-range goals and objectives within the Administration relating to women’s health within the jurisdiction of the Administration, including, where relevant and appropriate, adequate inclusion of women and analysis of data by sex in Administration protocols and policies;

``(3) provide information to women and health care providers on those areas in which differences between men and women exist;

``(4) consult with pharmaceutical, biologic, and device manufacturers, health professionals with expertise in women’s issues, consumer organizations, and women’s health professionals on Administration policy with regard to women;

``(5) make annual estimates of funds needed to monitor clinical trials and analysis of data by sex in accordance with needs that are identified; and

``(6) serve as a member of the Department of Health and Human Services Coordinating Committee on Women’s Health (established under section 229(b)(4) of the Public Health Service Act).

``(d) LIMITATION ON TERMINATION.—Notwithstanding any other provision of law, a Federal office of women’s health (including the Office of Research on Women’s Health of the National Institutes of Health) or Federal appointive position with primary responsibility over women’s health issues that is in existence on the date of enactment of this section shall not be terminated, reorganized, or have any of its personnel duties transferred unless such termination, reorganization, or transfer is approved by an Act of Congress.

``SEC. 2589. LONG-TERM CARE AND FAMILY CARE GIVER SUPPORT.

``(a) AMENDMENTS TO THE OLDER AMERICANS ACT OF 1965.—

``(1) PROMOTION OF DIRECT CARE WORKFORCE.—Section 202(b)(1) of the Older Americans Act of 1965 (42 U.S.C. 3012(b)(1)) is amended by inserting before the semicolon the following: ‘‘; and, in carrying out the purposes of this paragraph, shall make recommendations to other Federal entities regarding appropriate and effective means of identifying, promoting, and implementing investments in the direct care workforce necessary to meet the growing demand for long-term health services and supports and of assisting States in developing a comprehensive State long-term care plan with respect to such workforce, including assisting efforts to systematically assess, track, and report on workforce adequacy and capacity.’’

``(2) PERSONAL CARE ATTENDANT WORKFORCE ADVISORY PANEL.—Section 202 of such Act (42 U.S.C. 3012) is amended by adding at the end the following:

``(q) Not later than 90 days after the date of the enactment of this subsection, the Assistant Secretary shall establish a Personal Care Attendant Workforce Advisory Panel to examine and formulate recommendations on—

``(A) working conditions and training for workers providing long-term services and supports, including home health aides, certified nurse aides, and personal care attendants;

``(B) other workforce issues related to such workers, including with respect to the adequacy of the number of such workers; the need for a continuous supply of workers; and access to the services provided by such workers.

``(2) The Panel shall include representatives of—

``(A) relevant home- and community-based service providers, health care agencies, and facilities (including personal or home care agencies and agencies that provide activities in other homes, assisted living facilities, and residential care facilities);
“(B) the disability community, including individuals with disabilities and family caregivers;

(C) the nursing community;

(D) direct care workers (which may include union and national organizations);

(E) other individuals, including senior individuals and family caregivers;

(F) State and Federal health care entities; and

(G) experts in workforce development and adult learning.

(2) Within 180 days after receipt by the Assistant Secretary of the report under paragraph (3), the Assistant Secretary shall establish a 3-year demonstration program in 4 States to pilot and evaluate the effectiveness of the competencies articulated by the Panel and the training curricula and training methods recommended by the Panel.

(3) Not later than 1 year after the completion of the demonstration program under paragraph (4), the Assistant Secretary shall submit to the Congress a report containing the results of the evaluations by the Assistant Secretary pursuant to paragraph (4), together with such recommendations for legislation or administrative action as the Assistant Secretary determines appropriate:—

(a) AUTHORIZATION OF ADDITIONAL APPROPRIATIONS FOR THE FAMILY CAREGIVER SUPPORT PROGRAM UNDER THE OLDER AMERICANS ACT OF 1998.—Section 303(e)(2) of the Older Americans Act of 1998 (42 U.S.C. 3023(e)(2)) is amended by striking ‘‘, $173,000,000’’ and all that follows through ‘‘2011, and $50,000,000 for each of fiscal years 2012, 2013’’.

(b) AUTHORIZATION OF ADDITIONAL APPROPRIATIONS FOR THE FAMILY CAREGIVER SUPPORT PROGRAM UNDER THE OLDER AMERICANS ACT OF 1965.—Section 303(e)(2) of the Older Americans Act of 1965 (42 U.S.C. 3023(e)(2)) is amended by striking ‘‘, $173,000,000’’ and all that follows through ‘‘2011, and $50,000,000 for each of fiscal years 2012, 2013’’.

(2) be publicly accessible;

(2) be publicly accessible;

(3) be in English and the second most prevalent language spoken based on the latest Census information.

SEC. 2591. ONLINE HEALTH WORKFORCE TRAINING PROGRAM.

(a) IN GENERAL.—The Secretary in consultation with the Secretary of Health and Human Services, shall award National Workforce Health Online Training Grants on a competitive basis to eligible entities to enable such entities to train out for carrying out training for individuals to attain or advance in health care occupations. An entity may leverage such grants and other Federal, State, local, and private resources, in order to expand the participation of businesses, employees, and individuals in such training programs.

(b) ELIGIBILITY.—In order to receive a grant under the program established under this paragraph—

(i) an entity shall be an educational institution, community-based organization, non-profit organization, workforce investment board, or local or county government; and

(ii) an entity shall provide online workforce training and education programs; and

(c) PRIORITY.—Priority in awarding grants under this paragraph shall be given to entities that—

(i) have demonstrated experience in implementing and operating online worker skills training and education programs;

(ii) have demonstrated experience coordinating activities, where appropriate, with the workforce investment system; and

(iii) conduct training for occupations with national or local shortages.

(d) DATA COLLECTION.—Grantees under this paragraph shall collect and report information on—

(i) the number of participants;

(ii) the services received by the participants;

(iii) program completion rates;

(iv) factors determined as significantly interfering with program participation or completion;

(v) the rate of job placement; and

(vi) other information as determined as needed by the Secretary.

(e) GRANTEES UNDER THIS PARAGRAPH SHALL USE SUCH GRANTS TO CONDUCT OUTREACH ACTIVITIES TO DISSEMINATE INFORMATION ABOUT THEIR PROGRAM AND RESULTS TO WORKFORCE INVESTMENT BOARDS, LOCAL GOVERNMENTS, EDUCATIONAL INSTITUTIONS, AND OTHER WORKFORCE TRAINING ORGANIZATIONS.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary to carry out this section $50,000,000 for each of fiscal years 2011 through 2020.

(2) ONLINE HEALTH PROFESSIONS TRAINING PROGRAM CLEARINGHOUSE.

(a) DESCRIPTION OF GRANT.—The Secretary may award one or more grants to eligible postsecondary educational institutions to provide the services described in this paragraph.

(2) ELIGIBILITY.—To be eligible to receive grants under this paragraph, a postsecondary educational institution shall—

(i) provide technical assistance to entities that receive grants under paragraph (1); and

(ii) collect and nationally disseminate the data gathered by entities that receive grants under paragraph (1); and

(iii) disseminate the best practices identified by the National Workforce Health Online Training Grant Program to other workforce training organizations.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary to carry out this section $1,000,000 for each of fiscal years 2011 through 2020.

SEC. 2592. ACCESS FOR INDIVIDUALS WITH DISABILITIES.

Title V of the Rehabilitation Act of 1973 (29 U.S.C. 791 et seq.) is amended by adding at the end of the following:

SEC. 510. STANDARDS FOR ACCESSIBILITY OF MEDICAL DIAGNOSTIC EQUIPMENT.

(a) STANDARDS.—Not later than 1 year after the date of enactment of the Affordable Health Care for America Act, the Architectural and Transportation Barriers Compliance Board (Access Board) shall issue guidelines setting forth the minimum technical criteria for new medical diagnostic equipment to be purchased for use in—

(1) public, private, nonprofit, or other for-profit hospitals;

(2) nursing facilities and other long-term care facilities;

(3) other health care providers; and

(4) other medical or health care facilities.

(b) MEDICAL DIAGNOSTIC EQUIPMENT COVERAGE.—The guidelines issued under sub-section (a) for medical diagnostic equipment shall apply to new purchases of equipment that includes examination tables, examination chairs (including chairs used for eye examinations or procedures, and dental examinations or procedures), weight scales, mammography equipment, x-ray machines, and other equipment commonly used for diagnostic or examination purposes by health professionals.
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"(c) Regulations.—Not later than 6 months after the date of the issuance of the guidelines under subsection (a), each appropriate Federal agency authorized to promulgate regulations under this Act or under the Americans with Disabilities Act shall—

"(1) prescribe regulations in an accessible format as necessary to carry out the provisions of this Act and section 504 of this Act that include accessibility standards that are consistent with the guidelines issued under subsection (a); and

"(2) ensure that health care providers and health care plans covered by the Affordable Health Care for America Act meet the requirements of the Americans with Disabilities Act, including regulations ensuring that individuals with disabilities receive equal access to all aspects of the health care delivery system.

"(d) Review and amendment.—The Architectural and Transportation Barriers Compliance Board shall periodically review and, as appropriate, amend the guidelines as prescribed under subsection (a). Not later than 6 months after the date of the issuance of such revised guidelines, revised regulations consistent with such guidelines shall be promulgated in an accessible format by the appropriate Federal agencies described in subsection (c)."

SEC. 2593. DUPLICATIVE GRANT PROGRAMS.

(a) Secretary.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall conduct a study to determine if any new division C grant program is duplicative of one or more other grant programs of the Department of Health and Human Services that—

(1) are specifically authorized in the Public Health Service Act (42 U.S.C. 201 et seq.); or

(2) are receiving appropriations.

(b) Duplicative Programs.—If the Secretary determines under subsection (a) that a new division C grant program is duplicative of one or more other grant programs described in such subsection, the Secretary shall—

(1) attempt to integrate the new division C grant program with the duplicative programs; and

(2) if the Secretary determines that such integration is not appropriate or has not been successful, promulgate a rule eliminating the duplication, including, if appropriate, by terminating one or more programs.

(c) Continued Availability of Funds.—Any funds appropriated to carry out a program that is terminated under subsection (b) shall remain available for obligation for the one or more programs that—

(1) were determined under subsection (a) to be duplicative of such program; and

(2) remain in effect.

(d) Report.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to the Congress and make publicly available a report that contains the results of the study required under subsection (a).

(1) Congressional review.—Any rule under subsection (b) terminating a program is deemed to be a major rule for purposes of chapter 8 of title 5, United States Code.

(2) Definition.—In this section, the term "new division C grant program" means a grant program first established by this division.

SEC. 2594. DIABETES SCREENING COLLABORATIVE 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 section as the "Secretary"), in collaboration with the Centers for Disease Control and Prevention (referred to in this section as the "Director"), shall—

(1) review existing diabetes screening benefits, consistent with recommendations of the Task Force on Clinical Preventive Services (established under section 311B of the Public Health Service Act as added by section 2301 of this Act), to identify and address any existing problems, with regard to uptake and utilization and related data collection efforts; and

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

(b) Consultation.—The Secretary shall carry out this section in consultation with—

(1) the heads of appropriate health agencies and offices in the Department of Health and Human Services, including the Office of Minority Health; and

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

(c) Report.—The Secretary shall submit an annual report to the Congress on the activities carried out under this section.

SEC. 2595. IMPROVEMENT OF VITAL STATISTICS.

(a) In general.—The Secretary of Health and Human Services (in this section referred to as 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 certification data and how to properly complete these documents in accordance with State law, including the collection of such data for diabetes and other chronic diseases as appropriate; and

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

(b) Consultation.—The Secretary shall work with States to re-engineer their vital statistics systems in order to provide cost-effective, timely, and accurate vital systems data.

(c) Death Certificate Additional Language.—The Secretary may promote improvements to the collection of diabetes mortality data, including, as appropriate, the addition by States of specific questions, such as individual certifying the cause of death regarding whether the deceased had diabetes.

SEC. 2596. NATIONAL HEALTH SERVICES CORPS.

(a) In general.—The Secretary of Health and Human Services may establish a demonstration program under which, in addition to the salary and benefits otherwise owed to any such member who is assigned to a health professional shortage area with extreme need and who was determined under subsection (a) to be a medical or dental graduate from an institution of higher education, the Secretary shall—

(1) pay the member as designated by the Secretary an annual demonstration program stipend of up to $25,000;

(b) Grant Program.—Any amounts received by a State for the purposes of carrying out a program under this section shall be used to provide the necessary health care services to those with diabetes or prediabetes.

(c) Authorization of Appropriations.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2015.

DIVISION D—INDIAN HEALTH CARE IMPROVEMENT

SEC. 3001. SHORT TITLE; TABLE OF CONTENTS.

(a) Short Title.—This division may be cited as the "Indian Health Care Improvement Act Amendments of 2009".

(b) Table of Contents.—The table of contents of this division is as follows:

"Sec. 1. Short title; table of contents.
"Sec. 2. Findings.
"Sec. 3. Declaration of policy.
"Sec. 4. Definitions.
"Sec. 5. Authorization of appropriations.
"Sec. 6. Indian Health Care Improvement Act Amendments of 2009 (25 U.S.C. 1601 et seq.) is amended to read as follows:

TITLE I—AMENDMENTS TO INDIAN LAWS

Sec. 3101. Indian Health Care Improvement Act.

Sec. 3102. Indian Health Care Improvement Act Amendments of 2009.

Sec. 3103. Indian Health Care Improvement Act Amendments of 2009. (a) Short Title.—This Act may be cited as the 'Indian Health Care Improvement Act'.

(b) Table of Contents.—The table of contents for this Act is as follows:

"Sec. 1. Short title; table of contents.
"Sec. 2. Findings.
"Sec. 3. Declaration of national Indian health policy.
"Sec. 4. Definitions.

"TITLE I—INDIAN HEALTH, HUMAN RESOURCES, AND DEVELOPMENT

"Sec. 101. Purpose.
"Sec. 102. Health professions recruitment program for Indians.
"Sec. 103. Health professions preparatory scholarship program for Indians.
"Sec. 104. Indian health professions scholarships.
"Sec. 105. American Indians Into Psychology Program.
"Sec. 106. Scholarship programs for Indian professionals.
"Sec. 107. Indian Health Care Improvement Act Amendments of 2009.

"Sec. 2. Findings.

TITLE II—IMPROVEMENT OF INDIAN HEALTH CARE PROVIDED UNDER THE SOCIAL SECURITY ACT

Sec. 3201. Expansion of findings for health care coverage in SCHIP and Medicaid.

Sec. 3202. Additional provisions to increase coverage to Indians in SCHIP and Medicaid.

Sec. 3203. Solicitation of proposals for primary care physicians and licensed mental health professionals for health care services for Indians.

Sec. 3204. Annual report on services served by Indian Health Service.

Sec. 3205. Development of recommendations to improve interstate coordination of Medicaid and SCHIP coverage for Indian children and other children who are outside of their State of residency because of educational or other needs.

TITLE III—ADVANCES IN RESEARCH, EDUCATION, AND TRAINING

Sec. 3301. Indian Research Center.

Sec. 3302. Indian Health Service education and training programs.

Sec. 3303. Health professions recruitment program for Indians.

Sec. 3304. Indian Health Service education and training programs.

"Sec. 1. Short title; table of contents.
"Sec. 2. Findings.
"Sec. 3. Declaration of national Indian health policy.
"Sec. 4. Definitions.
"Sec. 5. Authorization of appropriations.

"TITLE IV—PRIVATE SECTOR COOPERATION

"Sec. 101. Purpose.
"Sec. 102. Health professions recruitment program for Indians.
"Sec. 103. Health professions preparatory scholarship program for Indians.
"Sec. 104. Indian health professions scholarships.
"Sec. 105. American Indians Into Psychology Program.
"Sec. 106. Scholarship programs for Indian professionals.
"Sec. 107. Indian Health Care Improvement Act Amendments of 2009.

"Sec. 2. Findings.

"TITLE V—PAYMENTS TO INDIANS FOR DIAGNOSTIC SERVICES

"Sec. 101. Purpose.
"Sec. 102. Medical billing proposal.
"Sec. 103. Medical billing proposal.
"Sec. 104. Indian health professions scholarships.
"Sec. 105. American Indians Into Psychology Program.
"Sec. 106. Scholarship programs for Indian professionals.
"Sec. 107. Indian Health Care Improvement Act Amendments of 2009.
"(2) A major national goal of the United States is to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population.

"(3) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum participation of Indians in the planning and management of those services.

"(4) Federal health services to Indians have developed to include reduction in the prevalence and incidence of preventable illnesses among, and unnecessary and premature deaths of, Indians.

"(5) Despite such services, the unmet health needs of the American Indian people are severe and the health status of the Indians is far below that of the general population of the United States.

**SEC. 3. DECLARATION OF NATIONAL INDIAN HEALTH POLICY.**

"Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—

"(1) to assure the highest possible health status for Urban Indians and to provide all resources necessary to effect that policy;

"(2) to raise the health status of Indians and Urban Indians to at least the levels set forth in the goals contained within the Health People 2010 or successor objectives;

"(3) to the greatest extent possible, to allow them to set their own health care priorities and establish goals that reflect their unmet needs;

"(4) to increase the proportion of all degrees of health professionals and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each Service Area is raised to at least the level of that of the general population;

"(5) to require meaningful consultation with Indian Tribes, Tribal Organizations, and urban organizations or individuals to implement this Act and the national policy of Indian self-determination; and

"(6) to provide funding for programs and facilities to be provided by the Tribes, Tribal Organizations, and Urban Indian Organizations in amounts that are not less than the amounts provided to programs and facilities operated or funded by the Service.

**SEC. 4. DEFINITIONS.**

"For purposes of this Act:

"(1) The term 'accredited and accessible' means on or near a reservation and accredited by a national or regional organization with accrediting authority.

"(2) The term 'Area Office' means an administrative entity of the Service, or a Tribal Administrative Unit, which, within the Service through which services and funds are provided to the Service Units within a defined geographic area.

"(3) The term 'Assistant Secretary' means the Assistant Secretary of Indian Health.

"(4)(A) The term 'behavioral health' means the blending of substance (including alcohol, drugs, inhalants, and tobacco) abuse and mental health prevention and treatment, for the purpose of providing comprehensive services.

"(B) The term 'behavioral health' includes the joint development of substance abuse and mental health treatment planning and coordinated case management using a multidisciplinary approach.

"(5) The term 'California Indians' means those Indians who are eligible for health services of the Service pursuant to section 805.

"(6) The term 'community college' means—

"(A) a tribal college or university, or

"(B) a two-year college.

"(7) The term 'contract health service' means health services provided at the expense of the Service or a Tribal Health Program by public or private medical providers or hospitals, other than the Service Unit or the Tribal Health Program at whose expense the services are provided.

"(8) The term 'consumption' means, unless otherwise designated, the Department of Health and Human Services.

"(9) The term 'disability prevention' means the reduction, limitation, and prevention of disease and its complications and reduction in the consequences of disease, including—

"(A) controlling—

"(i) the development of diabetes;

"(ii) high blood pressure;

"(iii) infectious agents;

"(iv) injuries;

"(v) occupational hazards and disabilities;

"(vi) sexually transmissible diseases; and

"(vii) toxic agents; and

"(B) providing—

"(i) fluoridation of water; and

"(ii) immunizations.

"(10) The term 'health profession' means allopathic medicine, family medicine, internal medicine, pediatrics, geriatric medicine, obstetrics and gynecology, podiatric medicine, nursing, public health nursing, dentistry, psychology, optometry, pharmacy, psychology, public health, social work, marriage and family therapy, chiropractic medicine, environmental health and engineering, allied health professions, naturopathic medicine, and any other health profession.

"(11) The term 'health promotion' means—

"(A) fostering social, economic, environmental, and personal factors conducive to health, including raising public awareness about health matters and enabling the people to cope with health problems by increasing their knowledge and providing them with valid information;

"(B) encouraging adequate and appropriate diet, exercise, and sleep;

"(C) promoting education and work in conformity with physical and mental capacity; and

"(D) making available safe water and sanitary facilities.

"(12) The term 'high blood pressure' means—

"(A) any Tribal Health Program administered directly by the Service;

"(B) any Tribal Health Program; or

"(C) any Indian Tribe or Tribal Organization to which the Secretary provides funding pursuant to section 23 of the Act of June 25, 1910 (25 U.S.C. 461) (commonly known as the 'Buy Indian Act').

"(14) The term 'Indian Tribe' has the meaning given the term in the Indian Self-Determination and Education Assistance Act (25 U.S.C. 460).

"(15) The term 'Indian Tribe' has the meaning given the term by section 802 of the Higher Education Act of 1965 (20 U.S.C. 1058).

"(16) The term 'reservation' means any federal recognized Indian Tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Indian allotments, and Alaska Native Regional corporations pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.).

"(17) The term 'Secretary', unless otherwise designated, means the Secretary of Health and Human Services.

"(18) The term 'Service' means the Indian Health Service.

"(19) The term 'Service Area' means the geographical area served by each Area Office.

"(20) The term 'Service Unit' means an administrative entity of the Service, or a Tribal Health Program through which services are provided, directly or by contract, to eligible Indians within a defined geographic area.

"(21) The term 'telehealth' has the meaning given the term 'telehealth' in section 330(k)(4) of the Public Health Service Act (42 U.S.C. 254c-16(a)).

"(22) The term 'teledermatology' means telecommunications link to an end user through the use of eligible equipment that electronically links health professionals or patients similar to the use of eligible equipment that electronically links health professionals or patients.
and health professionals at separate sites in order to exchange health care information in audio, video, graphic, or other format for the purpose of providing improved health care services.

"The term "tribal college or university" has the meaning given the term in section 316(b)(3) of the Higher Education Act (20 U.S.C. 1064(b)(3))."

"The term "Indian Tribe Health Program" means Indian Tribe or Tribal Organization that operates any health program, service, facility, activity, or facility funded in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)."

"The term "tribal organization" has the meaning given the term in the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)."

"The term "Urban Center" means any community which has a sufficient Urban Indian population with unmet health needs to warrant assistance under title V of this Act, as determined by the Secretary.

"The term "urban Indian" means any individual who resides in an Urban Center and who meets 1 or more of the following criteria:"

1. "(A) is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups that are recognized by the States in which they reside, or who is a descendant in the first or second degree of any such member;"
2. "(B) The individual is an Eskimo, Aleut, or other Alaska Native;"
3. "(C) The individual is considered by the Secretary of the Interior to be an Indian for any purpose;"
4. "(D) The individual is determined to be an Indian under regulations promulgated by the Secretary.

"The term "urban Indian organization" means a nonprofit corporate body that (A) is situated in an Urban Center; (B) is governed by an Urban Indian-controlled board of directors; (C) is the recipient of a service obligation under a written contract referred to in paragraph (1) and who resides in an Urban Center and who meets 1 or more of the following criteria:"

"(A) is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups that are recognized by the States in which they reside, or who is a descendant in the first or second degree of any such member;"
"(B) The individual is an Eskimo, Aleut, or other Alaska Native;"
"(C) The individual is considered by the Secretary of the Interior to be an Indian for any purpose;"
"(D) The individual is determined to be an Indian under regulations promulgated by the Secretary.

"The term "urban Indian nursing program" means a program or urban Indian organization to assist such entities in meeting the costs of increasing the number of registered nurses at an accredited institution; and

"The term "Indian" means any individual who is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups that are recognized by the States in which they reside, or who is a descendant in the first or second degree of any such member;"

"The term "Indian health program" means any program or urban Indian organization to assist such entities in meeting the costs of increasing the number of registered nurses at an accredited institution; and

"The term "Indian Health Program" means an Indian Tribe or Tribal Organization that operates any health program, service, facility, activity, or facility funded in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)."

"The term "Indian Health Program" means an Indian Tribe or Tribal Organization that operates any health program, service, facility, activity, or facility funded in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)."

"The term "Indian Health Program" means an Indian Tribe or Tribal Organization that operates any health program, service, facility, activity, or facility funded in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)."

"The term "Indian Health Program" means an Indian Tribe or Tribal Organization that operates any health program, service, facility, activity, or facility funded in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)."

"The term "Indian Health Program" means an Indian Tribe or Tribal Organization that operates any health program, service, facility, activity, or facility funded in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)."

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"The term "Indian Health Program" means an Indian Tribe or Tribal Organization that operates any health program, service, facility, activity, or facility funded in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)."

"The term "Indian Health Program" means an Indian Tribe or Tribal Organization that operates any health program, service, facility, activity, or facility funded in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)."

"The term "Indian Health Program" means an Indian Tribe or Tribal Organization that operates any health program, service, facility, activity, or facility funded in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)."

"The term "Indian Health Program" means an Indian Tribe or Tribal Organization that operates any health program, service, facility, activity, or facility funded in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)."

"The term "Indian Health Program" means an Indian Tribe or Tribal Organization that operates any health program, service, facility, activity, or facility funded in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)."

"The term "Indian Health Program" means an Indian Tribe or Tribal Organization that operates any health program, service, facility, activity, or facility funded in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)."

"The term "Indian Health Program" means an Indian Tribe or Tribal Organization that operates any health program, service, facility, activity, or facility funded in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)."

"The term "Indian Health Program" means an Indian Tribe or Tribal Organization that operates any health program, service, facility, activity, or facility funded in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)."

"The term "Indian Health Program" means an Indian Tribe or Tribal Organization that operates any health program, service, facility, activity, or facility funded in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)."

"The term "Indian Health Program" means an Indian Tribe or Tribal Organization that operates any health program, service, facility, activity, or facility funded in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)."

"The term "Indian Health Program" means an Indian Tribe or Tribal Organization that operates any health program, service, facility, activity, or facility funded in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)."

"The term "Indian Health Program" means an Indian Tribe or Tribal Organization that operates any health program, service, facility, activity, or facility funded in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)."

"The term "Indian Health Program" means an Indian Tribe or Tribal Organization that operates any health program, service, facility, activity, or facility funded in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)."

"The term "Indian Health Program" means an Indian Tribe or Tribal Organization that operates any health program, service, facility, activity, or facility funded in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)."

"The term "Indian Health Program" means an Indian Tribe or Tribal Organization that operates any health program, service, facility, activity, or facility funded in whole or part, by the Service through, or provided for in, a contract or compact with the Service under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)."
such student is enrolled.

(5) EXTREME HARDSHIP.—Notwithstanding any other provision of law, in any case of extreme hardship or for other good cause shown, the Secretary may waive, in whole or in part, the right of the United States to recover funds made available under this section.

(6) BANKRUPTCY.—Notwithstanding any other provision of law, with respect to a recipient an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under title 11, United States Code, unless that discharge is in effect, prior to the completion of the greater of—

(A) the period of obligated service described in subsection (b)(1) shall be equal to the greater of—

(1) such scholarship shall be for a period of not less than 6 years or 10 years, as determined by the Secretary; or

(2) the period of obligated service described in subsection (b)(1) shall be equal to the greater of—

(1) such scholarship shall be for a period of not less than 4 years, as determined by the Secretary; or

(2) the period of obligated service described in subsection (b)(1) shall be equal to the greater of—

(A) the period of obligated service for an individual who is enrolled for not less than 3 years; and

(B) 2 years; and

(3) the amount of the monthly stipend specified in section 338a(g)(1)(B) of the Public Health Service Act (42 U.S.C. 254h(g)(1)(B)) shall be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled.

(7) BANKRUPTCY.—Notwithstanding any other provision of law, with respect to a recipient an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under title 11, United States Code, unless that discharge is in effect, prior to the completion of the greater of—

(A) the period of obligated service described in subsection (b)(1) shall be equal to the greater of—

(1) such scholarship shall be for a period of not less than 6 years or 10 years, as determined by the Secretary; or

(2) the period of obligated service described in subsection (b)(1) shall be equal to the greater of—

(A) the period of obligated service for an individual who is enrolled for not less than 3 years; and

(B) 2 years; and

(3) the amount of the monthly stipend specified in section 338a(g)(1)(B) of the Public Health Service Act (42 U.S.C. 254h(g)(1)(B)) shall be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled.

(8) GRANTS AUTHORIZED.—The Secretary, acting through the Service, shall make grants of not more than $300,000 to each of 9 colleges and universities for the purpose of developing and maintaining Indian psychology career recruitment programs as a means of encouraging Indians to enter the behavioral health field. These programs shall be located at public institutions of higher education throughout the country to maximize their availability to Indian students and new programs shall be established in different locations from time to time.

(9) CANCELLATION UPON DEATH OF RECIPIENT.—Upon the death of an individual who meets the obligation or makes the payment required under such contract before the completion of such training; or

(10) EXTREME HARDSHIP.—Notwithstanding any other provision of law, with respect to a recipient an Indian Health Scholarship, no obligation for payment may be released by a discharge in bankruptcy under title 11, United States Code, unless that discharge is in effect, prior to the completion of the greater of—

(A) the period of obligated service described in subsection (b)(1) shall be equal to the greater of—

(1) such scholarship shall be for a period of not less than 6 years or 10 years, as determined by the Secretary; or

(2) the period of obligated service described in subsection (b)(1) shall be equal to the greater of—

(A) the period of obligated service for an individual who is enrolled for not less than 3 years; and

(B) 2 years; and

(3) the amount of the monthly stipend specified in section 338a(g)(1)(B) of the Public Health Service Act (42 U.S.C. 254h(g)(1)(B)) shall be reduced pro rata (as determined by the Secretary) based on the number of hours such student is enrolled.

(11) SCHOLARSHIP PROGRAMS.—The Secretary, acting through the Service, shall make grants to Tribal Health Programs for the purpose of providing scholarships for Indians to serve as health professionals in Indian communities.

(12) AMOUNT.—Amounts available under paragraph (1) for any fiscal year shall not exceed 5 percent of the amounts available for each fiscal year for Indian Health Scholarships under section 106.

(13) APPLICATION.—An application for a grant under subsection (a) shall be in such form and contain such agreements, assurances, and information as consistent with this section.

(14) REQUIREMENTS.— Such an application for a grant under subsection (a) shall contain—

(A) a description of the proposed program; and

(B) a statement of objectives and proposed activities.

(15) SCHOLARSHIP PROGRAMS.—The Secretary, acting through the Service, shall make grants to Tribal Health Programs for the purpose of providing scholarships for Indians to serve as health professionals in Indian communities.

(16) AMOUNT.—Amounts available under paragraph (1) for any fiscal year shall not exceed 5 percent of the amounts available for each fiscal year for Indian Health Scholarships under section 106.

(17) APPLICATION.—An application for a grant under subsection (a) shall be in such form and contain such agreements, assurances, and information as consistent with this section.

(18) REQUIREMENTS.—Such an application for a grant under subsection (a) shall contain—

(A) a description of the proposed program; and

(B) a statement of objectives and proposed activities.

(19) SCHOLARSHIP PROGRAMS.—The Secretary, acting through the Service, shall make grants to Tribal Health Programs for the purpose of providing scholarships for Indians to serve as health professionals in Indian communities.

(20) AMOUNT.—Amounts available under paragraph (1) for any fiscal year shall not exceed 5 percent of the amounts available for each fiscal year for Indian Health Scholarships under section 106.

(21) APPLICATION.—An application for a grant under subsection (a) shall be in such form and contain such agreements, assurances, and information as consistent with this section.

(22) REQUIREMENTS.—Such an application for a grant under subsection (a) shall contain—

(A) a description of the proposed program; and

(B) a statement of objectives and proposed activities.

(23) SCHOLARSHIP PROGRAMS.—The Secretary, acting through the Service, shall make grants to Tribal Health Programs for the purpose of providing scholarships for Indians to serve as health professionals in Indian communities.

(24) AMOUNT.—Amounts available under paragraph (1) for any fiscal year shall not exceed 5 percent of the amounts available for each fiscal year for Indian Health Scholarships under section 106.

(25) APPLICATION.—An application for a grant under subsection (a) shall be in such form and contain such agreements, assurances, and information as consistent with this section.

(26) REQUIREMENTS.—Such an application for a grant under subsection (a) shall contain—

(A) a description of the proposed program; and

(B) a statement of objectives and proposed activities.

(27) SCHOLARSHIP PROGRAMS.—The Secretary, acting through the Service, shall make grants to Tribal Health Programs for the purpose of providing scholarships for Indians to serve as health professionals in Indian communities.

(28) AMOUNT.—Amounts available under paragraph (1) for any fiscal year shall not exceed 5 percent of the amounts available for each fiscal year for Indian Health Scholarships under section 106.

(29) APPLICATION.—An application for a grant under subsection (a) shall be in such form and contain such agreements, assurances, and information as consistent with this section.

(30) REQUIREMENTS.—Such an application for a grant under subsection (a) shall contain—

(A) a description of the proposed program; and

(B) a statement of objectives and proposed activities.
determined by the Secretary) based on the number of hours such student is enrolled, and not to exceed, for any year of attendance for which the scholarship is provided, the total amount required for the year for the purposes authorized in this clause; and

(ii) may not exceed, for any year of attendance for which the scholarship is provided, the total amount required for the year for the purposes authorized in clause (i); and

(C) require the recipient of such scholarship to maintain an acceptable level of academic standing as determined by the educational institution in accordance with regulations issued pursuant to this Act; and

(D) require of such scholarship to meet the educational and licensure requirements appropriate to each health profession.

3. SERVICE IN OTHER SERVICE AREAS.—The contract may allow the recipient to serve in another Service Area, provided the Tribal Health Program and Secretary approve and services are not diminished to Indians in the Service Area where the Tribal Health Program providing the scholarship is located.

(e) BREACH OF CONTRACT.—

(1) Breach of Contract.—An individual who has entered into a written contract with the Secretary and a Tribal Health Program under this subparagraph who shall be liable to the United States for the Federal share of the amount which has been paid to him or her, or on his or her behalf, under the contract if that individual—

(A) fails to maintain an acceptable level of academic standing in the educational institution in which he or she is enrolled (such level as determined by the educational institution under regulations of the Secretary);

(B) is dismissed from such educational institution for disciplinary reasons;

(C) terminates the training in such an educational institution for which he or she is enrolled or is a scholarship awarded under such contract before the completion of such training; or

(D) fails to accept payment, or instructs the educational institution in which he or she is enrolled not to accept payment, in whole or in part, of a scholarship under such contract, in lieu of any service obligation arising under such contract.

(2) OTHER BREACHES.—If for any reason not specified in paragraph (1), an individual breaches a written contract by failing to either begin such individual's service obligation required under such contract or to complete such service obligation, the United States shall be entitled to recover from the individual an amount determined in accordance with the formula specified in subsection (b) of section 110 in the manner provided for in such subsection.

(f) CANCELLATION UPON DEATH OF RECIPIENT.—Upon the death of an individual who received a scholarship, any outstanding obligation of that individual for service or payment that relates to that scholarship shall be canceled.

(g) ADMISSION TO PROFESSION.—The Secretary may carry out this subsection on the basis of the Secretary's determination that it is necessary to maintain accreditation of, and the supply of trained health professionals necessary to the Health Profession in which he or she is enrolled, including a high school program, authorized under section 102(a) may be employed by the Service or by a Tribal Health Program or an urban Indian Health Program, for a nonacademic period of the year. Any such employment shall not exceed 120 days during any calendar year.

(h) NONAPPLICABILITY OF COMPETITIVE PERSONNEL SYSTEM.—Any employment pursuant to this subsection shall be made without regard to any competitive personnel system or agency personnel limitation and to a position which will enable the individual so employed to receive practical experience in the health profession in which he or she is enrolled. Such individual so employed shall receive payment for his or her services comparable to the salary he or she would receive if he or she were employed in the competitive personnel system. Any individual so employed shall be counted against any employment affecting the Service or the Department.

SEC. 107. INDIAN HEALTH SERVICE EXTERNAL PROGRAMS.

(a) EMPLOYMENT PREFERENCE.—Any individual who has received a scholarship pursuant to section 104 or 106 shall be given preference for employment in the Service, or may be employed by a program or an agency or organization that provides health services to Indians in an urban Indian organization, or other agencies of the Department as available, during any nonacademic period of the year. The Secretary may make grants to educational institutions and other nonprofit organizations to provide health care to underserved populations.

(b) NON-EDITORIAL DUTY SERVICE OBLIGATION.—Periods of employment pursuant to this subsection shall not be counted against any service obligation incurred as a condition of the scholarship.

(c) TIMING; LENGTH OF EMPLOYMENT.—Any individual enrolled in a program, including a high school program, authorized under section 102(a) may be employed by the Service or by a Tribal Health Program or an urban Indian Health Program, for a nonacademic period of the year. Any such employment shall not exceed 120 days during any calendar year.

SEC. 108. CONTINUING EDUCATION ALLOWANCES.

In order to encourage scholarship and stipend recipients under sections 104, 105, 106, and 115 and health professionals, including community health representatives and emergency medical technicians, to join or continue in the Health Profession, and to provide their services in the rural and remote areas where a significant portion of Indians reside, the Secretary, acting through the Service, may

(1) provide programs or allowances to transition into an Indian Health Program, including licensing, board or certification examination assistance, and technical assistance in fulfilling service obligations under sections 104, 105, 106, and 115; and

(2) provide programs or allowances to transition into an Indian Health Program to enable them for a period of time each year prescribed by regulation of the Secretary to take leave of their duty status to receive professional consultation, management, leadership, and refresher training courses.

SEC. 109. COMMUNITY HEALTH REPRESENTATIVE PROGRAM.

(a) IN GENERAL.—Under the authority of the Secretary of November 13, 1944 (commonly known as the Snyder Act), the Secretary, acting through the Service, shall maintain a Community Health Representative Program under which Indian Health Programs—

(1) provide for the training of Indians as community health representatives; and

(b) use such community health representatives in the provision of health care, health promotion, and disease prevention services to Indian communities.

(c) INDIAN HEALTH SERVICE REPRESENTATIVE PROGRAM OF THE SERVICE.—

(1) provide a high standard of training for community health representatives to ensure the quality of community health representatives; provide quality health care, health promotion, and disease prevention services to the Indian communities served by the Program; and

(2) in order to provide such training, develop and maintain a curriculum that—

(A) combines education in the theory of health care with supervised practical experience in the provision of health care; and

(B) provides instruction and practical experience in health education, disease prevention activities, with appropriate consideration given to lifestyle factors that have an impact on Indian health status, such as alcoholism, family dysfunction, and poverty;

(3) maintain a system which identifies the needs of community health representatives for continuing education in health care, health promotion, and disease prevention and develop programs that meet the needs for continuing education;

(4) maintain a system that provides close supervision of Community Health Representatives;

(5) maintain a system under which the work of Community Health Representatives is reviewed and evaluated; and

(6) promote traditional health care practices of the Indian Tribes served consistent with the Service standards for the provision of health care, health promotion, and disease prevention.

SEC. 110. INDIAN HEALTH SERVICE LOAN REPAYMENT PROGRAM.

(a) ESTABLISHMENT.—The Secretary, acting through the Service, shall establish and administer a program to be known as the Indian Health Service Loan Repayment Program (commonly referred to as the 'Loan Repayment Program') in order to ensure an adequate supply of trained health professionals necessary to maintain accreditation of, and to provide health care services to Indians through, Indian Health Programs and urban Indian organizations.

(b) ELIGIBLE INDIVIDUALS.—To be eligible to participate in the Loan Repayment Program, an individual must—

(1) be enrolled—

(i) in a course of study or program in an accredited educational institution (as determined by the Secretary under section 382(b)(1)(c)(i) of the Public Health Service Act (42 U.S.C. 294l(b)(1)(c)(i))) and is scheduled to complete such course of study in the same year such individual applies to participate in such program; or

(ii) in an approved graduate training program in a health profession; or

(2) have—

(i) a license in a health profession; and

(ii) a license to practice a health profession.

(3) A) be eligible for, or hold, an appointment as a commissioned officer in the Regular or Reserve Corps of the Public Health Service;
“(B) meet the professional standards for civil service employment in the Service; or
“(C) be employed in an Indian Health Program or urban Indian organization without a service obligation.”

“(3) submit to the Secretary an application for a contract described in subsection (e).”

“(C) VIOLATION.
“(1) INFORMATION TO BE INCLUDED WITH FORMS.—In disseminating application forms and contract forms to individuals desiring to participate in the Loan Repayment Program, the Secretary shall include with such forms a fair summary of the rights and liabilities of an individual whose application is approved (and whose contract is accepted) by the Secretary, including in the summary a clear explanation of the damages to which the United States is entitled under subsection (d).”

“(2) CLEAR LANGUAGE.—The application form, contract form, and all other information made available by the Secretary with this section shall be written in a manner calculated to be understood by the average individual applying to participate in the Loan Repayment Program on a date sufficiently early to ensure that such individuals have adequate time to carefully review and evaluate such forms and information.”

“(d) PRIORITIES.—
“(1) LIST.—Consistent with subsection (j), the Secretary shall annually:
“(A) identify the positions in each Indian Health Program or urban Indian organization for which there is a need or a vacancy; and
“(B) rank those positions in order of priority.

“(2) APPROVALS.—Consistent with the priority determined under paragraph (1), the Secretary, in determining which applications under the Loan Repayment Program to approve (and which contracts to accept), shall:
“(A) give first priority to applications made by individual Indians; and
“(B) after making determinations on all applications submitted by individual Indians as required under subparagraph (A), give priority to—
“(i) individuals recruited through the efforts of an Indian Health Program or urban Indian organization; and
“(ii) other individuals based on the priority determined by the Secretary in assigning individuals to serve in American Health Programs and urban Indian organizations pursuant to contracts entered into under this section.”

“(e) VIOLATION.
“(1) CONTRACT REQUIRED.—An individual becomes a participant in the Loan Repayment Program only upon the Secretary and the individual entering into a written contract described in paragraph (2).

“(2) CONTRACTS.—The written contract to be entered into between the Secretary and an individual shall contain—
“(A) an agreement under which—
“(i) the Secretary, subject to subparagraph (C), the Secretary agrees—
“(II) to accept loan payments on behalf of the individual

“(II) in the case of an individual described in subsection (b)(1)—
“(aa) to maintain enrollment in a course of study or training described in subsection (b)(1)(A) until the individual completes the course of study or training; and
“(bb) while enrolled in such course of study or training, to maintain an acceptable level of academic standing (as determined under regulations of the Secretary by the educational institution offering such course of study or training);
“(III) to serve for a time period (in this section referred to as the ‘period of obligated service’) equal to 2 years or such longer period as the individual may agree to serve in the full-time clinical practice of such individual’s profession in an Indian Health Program or urban Indian organization to which the individual may be assigned by the Secretary; and
“(B) a provision permitting the Secretary to extend for such longer additional periods, and the number of such periods, the period of obligated service agreed to by the individual under subparagraph (A)(i)(II);
“(C) a provision that any financial obligation of the United States arising out of a contract entered into under this section and any obligation of the individual which is conditioned thereon is contingent upon funds being appropriated for loan repayments under this section;
“(D) a statement of the damages to which the United States is entitled under subsection (k) for the individual’s breach of the contract; and
“(E) such other statements of the rights and liabilities of the Secretary and of the individual, not inconsistent with this section.

“(f) DEADLINE FOR DECISION ON APPLICATION.—The Secretary shall provide written notice to an individual within 21 days on—
“(1) the Secretary’s approving, under subsection (e)(1), of the individual’s participation in the Loan Repayment Program, including extending an aggregate period of obligated service in excess of 4 years; or
“(2) the Secretary’s disapproving an individual’s participation in such Program.

“(g) PAYMENTS.—
“(1) IN GENERAL.—A loan repayment program described in clause (1) or (2) of this subsection shall consist of payment, in accordance with clauses (2) and (3), on behalf of the individual of—
“(A) tuition expenses;
“(B) all other reasonable educational expenses, including fees, books, and laboratory expenses, incurred by the individual; and
“(C) reasonable living expenses as determined by the Secretary.

“(2) AMOUNT.—For each year of obligated service that an individual contracts to serve under subsection (e), the Secretary may pay up to $35,000 or an amount equal to the amount specified in section 333 of the Public Health Service Act of 1970, whichever is more, on behalf of the individual for loans described in paragraph (1). In making a determination of the amount to pay for a year of obligated service, the Secretary shall consider the extent to which each such determination—

“(A) affects the ability of the Secretary to maximize the number of contracts that can be provided under the Loan Repayment Program from the amounts appropriated for such contracts;

“(B) provides an incentive to serve in Indian Health Programs and urban Indian organizations with the greatest shortages of health professionals; and

“(C) provides an incentive with respect to the health professional involved remaining in an Indian Health Program or urban Indian organization with a health services shortage, and continuing to provide primary health services, after the completion of the period of obligated service under the Loan Repayment Program.

“(3) TIMING.—Any arrangement made by the Secretary for the making of loan repayments in accordance with this subsection shall provide that any repayments for a year of obligated service shall be made no later than the end of the fiscal year in which the individual completes such year of service.

“(4) REIMBURSEMENTS FOR TAX LIABILITY.—For the purpose of providing reimbursements for tax liability resulting from a payment under paragraph (2) on behalf of an individual, the Secretary—

“(A) in addition to such payments, may make payments to the individual in an amount equal to not less than 20 percent and not more than 39 percent of the amount of loan repayments made for the taxable year involved; and

“(B) may make such additional payments as the Secretary determines to be appropriate with respect to such purpose.

“(5) PAYMENT SCHEDULE.—The Secretary may enter into an agreement with the holder of a loan for which payments are made under the Loan Repayment Program to establish a schedule for the making of such payments.

“(6) EMPLOYMENT CEILING.—Notwithstanding any other provision of law, individuals who have entered into written contracts with the Secretary under this section shall not be counted against any employment ceiling affecting the Department while those individuals are undergoing academic training.

“(i) RECRUITMENT.—The Secretary shall conduct recruiting programs for the Loan Repayment Program and other manpower programs of the Service at educational institutes retaining health professionals or specialists identified in subsection (a).

“(j) APPLICABILITY OF LAW.—Section 214 of the Public Health Service Act (42 U.S.C. 215) shall not apply to individuals during their period of obligated service under the Loan Repayment Program.

“(k) ASSIGNMENT OF INDIVIDUALS.—The Secretary, in assigning individuals to serve in Indian Health Programs or urban Indian organizations pursuant to contracts entered into under this section, shall—

“(1) ensure that the staffing needs of Tribal Health Programs and urban Indian organizations receive consideration on an equal basis with programs that are administered directly by the Service; and

“(2) give priority to assigning individuals to serve in Indian Health Programs and urban Indian organizations that have a need for health professionals to provide health care services as a result of individuals having breached contracts entered into under this section.

“(l) BREACH OF CONTRACT.—

“(1) SPECIFIC BREACHES.—An individual who has entered into a written contract with the Secretary under this section but has not received a waiver under subsection (m) shall be liable, in lieu of any service obligation arising under such contract, to the United States for the amounts for which the Secretary has been paid on such individual’s behalf under the contract if that individual—

“...
Section 3718 of title 31, United States Code, the contractor in collecting such damages.

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(2) Waiver Program.—The Secretary,

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the Secretary, acting through the Service, to make payments to

an Indian Health Program—

(2) Service Obligation.—An individual who participates in a program under

subsection (a), where the educational costs are

borne by the Service, shall incur an obliga-

tion, and only if the bankruptcy court

finds that nondischarge of the obligation

required, and only if the bankruptcy court

finds that nondischarge of the obligation

would be unconscionable.

The Secretary shall submit to the

President, for inclusion in the report

required to be submitted to Congress under

section 801, a report concerning the previous

fiscal year which sets forth by Service Area

the following:

(1) A list of the health professional posi-

tions maintained by Indian Health Programs

and urban Indian organizations for which

recruitment or retention is difficult.

(2) The Loan Repayment Pro-

illion in year in which

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''(1) A' is the amount the United States is

entitled to recover;

''(2) Z is the sum of the amounts paid

under this section to, or on behalf of, the

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which would be payable if, at the time the

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Health Programs and urban Indian organizations shall be given an equal opportunity to participate in the program under subsection (a).

**SEC. 115. QUINTIN N. BURDICK AMERICAN INDIANS INTO NURSING PROGRAM.**

(a) Grants Authorized.—For the purpose of increasing the number of nurses, nurse midwives, and advanced practice nurses who provide health care services to Indians, the Secretary, acting through the Service, shall award grants to the following:

(1) Public or private schools of nursing.

(2) Tribal colleges or universities.

(3) Nurse midwife programs and advanced practice nurse programs that are provided by any tribal college or university accredited nursing program, or in the absence of such, any other public or private institutions.

(b) Grants.—Grants provided under subsection (a) may be used for 1 or more of the following:

(1) To recruit individuals for programs which train individuals to be nurses, nurse midwives, or advanced practice nurses.

(2) To provide scholarships to Indians enrolled in such programs that may pay the tuition charged for such program and other expenses incurred in connection with such program, including books, fees, room and board, and stipends for living expenses.

(3) To establish and maintain a program that encourages nurses, nurse midwives, and advanced practice nurses to provide, or continue to provide, health care services to Indians.

(4) To provide a program that increases the skills of, and provides continuing education to, nurses, nurse midwives, and advanced practice nurses.

(5) To provide any program that is designed to achieve the purpose described in subsection (a).

(c) Regulations.—Each application for a grant under subsection (a) shall include such information as the Secretary may require to establish the connection between the program of the applicant and a health care facility that primarily serves Indians.

(d) Preferences for Grant Recipients.—In granting grants under subsection (a), the Secretary shall extend a preference to the following:

(1) Programs that provide a preference to Indians.

(2) Programs that train nurse midwives or advanced practice nurses.

(3) Programs that are interdisciplinary.

(4) Programs that are conducted in cooperation with any program for gifted and talented Indian students.

(5) Programs conducted by tribal colleges and universities.

(e) QUINTIN N. BURDICK PROGRAM GRANT.—The Secretary shall provide 1 of the grants authorized under subsection (a) to establish and maintain a program at the University of North Dakota to be known as the ‘Quentin N. Burdick Indian Nursing Program’. Such program shall, to the maximum extent feasible, coordinate with the Quentin N. Burdick Indian Health Programs established under section 117(b) and the Quentin N. Burdick American Indians Into Psychology Program established under section 105(b).

(f) Active Duty Service Obligation.—The active duty service obligation prescribed under section 330C of the Public Health Service Act (42 U.S.C. 254m) shall be met by each individual who receives training or assistance described in paragraph (1) or (2) of subsection (a) and provide under a grant provided under subsection (a). Such obligation shall be met by service—

(1) in the Service;

(2) in the performance of an Indian Tribe or Tribal Organization conducted under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) (including programs under agreements with the Bureau of Indian Affairs);

(3) in a program assisted under title V of this Act;

(4) in the private practice of nursing if, as determined by the Secretary, in accordance with guidelines promulgated by the Secretary, the practice is situated in a physician or other health shortage area and addresses the health care needs of a substantial number of Indians; or

(5) in a teaching capacity in a tribal college or university nursing program (or a related health profession program) if, as determined by the Secretary, health services provided to Indians would not decrease.

**SEC. 116. TRIBAL CULTURAL ORIENTATION.**

(a) Cultural Education of Employees.—The Secretary, acting through the Service, shall require that appropriate employees of the Service who serve Indian Tribes in each Service Area receive educational instruction in the history and culture of such Indian Tribes and their relationship to the Service.

(b) Program.—In carrying out subsection (a), the Secretary shall establish a program which shall, to the extent feasible—

(1) be designed to provide consultation with the affected Indian Tribes, Tribal Organizations, and urban Indian organizations;

(2) be carried out through tribal colleges or universities;

(3) include instruction in American Indian studies; and

(4) describe the use and place of traditional health care practices within the Indian Tribes in the Service Area.

**SEC. 117. INMED PROGRAM.**

(a) Grants Authorized.—The Secretary, acting through the Service, is authorized to make grants to any college or university that is accredited and accessible community college located on a reservation, for the purpose of maintaining the program and recruiting students for the program.

(b) Grants for Maintenance and Recertification.—In general.—The Secretary, acting through the Service, shall make grants to colleges and universities of the United States for the purpose of maintaining the program and recruiting students for the program.

(c) Requirements.—Grants may only be made under this section to a community college which—

(1) is accredited;

(2) has a relationship with a hospital facility, clinic, or hospital that could provide training of nurses or health professionals;

(3) has entered into an agreement with an accredited college or university medical school, the terms of which—

(i) provide a program that enhances the transition and recruitment of students into accredited baccalaureate or post-baccalaureate programs that train health professionals; and

(ii) stipulate certifications necessary to approve internship and field placement opportunities at Indian Health Programs;

(4) has a qualified staff which has the appropriate certifications;

(5) is capable of obtaining State or regional accreditation; and

(6) agrees to provide for Indian preference for applicants for programs under this section.

(d) Technical Assistance.—The Secretary shall encourage community colleges described in subsection (b)(2) to establish and maintain programs described in subsection (a)(1). Such programs shall—

(1) enter into agreements with such colleges for the provision of qualified personnel of the Service to teach courses of study in such programs; and

(2) providing technical assistance to support such colleges.

(e) Advanced Training.—

(1) Required.—Any program receiving assistance under this section that is conducted with respect to a health profession shall also offer courses of study which provide advanced training for any health professional who—

(A) has already received a degree or diploma in such health profession; and

(B) provides clinical services on or near a reservation or for an Indian Health Program.

(2) May be offered at alternate site.—Such courses of study may be offered in conjunction with the college or university with which the community college has entered into the agreement required under subsection (a)(1).

(f) Priority.—Where the requirements of subsection (b) are met, grant award priority...
shall be provided to tribal colleges and universities in Service Areas where they exist.

**SEC. 119. RETENTION BONUS.**

(a) BONUS AUTHORIZED.—The Secretary may pay a retention bonus to any health professional employed by, or assigned to, and serving in an Indian Health Program or urban Indian organization either as a civilian employee or as a commissioned officer in the Regular or Reserve Corps of the Public Health Service who—

(1) is assigned to, and serving in, a position in which recruitment or retention of personnel is difficult; and

(2) the Secretary determines is needed by Indian Health Programs and urban Indian organizations;

(b) completed 2 years of employment with an Indian Health Program or urban Indian organization; or

(c) completed any service obligations incurred as a requirement of—

(1) any Federal scholarship program; or

(2) any Federal education loan repayment program; and

(d) enters into an agreement with an Indian Health Program or urban Indian organization for continued employment for a period of not less than 1 year.

(b) RATIES.—The Secretary may establish rates for the retention bonus which shall provide a lower annual rate for multiyear agreements than for single year agreements referred to in subsection (a)(4), but in no event shall the annual rate be more than $25,000 per annum.

(c) DEFAULT OF RETENTION AGREEMENT.—Any health professional failing to complete the agreed upon term of service, except where failure is through no fault of the individual, shall be obligated to refund to the Government the full amount of the retention bonus for the period covered by the agreement, plus interest as determined by the Secretary in accordance with section 110(1)(2)(B).

(d) OTHER RETENTION BONUS.—The Secretary may pay a retention bonus to any health professional employed by a Tribal Health Program if such health professional is serving in a position which the Secretary determines—

(1) a position for which recruitment or retention is difficult; and

(2) necessary for providing health care services to Indians.

**SEC. 120. NURSING RESIDENCY PROGRAM.**

(a) ESTABLISHMENT OF PROGRAM.—The Secretary, acting through the Service, shall establish a program to enable Indians who are licensed practical nurses, licensed vocational nurses, and registered nurses who are working in an Indian Health Program or urban Indian organization, and have done so for a period of not less than 1 year, to pursue advanced training. Such program shall include a combination of education and work study, with Program or urban Indian organization leading to an associate or bachelor’s degree (in the case of a licensed practical nurse or licensed vocational nurse), a bachelor’s degree (in the case of a registered nurse), or advanced degrees or certifications in nursing and public health.

(b) SERVICE OBLIGATION.—An individual who participates in a program under subsection (a), where the educational costs are paid by the Service, shall incur an obligation to serve in an Indian Health Program or urban Indian organization for a period of obligating service equal to 1 year for every year that nonprofessional employee (licensed practical nurses, licensed vocational nurses, nursing assistants, and various health care technicians), or 2 years for every year that professional nurse (associate degree and bachelor-prepared registered nurses), participates in such program. In the event that the individual fails to complete such obligated service, the United States shall be entitled to receive, as compensation for the obligating service determined in accordance with the formula specified subsection (d)(1) of Section 104 for individuals failing to graduate from their degree program or subsection (1) of Section 110 for individuals failing to start or complete the obligated service.

**SEC. 121. COMMUNITY HEALTH AIDE PROGRAM.**

(a) GENERAL PURPOSES OF PROGRAM.—Under the authority of November 2, 1921 (25 U.S.C. 13) (commonly known as the ‘‘Snyder Act’’), the Secretary, acting through the Service, shall establish a program in Northern areas to train community health practitioners in the administration and planning of Tribal Health Programs, with priority to Indians.

(b) SPECIFIC PROGRAM REQUIREMENTS.—The Secretary, acting through the Community Health Aide Program of the Service, shall—

(1) using trainers accredited by the Program, provide a high standard of training to community health aides and community health practitioners to ensure that such aides and practitioners provide quality health care, health promotion, and disease prevention services to Alaska Natives living in villages in rural Alaska; and

(2) uses such aides or practitioners in the provision of health care, health promotion, and disease prevention services to Alaska Natives living in villages in rural Alaska;

(3) provides for the establishment of tele-conferencing capacity in health clinics located in areas served by community health aides or community health practitioners;

(4) establishes a community health aide program under paragraph (1), the Secretary, acting through the Service, shall develop and operate a Community Health Aide Program in Alaska under which the Service—

(1) provides for the training of Alaska Natives as health aides or community health practitioners;

(2) uses such aides or practitioners in the provision of health care, health promotion, and disease prevention services to Alaska Natives living in villages in rural Alaska, and

(3) provides for the establishment of tele-conferencing capacity in health clinics located in areas served by community health aides or community health practitioners.

**(c) RETENTION BONUS AUTHORIZED.**—The Secretary, acting through the Community Health Aide Program of the Service, shall—

(1) using trainers accredited by the Program, provide a high standard of training to community health aides and community health practitioners to ensure that such aides and practitioners provide quality health care, health promotion, and disease prevention services to Alaska Natives; and

(2) enters into an agreement with an Indian Health Program or urban Indian organization for multiyear agreements than for single year agreements referred to in subsection (a)(4), but in no event shall the annual rate be more than $25,000 per annum.

(d) SPECIFIC PROGRAM REQUIREMENTS.—The Secretary, acting through the Community Health Aide Program of the Service, shall—

(1) using trainers accredited by the Program, provide a high standard of training to community health aides and community health practitioners to ensure that such aides and practitioners provide quality health care, health promotion, and disease prevention services to Alaska Natives; and

(2) establishes a community health aide program under paragraph (1), the Secretary, acting through the Service, shall develop and operate a Community Health Aide Program in Alaska under which the Service—

(1) provides for the training of Alaska Natives as health aides or community health practitioners;

(2) uses such aides or practitioners in the provision of health care, health promotion, and disease prevention services to Alaska Natives; and

(3) provides for the establishment of tele-conferencing capacity in health clinics located in areas served by community health aides or community health practitioners.

**SEC. 122. TRIBAL HEALTH PROGRAM ADMINISTRATION.**

The Secretary shall, by contract or other arrangement, provide for the administration and planning of Tribal Health Programs, with priority to Indians.
may be necessary to enable grant recipients to comply with the provisions of this section.

(f) Report.—Each fiscal year, the Secretary shall submit to the President, for inclusion in the report which is required to be submitted under section 801 for that fiscal year, a report on the findings and conclusions derived from demonstration programs conducted under this section during that fiscal year.

(g) Definition.—For the purposes of this section, the term ‘educational curriculum’ means 1 or more of the following:

1. Classroom education.
2. Clinical work experience.
3. Continuing education workshops.

SEC. 126. BEHAVIORAL HEALTH TRAINING AND COMMUNITY EDUCATION PROGRAMS.

(a) Study; List.—The Secretary, acting through the Service, and the Secretary of the Interior, in consultation with Indian Tribes and Tribal Organizations, shall conduct a study and compile a list of the types of staff positions specified in subsection (b) whose qualifications include, or should include, programs of prevention, education, referral, or treatment of mental illness, or dysfunctional and self-destructive behavior.

(b) Positions.—The positions referred to in subsection (a) are—

1. Staff positions within the Bureau of Indian Affairs, including existing positions, in the fields of—

A. elementary and secondary education;
B. social services and family and child welfare;
C. law enforcement and judicial services; and
D. alcohol and substance abuse.

2. Staff positions within the Service; and

3. Staff positions similar to those identified in paragraphs (1) and (2) established and maintained by Indian Tribes, Tribal Organizations (without regard to the funding source), and urban Indian organizations.

(c) Training Criteria.—

1. In general.—The appropriate Secretary shall provide training criteria appropriate to each type of position identified in subsection (b)(1) and (b)(2) and ensure that appropriate training has been, or shall be, provided to any such position. With respect to any such individual in a position identified pursuant to subsection (b)(1) or (b)(2), the appropriate Secretary shall provide appropriate training to, or provide funds to, an Indian Tribe, Tribal Organization, or urban Indian organization for training of appropriate individuals. In the case of positions funded under a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 130 et seq.), the appropriate Secretary shall ensure that such training costs are included in the contract or compact, as the Secretary determines necessary.

2. Post-specific training criteria.—Position specific training criteria shall be culturally relevant to Indians and Indian Tribes and shall ensure that appropriate information and longitudinal traditional health care practices is provided.

3. Community Education on Mental Illness.—The Service shall develop and implement, on request of an Indian Tribe, Tribal Organization, or urban Indian organization, or assist the Indian Tribe, Tribal Organization, or urban Indian organization to develop an appropriate program of community education on mental illness. In carrying out this subsection, the Service shall, upon request of an Indian Tribe, Tribal Organization, or urban Indian organization, provide technical assistance to the Indian Tribe, Tribal Organization, or urban Indian organization to obtain and develop community educational materials on the identification, prevention, referral, and treatment of mental illness and dysfunctional and self-destructive behavior.

4. Plan.—Not later than 90 days after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary shall submit to the Senate and House of Representatives a plan under which the Service will increase the health care staff providing behavioral health services by at least 50 positions within 5 years after the date of enactment of this section, with at least 200 of such positions devoted to child, adolescent, and family services. The plan developed under this subsection shall be submitted under the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the ‘Snyder Act’).
(b) No Offset or Limitation.—Any funds appropriated under the authority of this section shall not be used to offset or limit any other appropriations made to the Service under this Act or the Act referred to in section 13 (25 U.S.C. 13) (commonly known as the ‘Snyder Act’), or any other provision of law.

(c) Allocation; Use.—

(1) Tribal Health Programs—Funds appropriated under the authority of this section shall be allocated to Service Units, Indian Tribes, or Tribal Organizations. The funds allocated to each Service Unit, Indian Tribe, or Tribal Organization under this paragraph shall be used by the Indian Tribe, Tribal Organization, or Service Unit under this paragraph to improve the health status and reduce the resource deficiency of each Indian Tribe served by such Service Unit, Indian Tribe, or Tribal Organization.

(2) Apportionment of Allocated Funds.—The apportionment of funds allocated to a Service Unit, Indian Tribe, or Tribal Organization under paragraph (1) among the health service responsibilities described in subsection (a)(5) shall be determined by the Service in consultation with, and with the active participation of, the affected Indian Tribes and Tribal Organizations.

(d) Provisions Relating to Health Status and Resource Deficiencies.—For the purposes of this section, the following definitions apply:

(1) 'Definition.'—The term 'health status and resource deficiency' means the extent to which

(A) the health status objectives set forth in section 3(2) are not being achieved; and

(B) the Indian Tribe or Tribal Organization observed health resources needed to achieve the actual cost of providing health care services given local geographic, climatic, rural, or other circumstances.

(2) Available Resources.—The health resources available to an Indian Tribe or Tribal Organization include health resources provided by the Service as well as health resources used by the Indian Tribe or Tribal Organization, including services and financing systems provided by any Federal programs, State or local governments, and programs of State or local governments.

(e) Eligibility for Funds.—Tribal Health Programs shall be eligible for funds appropriated under the authority of this section on an equal basis with programs that are administered directly by the Service.

(f) Report.—By no later than the date that is 3 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary shall submit to Congress the current health status and resource deficiency report of the Service for the preceding fiscal year which is allocated to all other Area Offices, subject to applicable patient privacy laws.

(g) Diabetes Projects.—The Secretary shall continue to maintain each model diabetes project in existence on the date of enactment of the Indian Health Care Improvement Act Amendments of 2009.

(h) Dialysis Programs.—The Secretary is authorized to provide through the Service, Indian Tribes, and Tribal Organizations, dialysis programs, including the purchase of dialysis equipment and the provision of necessary staffing.

(i) Other Duties of the Secretary.—

(1) IN GENERAL.—The Secretary shall, to the extent funding is available,

(A) in each Area Office, consult with Indian Tribes and Tribal Organizations regarding programs for the prevention, treatment, and control of diabetes;

(B) in each Area Office a registry of patients with diabetes to track the incidence of diabetes and the complications resulting from diabetes; and

(C) ensure that data collected in each Area Office regarding diabetes and related complications among Indians are disseminated to all other Area Offices, subject to applicable patient privacy laws.

(2) Diabetes Control Officers.—

(A) IN GENERAL.—The Secretary may establish and maintain in an Area Office a position of diabetes control officer to coordinate and manage any activity of that Area Office relating to the prevention, treatment, or control of diabetes to assure the Secretary in carrying out a program under this section or section 330C of the Public Health Service Act (42 U.S.C. 254k-3).

(B) Certain Activities.—Any activity carried out by a diabetes control officer under subparagraph (A) that is the subject of a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), and any funds made available to carry out such an activity, shall not be divisible for purposes of that Act.

SEC. 204. DIABETES SCREENING, PREVENTION, TREATMENT, AND CONTROL

(a) Determinations Regarding Diabete

The Secretary, acting through the Service, in consultation with Indian Tribes and Tribal Organizations, shall determine:

(1) by Indian Tribe and by Service Unit, the incidence of, and the types of complications resulting from, diabetes among Indians; and

(2) based on the determinations made pursuant to clause (1), the incidence of, and the types of complications resulting from, diabetes among Indian Tribes within that Service Unit.

(b) Diabetes Screening.—To the extent medically indicated and with informed consent, the Secretary shall screen each Indian who receives services from the Service for diabetes and for conditions that create a high risk that the individual will become diabetic and establish a cost-effective approach to ensure ongoing monitoring of diabetes indicators. Such monitoring may be conducted by a Tribal Health Program and may be conducted through appropriate Internet-based health care management programs.

(c) Diabetes Projects.—The Secretary shall continue to maintain each model diabetes project in existence on the date of enactment of the Indian Health Care Improvement Act Amendments of 2009.

(d) Dialysis Programs.—The Secretary is authorized to provide through the Service, Indian Tribes, and Tribal Organizations, dialysis programs, including the purchase of dialysis equipment and the provision of necessary staffing.

(e) Other Duties of the Secretary.—

(1) IN GENERAL.—The Secretary shall, to the extent funding is available,

(A) in each Area Office, consult with Indian Tribes and Tribal Organizations regarding programs for the prevention, treatment, and control of diabetes;

(B) in each Area Office a registry of patients with diabetes to track the incidence of diabetes and the complications resulting from diabetes; and

(C) ensure that data collected in each Area Office regarding diabetes and related complications among Indians are disseminated to all other Area Offices, subject to applicable patient privacy laws.

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(B) Certain Activities.—Any activity carried out by a diabetes control officer under subparagraph (A) that is the subject of a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), and any funds made available to carry out such an activity, shall not be divisible for purposes of that Act.
“(2) shall provide that expenses (including salaries) relating to services that are shared between the Service and the Tribal Health Program be allocated proportionately between the applicable Indian Tribe or Tribal Organization; and
“(3) may authorize such Indian Tribe or Tribal Organization to contract, renovate, or expand a long-term care or other similar facility (including the construction of a facility attached to a Service facility).

(c) MINIMUM REQUIREMENT.—Any nursing facility for which under this section shall not meet the requirements for nursing facilities under section 1919 of the Social Security Act.

(d) USE OF FUNDS.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

“(e) USE OF EXISTING OR UNDERUSED FACILITIES.—The Secretary shall encourage the use of existing facilities that are underused or allow the use of swing beds for long-term or similar care.

SEC. 205. HEALTH SERVICES RESEARCH.

(a) IN GENERAL.—The Secretary, acting through the Service, shall make funding available for research to further the performance of the health service responsibilities of Indian Health Programs.

(b) USE OF RESOURCES AND ACTIVITIES.—The Secretary shall encourage the maximum extent practicable, coordinate departmental research resources and activities to address relevant Indian Health Program research needs.

(c) AVAILABILITY.—Tribal Health Programs shall be given an equal opportunity to compete for, and receive, research funds under this section.

(d) USE OF FUNDS.—This funding may be used for both clinical and nonclinical research.

(e) EVALUATION AND DISSEMINATION.—The Secretary shall periodically—

(1) evaluate the impact of research conducted under this section; and

(2) disseminate to Tribal Health Programs information regarding that research as the Secretary determines to be appropriate.

SEC. 206. MAMMOGRAPHY AND OTHER CANCER SCREENING.

The Secretary, acting through the Service, shall provide for screening as follows:

(1) Screening mammography (as defined in section 1901(d)(12) of the Social Security Act (42 U.S.C. 290bb–4(a)(1))) for women at a frequency appropriate to such women under accepted and appropriate national standards, and under such terms and conditions as are consistent with standards established by the Secretary to ensure the safety and accuracy of screening mammography under part B of title XVIII of such Act.

(2) Other cancer screening that receives an A or B rating as recommended by the United States Preventive Services Task Force for screening under section 299b–4(a)(1) of the Public Health Service Act (42 U.S.C. 299b–4(a)(1)). The Secretary shall ensure that screening services provided for under this paragraph comply with the recommendations of the Task Force with respect to—

(A) frequency;

(B) the population to be served;

(C) the procedure or technology to be used;

(D) evidence of effectiveness; and

(E) other matters that the Secretary determines.

SEC. 207. PATIENT TRAVEL COSTS.

(a) DEFINITION OF QUALIFIED ESCORT.—In this section, the term ‘qualified escort’ means—

(1) an adult escort (including a parent, guardian, or other family member) who is required because of the physical or mental condition, or age, of the applicable patient;

(2) a health professional for the purpose of providing necessary medical care during travel by the applicable patient; or

(3) other escorts, as the Secretary or applicable Indian Health Program determines to be appropriate.

(b) PROVIDE OR FUNDS.—The Secretary, acting through the Service, is authorized to provide funds for the following patient travel costs, including qualified escorts, associated with receiving health care services provided in an intertribal consortium or Indian Tribe (either through direct or contract care or through a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)) under this Act—

(1) emergency air transportation and non-emergency air transportation where ground transportation is inaccessible;

(2) transportation by private vehicle (where no other means of transportation is available), specially equipped vehicle, and ambulance; and

(3) transportation by such other means as may be available and required when air or motor vehicle transportation is not available.

SEC. 208. EPIDEMIOLOGY CENTERS.

(a) ESTABLISHMENT OF CENTERS.—The Secretary shall establish an epidemiology center in each Service Area to carry out the functions described in subsection (b).

(b) FUNCTIONS OF CENTERS.—In consultation with and upon the request of Indian Tribes, Tribal Organizations, and Urban Indian communities, each Service Area epidemiology center established under this section shall, with respect to such Service Area—

(1) collect data relating to, and monitor progress made toward meeting, each of the health status objectives of the Service, the Indian Tribes, Tribal Organizations, and Urban Indian communities in the Service Area;

(2) evaluate existing delivery systems, data systems, and other systems that impact the improvement of Indian health;

(3) assist Indian Tribes and Tribal Organizations, and Urban Indian Organizations in identifying their highest priority health status objectives and the services needed to achieve such objectives, based on epidemiological data;

(4) make recommendations for the targeting of services needed by the populations served;

(5) make recommendations to improve health care delivery systems for Indians and Urban Indians;

(6) provide requested technical assistance to Indian Tribes, Tribal Organizations, and Urban Indian Organizations in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community; and

(7) provide disease surveillance and assist Indian Tribes, Tribal Organizations, and Urban Indian communities to promote public health.

(c) TECHNICAL ASSISTANCE.—The Director of the Centers for Disease Control and Prevention shall provide technical assistance to the centers in carrying out the requirements of this section.

(d) GRANTS FOR STUDIES.—

(1) IN GENERAL.—The Secretary may make grants to Indian Tribes, Tribal Organizations, Indian organizations, and eligible intertribal consortia to conduct epidemiological studies of Indian communities.

(2) ELIGIBLE INTERTRIBAL CONSORTIA.—An intertribal consortium or Indian organization is eligible to receive a grant under this subsection if—

(A) the intertribal consortium is incorporated for the primary purpose of improving Indian health; and

(B) the intertribal consortium is representative of the Indian Tribes or urban Indian communities in which the intertribal consortium is located.

(3) APPLICATIONS.—An application for a grant under this subsection shall be submitted in such manner and at such time as the Secretary shall prescribe.

(4) REQUIREMENTS.—An applicant for a grant under this subsection shall—

(A) demonstrate the technical, administrative, and financial expertise necessary to carry out the functions described in paragraph (5);

(B) consult and cooperate with providers of related health and social services in order to avoid duplication of existing services; and

(C) demonstrate cooperation from Indian Tribes or Urban Indian Organizations in the area to be served.

(5) USE OF FUNDS.—A grant awarded under paragraph (1) may be used—

(A) to carry out the functions described in paragraph (4);

(B) to provide information to and consult with tribal leaders, urban Indian community leaders, and related health staff on health care and health service management issues; and

(C) in collaboration with Indian Tribes, Tribal Organizations, and urban Indian communities, to provide the Service with information regarding ways to improve the health status of Indians.

SEC. 209. COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAMS.

(a) FUNDING FOR DEVELOPMENT OF PROGRAMS.—

(1) An epidemiology center operated by a grantee pursuant to a grant awarded under subsection (d) shall be treated as a public health authority for purposes of the Health Insurance Portability and Accountability Act of 1996, as such entities are defined in part 164.501 of title 45, Code of Federal Regulations.

(2) The Secretary shall grant to such epidemiology center access to use of the data, data sets, monitoring systems, delivery systems, and other pertinent health information in the possession of the Secretary.

(3) The activities of such an epidemiology center shall be for the purposes of research and for preventing and controlling disease, injury, or disability for purposes of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033), as such activities are described in part 164.512 of title 45, Code of Federal Regulations (or a successor regulation).

(4) FUNDS NOT DIVISIBLE.—An epidemiology center established under this section shall be subject to the provisions of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) but the funds for such center shall not be divisible.

SEC. 210. PROJECTS TO PREVENT ACQUIRED IMMUNE DEFICIENCY SYNDROME.

(1) The Department of Health and Human Services shall make grants for the development of programs to prevent and control acquired immune deficiency syndrome.
“(1) Developing health education materials both for regular school programs and after-school programs.

“(2) Training teachers in comprehensive school health education.

“(3) Integrating school-based, community-based, and other public and private health promotion efforts.

“(4) Anticipating healthy, tobacco-free school environments.

“(5) Coordinating school-based health programs with existing services and programs available in the community.

“(6) Developing school programs on nutrition education, personal health, oral health, and fitness.

“(7) Developing behavioral health wellness programs.

“(8) Developing chronic disease prevention programs.

“(9) Developing substance abuse prevention programs.

“(10) Developing injury prevention and safety education programs.

“(11) Developing activities for the prevention and control of communicable diseases.

“(12) Developing community and environmental health education programs that include traditional health care practitioners.

“(13) Violence prevention.

“(14) Such other health issues as are appropriate.

“(c) TECHNICAL ASSISTANCE.—Upon request, the Secretary, acting through the Service, shall provide technical assistance to Indian Tribes and Tribal Organizations in the development of comprehensive health education plans and the dissemination of comprehensive health education materials and information on existing health programs and resources.

“(d) CRITERIA FOR REVIEW AND APPROVAL OF APPLICATIONS.—The Secretary, acting through the Service, shall establish criteria for the review and approval of applications for grants awarded under this section.

“(e) DEVELOPMENT OF PROGRAM FOR HIA-FUNDED SCHOOLS.—

“(1) IN GENERAL.—The Secretary of the Interior, acting through the Bureau of Indian Affairs in cooperation with the Secretary, acting through the Service, shall develop a comprehensive school health education program to provide health education to students from preschool through grade 12 in schools for which support is provided by the Bureau of Indian Affairs.

“(2) REQUIREMENTS FOR PROGRAMS.—Such programs shall include:

“(A) Programs on nutrition education, personal health, oral health, and fitness;

“(B) Behavioral health wellness programs;

“(C) Chronic disease prevention programs;

“(D) Substance abuse prevention programs;

“(E) Injury prevention and safety education programs;

“(F) Activities for the prevention and control of communicable diseases.

“(f) DUTIES OF THE SECRETARY.—The Secretary, acting through the Service, and after consultation with Tribal Organizations, may also provide funding under this section, the following definitions shall apply:

“(1) The term ‘assisted living services’ means any service provided by an assisted living facility (as defined in section 232(b) of the National Housing Act (12 U.S.C. 1715w(b))), except that such an assisted living facility:

“(a) shall not be required to obtain a license; and

“(b) shall meet all applicable standards for licensure.

“(2) The term ‘home- and community-based services’ means the services specified in paragraphs (1) through (9) of section 1919(h)(1) of the Social Security Act (42 U.S.C. 1396n(a)) (whether provided by the Secretary or by an Indian Tribe, Tribal Organization pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) that are or will be provided in accordance with applicable standards.

“(3) The term ‘hospice care’ means the items and services specified in subparagraph (A) of section 1917(a)(1) of the Social Security Act (42 U.S.C. 1396d(1)), and such other services which an Indian Tribe or Tribal Organization determines are necessary and appropriate to provide in furtherance of this care.

“(4) The term ‘long-term care services’ has the meaning given the term “qualified long-term care services’ in section 7702B(c) of the Internal Revenue Code of 1986.

“(d) AUTHORIZATION OF CONVENIENT CARE SERVICES.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may also provide funding under this Act to meet the objectives set forth in section 3 of this Act for convenient care services programs pursuant to section 306(c)(2)(A).

“SEC. 212. OTHER AUTHORITY FOR PROVISION OF SERVICES.

“(a) FUNDING AUTHORIZED.—The Secretary may provide funding under this Act to meet the objectives set forth in section 3 of this Act through health-related services and programs of the Service, Indian Tribes, and Tribal Organizations not otherwise described in this Act for the following services:

“(1) Hospice care.

“(2) Assisted living services.

“(3) Long-term care services.

“(4) Home- and community-based services.

“(b) ELIGIBILITY.—The following individuals shall be eligible to receive long-term care under this section:

“(1) Individuals who are unable to perform a certain number of activities of daily living without assistance.

“(2) Individuals with a mental impairment, such as dementia, Alzheimer’s disease, or another disabling mental illness, who may be able to perform activities of daily living under supervision.

“(3) Such other individuals as an applicable Indian Health Program determines to be appropriate.

“(c) DEFINITIONS.—For the purposes of this section, the following definitions shall apply:

“(1) The term ‘assisted living services’ means any service provided by an assisted living facility (as defined in section 232(b) of the National Housing Act (12 U.S.C. 1715w(b))), except that such an assisted living facility:

“(a) shall not be required to obtain a license; and

“(b) shall meet all applicable standards for licensure.

“(2) The term ‘home- and community-based services’ means the services specified in paragraphs (1) through (9) of section 1919(h)(1) of the Social Security Act (42 U.S.C. 1396n(a)) (whether provided by the Secretary or by an Indian Tribe, Tribal Organization pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) that are or will be provided in accordance with applicable standards.

“(3) The term ‘hospice care’ means the items and services specified in subparagraph (A) of section 1917(a)(1) of the Social Security Act (42 U.S.C. 1396d(1)), and such other services which an Indian Tribe or Tribal Organization determines are necessary and appropriate to provide in furtherance of this care.

“(4) The term ‘long-term care services’ has the meaning given the term ‘qualified long-term care services’ in section 7702B(c) of the Internal Revenue Code of 1986.

“(d) AUTHORIZATION OF CONVENIENT CARE SERVICES.—The Secretary, acting through the Service, Indian Tribes, and Tribal Organizations, may also provide funding under this Act to meet the objectives set forth in section 3 of this Act for convenient care services programs pursuant to section 306(c)(2)(A).

“SEC. 213. INDIAN WOMEN’S HEALTH CARE.

“The Secretary, acting through the Service, Indian Tribes, Tribal Organizations, and Urban Indian Organizations, shall monitor and improve the quality of health care for Indian women of all ages through the planning and delivery of programs administered by the Service, in order to improve and enhance the treatment models of care for Indian women.

“SEC. 214. ENVIRONMENTAL AND NUCLEAR HEALTH HAZARDS.

“(a) STUDIES AND MONITORING.—The Secretary, acting through the Service shall conduct, in conjunction with other appropriate Federal agencies and in consultation with concerned
Indian Tribes and Tribal Organizations, studies and ongoing monitoring programs to determine trends in the health hazards to Indians and to Indians on or near reservations, the result of environmental hazards which may result in chronic or life threatening health problems, including uranium mining, uranium mill tailings, nuclear power plant operation and construction, and nuclear waste disposal; oil and gas production or transportation; and contamination of water supplies.
SEC. 220. PROGRAMS OPERATED BY INDIAN TRIBES AND TRIBAL ORGANIZATIONS.

The Service shall provide funds for health care programs, functions, services, activities, information technology, and facilities operated by Tribal Health Programs on the same terms and conditions as are provided to programs, functions, services, activities, information technology, and facilities operated directly by the Service.

SEC. 221. LICENSING.

Licensed health care professionals employed by a Tribal Health Program shall, if licensed in any State, be exempt from the licensing requirements of the State in which the Tribal Health Program performs the services described in its contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) while performing such services.

SEC. 222. NOTIFICATION OF PROVISION OF EMERGENCY CONTRACT HEALTH SERVICES.

With respect to an elderly Indian or an Indian with a disability receiving emergency medical care or services from a non-Service provider of a non-Service facility under the authority of this Act, the time limitation (as a condition of payment) for notifying the Service of such treatment or admission shall be 30 days.

SEC. 223. PROMPT ACTION ON PAYMENT OF CLAIMS.

(a) Deadline for Response.—The Service shall respond to a notification of a claim by a provider of a contract care service within either an individual purchase order or a denial of the claim within 5 working days after the submission of such notification.

(b) Effect of Untimely Response.—If the Service fails to respond to a notification of a claim in accordance with subsection (a), the Service shall accept as valid the claim submitted by the provider of a contract care service.

(c) Deadline for Payment of Valid Claim.—The Service shall pay a valid contract care service claim within 30 days after the completion of the claim.

SEC. 224. LIABILITY FOR PAYMENT.

(a) No Patient Liability.—A patient who receives contract care services that are authorized by the Service shall not be liable for the payment of any charges or costs associated with the provision of such services.

(b) Notification.—The Secretary shall notify a contract care provider and any patient who receives contract health care services and the distance of such service that such patient is not liable for the payment of any charges or costs associated with the provision of such services not later than 5 business days after receipt of a notification of a claim by a provider of contract care services.

(c) No Recourse.—Following receipt of the notice provided under subsection (b), or if a claim is accepted under section 222(b), the provider shall have no further recourse against the patient who received the services.

SEC. 225. OFFICE OF INDIAN MEN'S HEALTH.

(a) Establishment.—The Secretary may establish within the Service an office to be known as the ‘Office of Indian Men’s Health’ (referred to in this section as the ‘Office’).

(b) Director.—

(1) In General.—The Office shall be headed by a director, to be appointed by the Secretary.

(2) Duties.—The director shall coordinate and promote the status of the health of Indian men in the United States.

(c) Repeal.—The Office shall cease to exist 2 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary, acting through the director of the Office, shall submit to Congress a report describing—

(1) any activity carried out by the director as of the date on which the report is prepared; and 

(2) any finding of the director with respect to the health of Indian men.

SEC. 226. CATASTROPHIC HEALTH EMERGENCY FUND.

(a) Establishment.—There is established an Indian Catastrophic Health Emergency Fund (hereafter in this section referred to as the ‘CHEF’) consisting of—

(1) the amounts deposited under subsection (f); and 

(2) the amounts appropriated to CHEF under this section.

(b) Administration.—CHEF shall be administered by the Secretary, acting through the headquarters of the Service, solely for the purpose of meeting the extraordinary medical care or services of victims of disasters or catastrophic illnesses who are within the responsibility of the Service.

(c) Conditions on Use of Fund.—No part of CHEF or its administration shall be subject to contract or grant under any law, including the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.); nor shall CHEF funds be allocated, apportioned, or delegated on an Area Office, Service Unit, or other similar basis.

(d) Regulations.—The Secretary shall promulgate regulations consistent with the provisions of this section.

(e) No Offset or Limitation.—Amounts appropriated to CHEF under this section shall be available in addition to other appropriations; and, in the case of amounts made available under section (f), no offset or limitation shall be applied to such amounts.

(f) Authorization of Appropriations.—There are authorized to be appropriated such sums as may be necessary to carry out this title.

TITLE III—FACILITIES

SEC. 301. CONSULTATION, CONSTRUCTION AND RENOVATION OF FACILITIES; REPORTS.

(a) Prerequisites for Expenditure of Funds.—Prior to the expenditure of, or the making of any binding commitment to expend, any funds appropriated by this Act, planning, design, construction, or renovation of facilities pursuant to the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the ‘Snyder Act’), the Secretary, acting through the Service, shall—

(1) consult with any Indian Tribe that would be significantly affected by such expenditure for the purpose of determining and, whenever practicable, honoring tribal preferences concerning size, location, type, and other characteristics of any facility on which such expenditure is to be made; and

(2) ensure, whenever practicable and applicable, that such facility meets the construction standards of any applicable body recognized by the Secretary for the purposes of the Medicare, Medicaid, and SCHIP programs under titles XVIII, XIX, and XXI of the Social Security Act by not later than 1 year after the date of construction or renovation of such facility is completed.

(b) Closures.—

(1) Evaluation Required.—Notwithstanding any other provision of law, no facility operated by the Service may be closed if the Secretary has not submitted to Congress, not later than 2 years before the date of the proposed closure, an evaluation, completed not more than 2 years before such submission, of the impact of the proposed closure that specifies, in addition to other considerations—

(A) the accessibility of alternative health care resources for the population served by such facility;

(B) the cost-effectiveness of such closure; and

(C) the quality of health care to be provided to the population served by such facility following such closure.

(2) Exception for Certain Temporary Closures.—Paragraph (1) shall not apply to any temporary closure of a facility or any portion of a facility if such closure is necessary for medical, environmental, or construction safety reasons.

(3) Health Care Facility Priority System.

(1) In General.—

(A) Priority System.—The Secretary, acting through the Service, shall—

(i) identify, as priorities, any Indian Tribe and Tribal Organization with a medical need identified as a highest priority; and

(ii) shall give Indian Tribes needs the highest priority; 

(B) Building Priority.—(i) There shall be included in the methodology required in paragraph (2)(B)(ii); and

(ii) Such methodology may include the following:

(B)(ii)(I) the level of use of such facility by all eligible Indians; and

(B)(ii)(II) the distance between such facility and the nearest operating Service hospital.

(2) Exception for Certain Temporary Closures.—Paragraph (1) shall not apply to any temporary closure of a facility or any portion of a facility if such closure is necessary for medical, environmental, or construction safety reasons.
“(iv) shall provide an opportunity for the nomination of planning, design, and construction projects by the Service, Indian Tribes, and Tribal Organizations for consideration by the priority system set in section 10 or part of the total unmet need for construction of health facilities, including those provided for in other sections of this title and other approaches.

**SEC. 302. SANITATION FACILITIES.**

(a) FINDINGS.—Congress finds the following:

(1) The provision of sanitation facilities is primarily a health consideration and function.

(2) Indian people suffer an inordinately high incidence of disease, injury, and illness directly attributable to the absence or inadequacy of sanitation facilities.

(3) The long-term cost to the United States of treating and curing such disease, injury, and illness is substantially greater than the short-term cost of providing sanitation facilities and other preventive health measures.

(4) Many Indian homes and Indian communities still lack sanitation facilities.

(b) FACILITIES AND SERVICES.—In furtherance of the findings made in subsection (a), the Secretary, acting through the Secretary, is authorized to provide: 

(1) Financial and technical assistance to Indian Tribes, Tribal Organizations, and Indian communities in the establishment, training, and equipping of utility organizations which operate and maintain sanitation facilities, including the provision of existing plans, standard details, and specifications available in the Department, to be used at the option of the Indian Tribe, Tribal Organization, or Indian community.

(2) Ongoing technical assistance and training to Indian Tribes, Tribal Organizations, and Indian communities in the establishment, training, and maintaining of sanitation facilities which operate and maintain sanitation facilities, including the provision of existing plans, standard details, and specifications available in the Department, to be used at the option of the Indian Tribe, Tribal Organization, or Indian community.

(3) Priority funding for operation and maintenance assistance and emergency repairs to sanitation facilities operated by an Indian Tribe, Tribal Organization or Indian community when necessary to avoid an immediate threat to health through the investment in sanitation facilities and the investment in the health benefits gained

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through the provision of sanitation facilities.

"(c) FUNDING.—Notwithstanding any other provision of law—

(1) If any Indian Tribe, Tribal Organizations, and Indian communities in an amount equal to the combined costs of operating, managing, and maintaining the facilities provided under the plan described in subsection (a) of this section.

(2) If any Indian Tribe, Tribal Organization, or Indian community substantially or entirely relies upon the provision of water supply, pollution control, or solid waste disposal facilities to the extent that the project or function to be contracted for will not be satisfactory or such
to the President, for inclusion in the report
ally in consultation with Indian Tribes and
maintain a separate priority list to address
pended.

"(1) ownership and control by Indians;
"(2) equipment;
"(3) bookkeeping and accounting proce-
dures;
"(4) substantive knowledge of the project or function to be contracted for;
"(5) adequate financial support; and
"(6) other necessary components of con-
tract performance.

"(b) Pay Rates.—For the purposes of im-
plementing the provisions of this title, the
Secretary shall assure that the rates of pay
for personnel engaged in the construction or ren-
ovation of facilities constructed or ren-
ovated in whole or in part by funds made
available pursuant to this title are not less
than the prevailing local wage rates for simi-
lar work as determined in accordance with
the Act of March 3, 1913 (40 U.S.C. 276a–276a-
5, known as the Davis-Bacon Act).

"(c) Labor Standards.—For the purposes of
implementing the provisions of this title, con-
struction or renovation of health care facilities, staff quarters, and
sanitation facilities, and related support in-
frastucture, funded in whole or in part with
funds available pursuant to this title, shall
contain a provision requiring compli-
ance with subchapter IV of chapter 31 of
title 40, United States Code (commonly
known as the 'Davis-Bacon Act').

SEC. 304. EXPENDITURE OF NON-SERVICE FUND
S FOR RENOVATION.

"(a) IN GENERAL.—Notwithstanding any
other provisions of law to the contrary, the
requirements of subsection (c) are met, the
Secretary, acting through the Service, is authorized to accept
any major expansion, renovation, or mod-
erization—

"(1) any plans or designs for such expan-
sion, renovation, or modernization;
"(2) any expansion, renovation, or mod-
erization for which funds appropriated
under any Federal law were lawfully ex-

"(b) Priority List.—

"(1) IN GENERAL.—The Secretary shall
maintain a separate priority list to address
the needs of such new facilities for increased op-
erating expenses, personnel, or equipment;
and

"(2) the expansion, renovation, or mod-
erization—

"(A) approved by the appropriate area
director of the Service for Federal facilities; and
and
"(B) is administered by the Indian Tribe or Tribal Orga-
nization in accordance with any applicable regulations prescribed by the
Secretary with respect to construction or ren-
ovation of Service facilities.

"(d) Appropriation for Expansion.—In addi-
tion to the requirements under subsection (c), for any expansion, the Indian
Tribe or Tribal Organization shall provide to
the Secretary additional information pursu-
ant to regulations, including additional
staffing, equipment, and other costs associ-
ated with the construction or renovation;

"(e) Closure or Conversion of Facilities.—If any Service facility which has been
expanded, renovated, or modernized by an In-
dian Tribe or Tribal Organization under this
section ceases to be used as a Service facility
during the 20-year period beginning on the
date such expansion, renovation, or
modernization is completed, such Indian Tribe or
Tribal Organization shall be entitled to re-
cover from the United States an amount
which bears the same ratio to the value of
such facility at the time of such cessation as
the value of such expansion, renovation, or
modernization to the total amount of any
funds provided specifically for such facility
under any Federal program that were ex-
}
the Service, is authorized to make grants to, and enter into construction contracts or construction project agreements with, Indian Tribes or Tribal Organizations under the Indian Tribes and Tribal Organizations Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), for the purpose of carrying out a health care delivery demonstration project to test alternative means of providing health care services to Indians through facilities.

(b) USE OF FUNDS.—The Secretary, in approving projects pursuant to this section, may authorize such contracts for the construction and renovation of hospitals, health centers, health stations, and other facilities to deliver health care services and is authorized to:

(1) waive any leasing prohibition;

(2) permit carryover of funds appropriated for the provision of health care services;

(3) permit the use of other available funds;

(4) permit the use of funds or property donated from any source for project purposes;

(5) provide for the reversion of donated real or personal property to the donor; and

(6) permit the use of Service funds to match other funds, including Federal funds.

c. RISK VS. REWARD.—The Secretary shall develop and promulgate regulations, not later than 1 year after the date of enactment of the Improving Health Care for Indians Act Amendments of 2009, for the review and approval of applications submitted under this section.

d. CRITERIA.—The Secretary may approve projects that meet the following criteria:

(1) There is a need for a new facility or program or the reorientation of an existing facility or program.

(2) A significant number of Indians, including those with low health status, will be served by the project.

(3) The project has the potential to deliver services in an efficient and effective manner.

(4) The project is economically viable.

(5) The Indian Tribe or Tribal Organization has the administrative and financial capability to administer the project.

(6) The project is integrated with providers of related health and social services and is coordinated with, and avoids duplication of, existing services.

e. PEER REVIEW PANEL.—The Secretary may provide for the establishment of peer review panels, as necessary, to review and evaluate applications using the criteria developed pursuant to subsection (d).

f. PRIORITY.—The Secretary shall give priority to applications for demonstration projects in each of the following Service Units to the extent that such applications are timely filed and meet the criteria specified in subsection (d):

(1) Cass Lake, Minnesota.

(2) Mescalero, New Mexico.

(3) Owyhee, Nevada.

(4) Schurz, Nebraska.

(5) Yu, California.

(g) TECHNICAL ASSISTANCE.—The Secretary shall provide such technical and other assistance as may be necessary to enable applicants to comply with the provisions of this section.

(h) SERVICE TO INELIGIBLE PERSONS.—Subject to the authority to provide services to persons otherwise ineligible for the health care benefits of the Service and the authority to extend hospital privileges in Service facilities to non-Service health practitioners as provided in section 806 may be included, subject to the terms of such section, in any demonstration project approved pursuant to this section:

(1) EQUITABLE TREATMENT.—For purposes of subsection (d)(1), the Secretary shall, in evaluating facilities operated under any contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), use the same criteria of the Service that the Secretary used for determining whether the facilities operated directly by the Service.

(2) EQUITABLE INTEGRATION OF FACILITIES.—The Secretary shall ensure that the planning, design, construction, renovation, and expansion needs of Service and non-Service facilities which are the subject of a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) for health services are fully and equitably integrated into the implementation of the health care delivery demonstration projects under this section.

SEC. 307. LAND TRANSFER.

Notwithstanding any other provision of law, the Bureau of Indian Affairs and all other agencies and departments of the United States are authorized to transfer, at no cost, land and improvements to the Service for the provision of health care services. The Secretary is authorized to accept such land and improvements for such purposes.

SEC. 308. LEASES, CONTRACTS, AND OTHER AGREEMENTS.

(a) IN GENERAL.—The Secretary may enter into leases, contracts, and other agreements with Indian Tribes and Tribal Organizations which hold (1) title to, (2) a leasehold interest in, or (3) a beneficial interest in (when title is held by the United States in trust for the benefit of an Indian Tribe) facilities used or to be used for the administration and delivery of health services by an Indian Health Program. Such leases, contracts, or agreements may include provisions for construction or renovation and provide for the provision and exchange of Services under section 301; and

(b) DETERMINATIONS.—In carrying out the Service, the Secretary shall determine:

(1) the manner of consultation made as required by subsection (a); and

(2) the results of the study, including any recommendations of the Secretary based on results of the study.

SEC. 309. STUDY ON LOANS, LOAN GUARANTEES, AND LOAN REPAYMENT.

(a) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, Indian Tribes, and Tribal Organizations, shall carry out a study to determine the feasibility of providing direct loans or loan guarantees to Indian Tribes and Tribal Organizations for the construction of health care facilities, including—

(1) inpatient facilities;

(2) outpatient facilities;

(3) staff quarters;

(4) hostels; and

(5) specialized care facilities, such as behavioral health and elder care facilities.

(b) DETERMINATIONS.—In carrying out the study under subsection (a), the Secretary shall determine—

(1) the maximum principal amount of a loan or loan guarantee that should be offered to a recipient from the loan fund;

(2) the percentage of eligible costs, not to exceed 100 percent, that may be covered by a loan or loan guarantee from the loan fund (including costs relating to planning, design, financing, site land development, construction, rehabilitation, renovation, conversion, improvements, medical equipment and furnishings, and other facility-related costs and capital purchase (but excluding staffing));

(3) the cumulative total of the principal of direct loans and loan guarantees, respectively, that may be outstanding at any 1 time;

(4) the maximum term of a loan or loan guarantee that may be made for a facility from the loan fund; and

(5) the maximum percentage of funds from the loan fund that should be allocated for payment of costs associated with planning and applying for a loan or loan guarantee;

(6) whether acceptance by the Secretary of a loan or loan guarantee from the loan fund would be appropriate;

(7) whether other funds of the Service or the Indian Tribe or Tribal Organization as security for any direct loan or loan guarantee from the loan fund would be appropriate;

(8) whether other funds of the Service would be used in the design and development of health facilities under this section, users eligible under section 806(c) may be included in any projection of patient population;

(9) whether loans or loan guarantees from the loan fund should be eligible for use in matching other Federal funds under other programs;

(10) whether, in the planning and design of health care facilities, users eligible under section 806(c) may be included in any projection of patient population;

(11) any legislative or regulatory changes required to implement recommendations of the Secretary based on results of the study.

(c) REQUIREMENTS.—Not later than September 30, 2010, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources and the Environment of the House of Representatives a report that describes—

(1) the manner of consultation made as required by subsection (a); and

(2) the results of the study, including any recommendations of the Secretary based on results of the study.

SEC. 310. TRIBAL LEASING.

A Tribal Health Program may lease permanent structures for the purpose of providing health care services without obtaining advance approval in appropriation Acts.

SEC. 311. INDIAN HEALTH SERVICE/TRIBAL FACILITIES JOINT VENTURE PROGRAM.

(a) IN GENERAL.—The Secretary, acting through the Service, shall make arrangements with Indian Tribes and Tribal Organizations to establish joint venture demonstration projects under which an Indian Tribe or Tribal Organization shall enter into a joint venture or leasehold, or acquire and improve, land under this subsection. An Indian Tribe or Tribal Organization shall be eligible to establish a joint venture project if, when it submits a letter of intent—

(1) it has begun but not completed the process of acquisition or construction of a health facility to be used in the joint venture project;

(2) it has not begun the process of acquisition or construction of a health facility for use in the joint venture project; or

(3) in its application for a joint venture agreement, agrees—

(A) to construct a facility for the joint venture which complies with the size and space criteria established by the Service; or

(B) if the facility it proposes for the joint venture is already in existence or under construction, that only the portion of such facility which complies with the size and space criteria established by the Service will be eligible for the joint venture agreement.

(b) REQUIREMENTS.—The Secretary shall make such an arrangement with an Indian Tribe or Tribal Organization as security for any direct loan or loan guarantee from the loan fund would be appropriate;

(2) whether other funds of the Service would be used in the design and development of health facilities under this section, users eligible under section 806(c) may be included in any projection of patient population;

(3) whether funds of the Service provided through loans or loan guarantees from the loan fund should be eligible for use in matching other Federal funds under other programs;

(4) whether, in the planning and design of health care facilities, users eligible under section 806(c) may be included in any projection of patient population;

(5) the maximum percentage of funds from the loan fund that should be allocated for payment of costs associated with planning and applying for a loan or loan guarantee;

(6) whether acceptance by the Secretary of a loan or loan guarantee from the loan fund would be appropriate;

(7) whether other funds of the Service as security for any direct loan or loan guarantee from the loan fund would be appropriate;

(8) whether other funds of the Service would be used in the design and development of health facilities under this section, users eligible under section 806(c) may be included in any projection of patient population;

(9) whether other funds of the Service would be used in the design and development of health facilities under this section, users eligible under section 806(c) may be included in any projection of patient population;

(10) any legislative or regulatory changes required to implement recommendations of the Secretary based on results of the study.

(c) REQUIREMENTS.—Not later than September 30, 2010, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources and the Environment of the House of Representatives a report that describes—

(1) the manner of consultation made as required by subsection (a); and

(2) the results of the study, including any recommendations of the Secretary based on results of the study.
the administrative and financial capabilities necessary to complete the timely acquisition or construction of the relevant health facility; and

(2) the Indian Tribe or Tribal Organization meets the need criteria determined using the criteria developed under the health care facility priority system under section 301, under regulations, pursuant to regulations, that other criteria will result in a more cost-effective and efficient method of facilitating and completing construction of the facility.

(c) CONTINUED OPERATION.—The Secretary shall negotiate an agreement with the Indian Tribe or Tribal Organization, regarding the continuation of the facility after the end of the initial 10 year no-cost lease period.

(d) BREACH OF AGREEMENT.—An Indian Tribe or Tribal Organization that has entered into a written agreement with the Secretary under this section, and that breaches or terminates without cause such agreement, shall be liable to the United States for the amount that has been paid to the Indian Tribe or Tribal Organization, or paid to a third party on the Indian Tribe’s or Tribal Organization’s behalf, under the agreement. The Secretary shall have the right to recover tangible property (including supplies) and equipment, less depreciation, and any funds expended for operations and maintenance under the agreement. The proceeding sentence does not apply to any funds expended for the delivery of health care services, personnel, or staffing.

(e) RECOVERY FOR NONUSE.—An Indian Tribe or Tribal Organization that has entered into a written agreement with the Secretary under this section shall be entitled to recover from the United States an amount that is proportional to the value of such facility if, at any time within the 10-year term of the agreement, the Service ceases to use the facility or otherwise breaches the agreement.

(f) DEFINITION.—For the purposes of this section, the term ‘health facility’ or ‘health facilities’ includes quarters needed to provide housing for staff of the relevant Tribal Health Program.

SEC. 312. LOCATION OF FACILITIES.

(a) United States.—In all matters involving the reorganization or development of Service facilities or in the establishment of related employment projects to address unemployment in Indian areas, the Bureau of Indian Affairs and the Service shall give priority to locating such facilities and projects on Indian lands, or lands in Alaska owned by any Alaska Native village, or village or regional corporation under the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.), or any land allotted to any Alaska Native, if requested by the Indian owner and the Indian Tribe with jurisdiction over such lands or other lands owned or leased by the Indian Tribe or Tribal Organization. Such priority shall be recognized by the Indian land owned by 1 or more Indian Tribes.

(b) DEFINITION.—For purposes of this section, the term ‘Indian lands’ means

(1) all lands within the exterior boundaries of any reservation; and

(2) any lands title to which is held in trust by the United States for the benefit of any Indian Tribe or individual Indian or held by any Indian Tribe or individual Indian subject to restriction by the United States against alienation.

SEC. 313. MAINTENANCE AND IMPROVEMENT OF HEALTH CARE FACILITIES.

(a) UPDATE.—The Secretary shall submit to the Congress an annual report on the establishment, development, and operation of the Tribal Health Program pursuant to section 301, which shall include, but not be limited to, information required to be transmitted to Congress under section 801, a report which identifies the

backlog of maintenance and repair work required at all Service and Tribal health care facilities, including new health care facilities expected to be in operation in the next fiscal year. The Secretary shall report the need for renovation and expansion of existing facilities to support the growth of health care programs.

(b) MAINTENANCE OF NEWLY CONSTRUCTED SPACE.—The Secretary, acting through the Service, is authorized to expend maintenance and repair funds to support the maintenance of newly constructed space only if such space falls within the approved supportable space allocation for the Indian Tribe or Tribal Organization. Supportable space allocation shall be defined through the health care facility priority system under section 301(c).

(c) REPLACEMENT FACILITIES.—In addition to using maintenance and improvement funds for renovation, modernization, and expansion of facilities, an Indian Tribe or Tribal Organization may use maintenance and improvement funds for construction of a replacement facility if the costs of renovation of such facility would exceed a maximum renovation cost threshold. The Secretary shall consult with Native Tribes and Tribal Organizations in determining the maximum renovation cost threshold.

SEC. 314. TRIBAL MANAGEMENT OF FEDERALLY OWNED QUARTERS.

(a) RENTAL RATES.—

(1) GENERAL.—Notwithstanding any other provision of law, a Tribal Health Program which operates a hospital or other health facility and the federally owned quarters associated therewith pursuant to a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.) shall have the authority to establish and collect rents from the occupants of such quarters by providing notice to the Secretary of its election to exercise such authority.

(2) OBJECTIVES.—In establishing rental rates pursuant to authority of this subsection, a Tribal Health Program shall endeavor to achieve the following objectives:

(A) To base such rental rates on the reasonable value of the quarters to the occupants thereof.

(B) To generate sufficient funds to prudently provide for the operation and maintenance of the quarters, and subject to the discretion of the Tribal Health Program, to supply reserved funds for capital repairs and replacement of equipment.

(C) To equitable funding.—Any quarters whose rental rates are established by a Tribal Health Program pursuant to this subsection shall remain eligible for quarters improvement and repair funds to the same extent as all federally owned quarters used to house personnel in Services-supported programs.

(D) NOTICE OF RATE CHANGE.—A Tribal Health Program which exercises the authority provided by paragraph (2) shall provide occupants with not less than 60 days notice of any change in rental rates.

(b) DIRECT COLLECTION OF RENT.—

(1) GENERAL.—In addition to any other provision of law, and subject to paragraph (2), a Tribal Health Program shall have the authority to collect rents directly from Federal employees, Federal employees of any other Tribal Health Program that has made an agreement with the Secretary or Tribal Health Program which has made an agreement with the Secretary, or other Federal agencies to accept funds from such Federal or State agencies or other sources to provide for the

and the Secretary shall have no further authority to collect rents from such employees through payroll deduction or otherwise.

(c) Such rent payments shall be retained by the Tribal Health Program and shall not be made payable to or otherwise be deposited with the United States.

(d) Such rent payments shall be deposited in a separate account used by the Tribal Health Program for the maintenance (including capital repairs and replacement) and operation of the quarters and shall become the Tribal Health Program shall determine.

SEC. 315. APPLICABILITY OF BUY AMERICAN ACT REQUIREMENT.

(a) APPLICABILITY.—The Secretary shall ensure that the requirements of the Buy American Act apply to all procurements made with funds provided pursuant to section 317. Indian Tribes and Tribal Organizations shall be exempt from these requirements.

(b) EFFECT OF VIOLATION.—If it has been finally determined by a court or Federal agency that any person intentionally affixed a label bearing a ‘Made in America’ inscription or any inscription with the same meaning, to any product sold in or shipped to the United States that is intended for sale to the United States, such person shall be ineligible to receive any contract or subcontract made with funds provided pursuant to section 317, pursuant to the debarment and ineligibility procedures described in section 9.400 through 9.409 of title 48, Code of Federal Regulations.

SEC. 316. OTHER FUNDING FOR FACILITIES.

(a) AUTHORITY.—The Secretary is authorized to accept from any source, including Federal and State agencies, funds that are available for the construction of health care facilities and use such funds to plan, design, and construct health care facilities for Indians and to place such funds into a contract or compact under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). Receipt of such funds shall have no effect on the priorities established pursuant to section 301.

(b) INTERAGENCY AGREEMENTS.—The Secretary is authorized to enter into interagency agreements with other Federal agencies and Tribal organizations to accept Federal grants and related programs to accept funds from such Federal or State agencies or other sources to provide for the
planning, design, and construction of health care facilities to be administered by Indian Health Programs in order to carry out the purposes of this Act and the purposes for which the funds are appropriated or for which the funds were otherwise provided.

(c) Transferred Funds.—Any Federal agency to which funds for the construction of health care facilities are appropriated is authorized to transfer such funds to the Secretary for the construction of health care facilities to carry out the purposes of this Act as well as the purposes for which such funds are appropriated to such other Federal agency.

(d) Establishment of Standards.—The Secretary, through the Service, shall establish standards by regulation for the planning, design, and construction of health care facilities serving Indians under this Act.

SEC. 317. AUTHORIZATION OF APPROPRIATIONS.

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

TITLE IV—ACCESS TO HEALTH SERVICES

SEC. 401. TREATMENT OF PAYMENTS UNDER SOCIAL SECURITY ACT HEALTH BENEFITS PROGRAMS.

(a) Discharge of Medicare, Medicaid, and SCHIP Obligations.—Any payments received by an Indian Health Program or by an urban Indian organization under title XVII, XIX, or XXI of the Social Security Act for services provided in appropriation Acts to Indians eligible for benefits under such respective titles shall not be considered in determining appropriations for the provision of health care and services to Indians.

(b) Nonpreferential Treatment.—Nothing in this Act shall be construed to provide to an Indian with coverage under title XVIII, XIX, or XXI of the Social Security Act in preference to an Indian with coverage in this Act authorizes the Secretary to provide the Indian Health Program making the election described in paragraph (1) with respect to a program under title XVIII, XIX, or XXI of the Social Security Act for services furnished without regard to subsection (c)(1), but all amounts so reimbursed shall be used by the Tribal Health Program for the same purposes with respect to such Program for which payment under subparagraph (A) of subsection (c)(1) to a facility of the Service may be used pursuant to subparagraph (B) of such subsection with respect to the Service.

(c) Identification of Source of Payments.—Any Tribal Health Program that receives reimbursements or payments under title XVIII, XIX, or XXI of the Social Security Act shall provide to the Service a list of each provider enrollment number (or other identifier) under which such Program receives such reimbursements or payments.

(d) Examination and Implementation of Changes.—

(1) IN GENERAL.—The Secretary, acting through the Service and with the assistance of the Administrator of the Centers for Medicare & Medicaid Services, shall examine on a quarterly basis the administration of the program established under this Act and any auditing requirements applicable to programs administered by an Indian Health Program.

(2) Cooperate.—The Secretary shall construe the program under title XVIII, XIX, or XXI of the Social Security Act as described in paragraph (1) with respect to a Tribal Health Program for the same purposes with respect to such Program for which payment under subparagraph (A) of subsection (c)(1) to a facility of the Service may be used pursuant to subparagraph (B) of such subsection with respect to the Service.

(3) Audits.—The amounts paid to a Tribal Health Program making the election described in paragraph (1) with respect to a program under title XVIII, XIX, or XXI of the Social Security Act shall be subject to all auditing requirements applicable to programs administered by an Indian Health Program.

SEC. 402. GRANTS TO AND CONTRACTS WITH THE SERVICE, INDIAN TRIBES, TRIBAL ORGANIZATIONS, AND URBAN INDIAN ORGANIZATIONS.

(a) Indian Tribes and Tribal Organizations.—The Secretary, acting through the Service and with the assistance of the Administrator of the Centers for Medicare & Medicaid Services, shall examine on a quarterly basis the administration of the program established under this Act and any auditing requirements applicable to programs administered by an Indian Health Program.

(b) Conditions.—The Secretary shall, as deemed necessary to effect the purpose of this section in any grant or contract which the Secretary makes with any Indian Tribe or Tribal Organization pursuant to this section, include requirements that the Indian Tribe or Tribal Organization shall comply with any such requirement and a reasonable opportunity to correct such noncompliance prior to the Secretary’s acceptance of the withdrawal of participation in the direct billing program established under this subsection.

(c) Application to Urban Indian Organizations.—

(1) IN GENERAL.—The provisions of subsection (a) shall apply with respect to grants and other funding to urban Indian organizations with respect to populations served by such organizations in the same manner they apply with respect to grants and other funding to urban Indian Tribes and Tribal Organizations with respect to programs or on or near reservations.
“(2) Requirements.—The Secretary shall include in the grants or contracts made or provided under paragraph (1) requirements that are—

(A) consistent with the requirements imposed by the Secretary under subsection (b); and

(B) appropriate to urban Indian organizations and urban Indians; and

(C) necessary to effect the purposes of this section.

“(d) Facilitating Cooperation in Enrollment and Retention.—The Secretary, acting through the Service, shall consult with States, the Service, Indian Tribes, Tribal Organizations, and urban Indian organizations relating to the provision of health services to a person who is injured or diseased, and disseminate best practices with respect to facilitating agreements between the States and Indian Tribes, Tribal Organizations, and urban Indian organizations relating to enrollment and retention of Indians in programs established under titles XVIII, XIX, and XXI of the Social Security Act.

“(e) Agreements to Improve Enrollment of Indians Under Social Security Act Health Benefits Programs.—For provisions relating to agreements between the Secretary, the Service, Indian Tribes, Tribal Organizations, and urban Indian organizations for the collection, preparation, and submission of applications by Indians for assistance under the Medicaid and children’s health insurance programs established under titles XIX and XXI of the Social Security Act, and benefits under the Medicare program provided under title XVIII of such Act, see subsections (a) and (b) of section 1319 of the Social Security Act.

“(f) Definitions.—In this section:

(1) Premium.—The term ‘premium’ includes any enrollment fee or similar charge.

(2) Cost sharing.—The term ‘cost sharing’ includes any deductible, copayment, coinsurance, or similar charge.

(3) Benefits.—The term ‘benefits’ means, with respect to—

(A) title XVIII of the Social Security Act, benefits under such title; and

(B) title XIX of such Act, medical assistance under such title; and

(C) title XXI of such Act, assistance under such title.

“SEC. 403. REIMBURSEMENT FROM CERTAIN THIRD PARTIES OF COSTS OF HEALTH SERVICES.

“(a) Right of Recovery.—Except as provided in subsection (f), the United States, an Indian Tribe, or Tribal Organization shall have the right to recover from a health maintenance organization, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State) the reasonable charges incurred by the Secretary, the Service, Indian Tribes, Tribal Organizations, or, if higher, the highest amount the third party would pay for care and services furnished by providers other than governmental entities providing health services through the Service, an Indian Tribe, or Tribal Organization to any individual to the same extent that such individual, or any nongovernmental provider of such services, would be eligible to receive damages, reimbursement, or indemnification for such charges if—

(1) such services were provided by a nongovernmental provider; and

(2) such individual had been required to pay such charges or expenses and did pay such amount.

“(b) Limitations on Recoveries from States.—Subsection (a) shall provide a right of recovery against any State, only if the injury, illness, or disability for which health services were provided is covered under—

(1) workers’ compensation laws; or

(2) a no-fault automobile accident insurance plan or program.

“(c) Nonapplication of Other Laws.—No law of any State, or of any political subdivision thereof, or of any contract, insurance or health maintenance organization policy, employee benefit plan, self-insurance plan, managed care plan, or other health care plan or program entered into or renewed after the date of the enactment of the Indian Health Care Amendments of 1988, shall prohibit or prevent the right of recovery provided under such Act for the period of such authorization.

“(d) No Effect on Private Rights of Action.—Nothing in this section shall be construed to limit any right of recovery provided under section 1175 of such Act, or in any other act, or under any ordinary tort action brought —

(i) by the individual for whom health services were provided by the Secretary, an Indian Tribe, or Tribal Organization;

(ii) by any representative or heirs of such individual, or

(iii) by a third party on behalf of an individual, or

(iv) by a third party on behalf of such individual.

“(e) Limitation.—Absent specific written authorization by the governing body of an Indian Tribe, or Tribal Organization to recover from a health maintenance organization, or any other responsible or liable third party (including a political subdivision or local governmental entity of a State) the reasonable charges incurred by the Service, Indian Tribes, Tribal Organizations, or urban Indian organizations, or the United States, an Indian Tribe, or Tribal Organization for the period of such authorization, no such charges shall be recoverable.

“(f) Statute of Limitations.—The provisions of section 2415 of title 28, United States Code, shall apply to all actions commenced under this section. Actions commenced hereunder, to the extent that such actions are brought against an Indian Tribe, or Tribal Organization, or such urban Indian organization, under the provisions of any applicable, Federal, State, or Tribal law, including medical lien laws.

“SEC. 404. CREDITING OF REIMBURSEMENTS.

“(a) Retention of Amounts for Use by Provider.—Except as provided in section 202(c) (relating to the Catastrophic Health Emergency Fund) and section 806 (relating to health services for ineligible persons), all reimbursements received or recovered, including under section 806, by reason of the provision of health services by the Service, by an Indian Tribe or Tribal Organization, by an urban Indian organization, or by an Indian Tribe for the period of such authorization, such Urban Indian Organization, or such urban Indian organization, or the United States, an Indian Tribe, or Tribal Organization, or such urban Indian organization, respectively, and may be used as provided in section 401. In the case of such a service provided by or through a Service Unit, such amounts shall be credited to such unit and used for such purposes.

“(b) No Offset or Abatement.—The Service may not offset or limit any amount obligated to any Service Unit or entity receiving funding from the Service because of the receipt of reimbursements under subsection (a).

“SEC. 405. PURCHASING HEALTH CARE COVERAGE.

“(a) Purchasing Coverage.—

(1) In general.—Insofar as amounts are made available under law (including a provision of the Social Security Act, the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.), or other law, other than under section 402) to Indian Tribes, Tribal Organizations, and urban Indian organizations for health benefits for Service beneficiaries, urban Indians, Tribes, Tribal Organizations, and urban Indian organizations may use such amounts to purchase insurance, including health insurance, individually, or through a group policy, for individuals, urban Indians, Indian Tribes, or Tribal Organizations.

(2) A tribal owned and operated health care plan;
“(b) A state or locally authorized or li-
censed health care plan;

“(c) A health insurance provider or man-
aged care organization; or

“(D) The self-insured plan.

“(2) EXCEPTION.—The coverage provided
under paragraph (1) may not include cov-
erage consisting of—

“(A) benefits provided under a health flexi-
ble spending arrangement (as defined in sec-
tion 106(c)(2) of the Internal Revenue Code of
1986); or

“(B) high deductible health plan (as de-
finite in section 223(c)(2) of such Code), with-
out regard to whether the plan is purchased
in conjunction with a health savings account
(as defined in section 223(d) of such Code).

“(3) PERMITTING PURCHASE OF COVERAGE
BASED ON FINANCIAL NEED.—The purchase
of coverage by an Indian Tribe, Tribal Orga-
nization, or urban Indian organization under
this subsection may be based on the finan-
cial needs of beneficiaries (as determined by
the Indian Tribe or Tribes being served based
on a schedule of income levels developed or
implemented by such Indian Tribe or Tribes).

“(b) EXPENSES FOR SELF-INSURED PLAN.—In
the case of a self-insured plan under subsec-
tion (a), benefits may be used for the pur-
purpose of operating the plan, including ad-
ministration and insurance to limit the fi-
nancial risks to the entity offering the plan.

“(c) Nothing in this subsection shall be con-
stituted as construing the use of any amounts
not referred to in subsection (a).

“SEC. 406. SHARING ARRANGEMENTS WITH FED-
ERAL AGENCIES.

“(a) AUTHORITY.—

“(1) IN GENERAL.—The Secretary may enter
into contracts or share arrangements for the shar-
ing of medical facilities and services between the
Service, Indian Tribes, and Tribal Orga-
nizations and the Department of Veterans Affairs
and the Department of Defense.

“(2) CONSULTATION BY SECRETARY RE-
QUIRED.—The Secretary may not finalize any
arrangement between the Service and a De-
partment described in paragraph (1) without first
consulting with the Indian Tribes which
will be significantly affected by the arrange-
ment.

“(b) LIMITATIONS.—The Secretary shall not
take any action under this section or under sub-
chapter IV of chapter 81 of title 38, United States Code,
which would impair—

“(1) the authority of any Indian Nation to health
care services provided through the Service and the eligibility of any Indian to receive health services through the Service;

“(2) the authority of any Indian Nation to health care services pro-
vided to any Indian through the Service;

“(3) the priority access of any veteran to health care services provided by the Depart-
ment of Veterans Affairs;

“(4) the quality of health care services pro-
vided by the Department of Veterans Affairs or the Department of Defense;

“(5) the eligibility of any Indian who is a veteran to receive health services through the Department of Veterans Affairs;

“(c) The Secretary of Veterans Affairs, or the Tribal Organization shall be reim-
bursed by the Department of Veterans Af-
fairs or the Department of Defense (as the case
may be) for the provision of services pursuant
to subsection (a).

“(d) CONSTRUCTION.—Nothing in this sec-
tion shall be construed as creating any right of
a non-Indian veteran to obtain health services
through the Service.

“SEC. 407. ELIGIBLE INDIAN VETERAN SERVICES.

“(a) FINDINGS; PURPOSE.—

“(1) FINDINGS.—Congress finds that—

“(A) collaborations between the Secretary
and the Secretary of Veterans Affairs regard-
ing the treatment of Indian veterans at fa-
cilities of the Service should be encouraged
to the maximum extent practicable; and

“(B) increased enrollment for services of the
Department of Veterans Affairs by vet-
erns who are members of Indian tribes
should be arranged to the maximum ex-
tent practicable.

“(2) PURPOSE.—The purpose of this section is to reaffirm the goals stated in the docu-
ment ‘Understanding Between the VA/Veterans Health Administration And HHS/Indian Health Service’ and dated February 25, 2003 (relating to cooperation and resource sharing between the Veterans Health Administration and Indian Health Service).

“(b) DEFINITIONS.—In this section—

“(1) ELIGIBLE INDIAN VETERAN.—The term ‘eligible Indian veteran’ means an Indian or Alaska Native veteran who receives any medical service that is—

“(A) authorized by the laws adminis-
tered by the Secretary of Veterans Affairs and;

“(B) administered at a facility of the Serv-
ice (including a facility operated by an In-
ian tribe or tribal organization through a
contract or compact with the Service under
the Indian Self-Determination and Edu-
cation Assistance Act (20 U.S.C. 1231v et seq.),

“(c) ELIGIBLE INDIAN VETERANS’ EX-
PENSES.—In general.—Notwithstanding any
other provision of law, the Secretary shall pro-
vide for veteran-related expenses incurred by eligible Indian veterans as described in subsection (b).

“(2) METHOD OF PAYMENT.—The Secretary shall establish such guidelines as the Sec-

tary determines to be appropriate regard-
ing the method of payments to the Secretary of Veterans Affairs and urban Indian organizations.

“(d) TRIBAL APPROVAL OF MEMORANDA.—In
negotiating a local memorandum of under-
standing with the Secretary of Veterans Af-
fairs regarding the provision of services to eligible Indian veterans, the Secretary shall consult with each Indian tribe that would be affected by the local memorandum of under-
standing.

“(e) FUNDING.—

“(1) TREATMENT.—Expenses incurred by the Secretary
pursuant to subsection (c)(1) shall not be considered to be Contract Health Service expenses.

“(2) USE OF FUNDS.—Of funds made avail-
able for facilities, Contract Health Services,
or contract support costs, the Secretary shall use such sums as are necessary to carry out this section.

“SEC. 408. PAYOR OF LAST RESORT.

“Indian Health Programs and health care
programs operated by Urban Indian Organi-
zations shall be the payor of last resort for services provided to persons eligible for serv-
ices from Indian Health Programs and Urban
Indian Organizations, notwithstanding any
Federal, State, or local law to the contrary.

“SEC. 409. CONSULTATION.

“For provisions related to consultation with representatives of Indian Health Pro-
grams and urban Indian organizations with respect to the health care programs estab-
lished under titles XVIII, XIX, and XXI of the Social Security Act, see section 1139(d) of the Social Security Act (42 U.S.C. 1396n-6(d)).

“SEC. 410. STATE CHILDREN’S HEALTH INSUR-
ANCE PROGRAM (SCHIP).

“For provisions relating to—

“(1) outreach to family-centered Indian children likely to be eligible for child health assist-
ance under the State children’s health insur-
ance program established under title XXI of the Social Security Act (42 U.S.C. 1905(c)(2)(C) and 1193(a) of such Act (42 U.S.C. 1397e(c)(2), 1320–9); and

“(2) ensuring that child health assistance is provided under such program to targeted low-income children who are Indians and that payments are made under such program to Indian Health Programs and urban Indian organizations operating in the State that provide such assistance, see sections 2102(b)(3)(D) and 2105(c)(6)(B) of such Act (42 U.S.C. 1397b(b)(3)(D), 1397ee(c)(6)(B)).

“SEC. 411. PREMIUM AND CO-PAYMENT PRO-
TECTIONS AND ELIGIBILITY DETER-
MINATIONS UNDER MEDICAID AND SI-
CHIP.

“For provisions relating to—

“(1) premiums or co-payments for insured

Index to Federal, State, or local law to the contrary.
to the State of Arizona, New Mexico, or Utah; “(2) providing assistance to the Navajo Na
tion in the development and implementation of such entity for the administration, eligi
bility, payment, and delivery of medical as-
sistence under title XIX of the Social Secu
ity Act; “(3) providing an appropriate level of
matching funds for Federal medical assist-
ance with respect to amounts such entity ex
pends for medical assistance for services and
related services to the extent such entity de
termines such services and related services
are not covered under title XIX of the Social
Security Act; “(4) authorizing the Secretary, at
the option of the Navajo Nation, to treat the Nav
ajo Nation as a State for the purposes of
title XIX of the Social Security Act (relating
to the State children’s health insurance pro-
gram) under terms equivalent to those de
scribed in paragraphs (2) through (4); “(c) Repeal.—Not later than 3 years after
the date of enactment of the Indian Health
Care Improvement Act Amendments of 2009,
the Secretary shall submit to the Committee
on Indian Affairs and Committee on Finance
of the Senate and the Committee on Natural
Resources and Committee on Energy and
Commerce of the House of Representatives a
report on the results of the study under this
section; “(d) exceptions for exempted
benefits.—The purposes of this title shall not
apply to the provision of exempted bene
fits described in paragraph (1)(A) or (3) of
section 279(c) of the Public Health Service Act
(42 U.S.C. 300g–9(c)). “(e) Authorization of Appropriations.—
These purposes are intended to be appropriated
such sums as may be necessary to carry out
this title.

TITLE V—HEALTH SERVICES FOR URBAN INDIANS

SEC. 501. PURPOSE. “The purpose of this title is to establish
and maintain programs in Urban Centers to
make health services more accessible and
available to Urban Indians.

SEC. 502. CONTRACTS WITH, AND GRANTS TO,
URBAN INDIAN ORGANIZATIONS. “Under authority of the Act of
November 2, 1921 (25 U.S.C. 13) (commonly
known as the ‘Snyder Act’), the Secretary, acting
through the Service, shall enter into contracts
with, or make grants to, urban Indian organiza
tions to assist such organizations in the es
tablissement and administration, within
Urban Centers, of programs which meet the
requirements set forth in this title. Subject
to section 506, the Secretary, acting through the
Service, shall include such conditions as the
Secretary considers necessary to effect
the purpose of this title in any contract into
which the Secretary enters with, or in any grant
Secretary makes to, any urban In
dian organization pursuant to this title.

SEC. 503. CONTRACTS WITH, AND GRANTS TO,
URBAN INDIAN ORGANIZATIONS. “(a) Requirements for Grants and Con
tracts.—Under authority of the Act of No
vember 2, 1921 (25 U.S.C. 13) (commonly
known as the ‘Snyder Act’), the Secretary, acting
through the Service, shall enter into contracts
with, and make grants to, urban Indian
organizations to assist such organizations
in the provision of health care and referral
services for Urban Indians. Any such contract or
grant shall in
clude requirements that the urban Indian
organization administering contracts enter into
to— “(1) estimate the population of Urban In
dians residing in the Urban Center or centers
that the organization proposes to serve who
are recipients of health care or referral
services; “(2) estimate the current health status
of Urban Indians residing in such Urban Center
or centers; “(3) estimate the current health care
needs of Urban Indians residing in such Urban
Center or centers; “(4) provide basic health educa
tion, including health promotion and disease
prevention education, to Urban Indians; “(5) make
recommendations to the Sec
ratory and Federal, State, local, and other
resource agencies on methods of improving
health service programs to meet the needs of
Urban Indians; and
“(6) when feasible, provide, or enter into
contracts for the provision of, health care
services for Urban Indians.

(b) Criteria.—The Secretary, acting
through the Service, shall enter into contracts
that be
prescribe the criteria for selecting urban In
dian organizations to enter into contracts or
receive grants under this section. Such cri
tera shall, among other factors, include
“(1) the extent of unmet health care needs
of Urban Indians in the Urban Center or cen
ters involved;
“(2) the extent of the urban Indian population
in the Urban Center or centers involved;
“(3) the extent, if any, to which the activi
ties set forth in subsection (a) would dupli
cate federal, state, local, or other related
resources available to that pop
ulation.

(c) Authorization of Appropriations.—
These purposes are intended to be appropriated
such sums as may be necessary to carry out
this title.

URBAN INDIAN ORGANIZATIONS.

SEC. 504. APPROPRIATIONS. “The amounts appropriated for
such purposes shall be used to
facilitate access to or provide services for
Urban Indians through grants made to urban In
dian organizations administering contracts
entered into or receiving grants under subsec
tion (a) to prevent and treat child abuse
(including sexual abuse) among Urban In
dian children.

SEC. 505. CONTRACTS WITH, AND GRANTS TO,
URBAN INDIAN ORGANIZATIONS. “(a) Requirements for Grants and Con
tracts.—Under authority of the Act of No
vember 2, 1921 (25 U.S.C. 13) (commonly
known as the ‘Snyder Act’), the Secretary, acting
through the Service, shall enter into contracts
with, and make grants to, urban Indian
organizations to assist such organizations
in the provision of health care and referral
services for Urban Indians. Any such contract or
grant shall in
clude requirements that the urban Indian
organization administering contracts enter into
to— “(1) estimate the population of Urban In
dians residing in the Urban Center or centers
that the organization proposes to serve who
are recipients of health care or referral
services; “(2) estimate the current health status
of Urban Indians residing in such Urban Center
or centers; “(3) estimate the current health care
needs of Urban Indians residing in such Urban
Center or centers; “(4) provide basic health educa
tion, including health promotion and disease
prevention education, to Urban Indians; “(5) make
recommendations to the Sec
ratory and Federal, State, local, and other
resource agencies on methods of improving
health service programs to meet the needs of
Urban Indians; and
“(6) when feasible, provide, or enter into
contracts for the provision of, health care
services for Urban Indians.

(b) Criteria.—The Secretary, acting
through the Service, shall enter into contracts
that be
prescribe the criteria for selecting urban In
dian organizations to enter into contracts or
receive grants under this section. Such cri
tera shall, among other factors, include
“(1) the extent of unmet health care needs
of Urban Indians in the Urban Center or cen
ters involved;
“(2) the extent of the urban Indian population
in the Urban Center or centers involved;
“(3) the extent, if any, to which the activi
ties set forth in subsection (a) would dupli
cate federal, state, local, or other related
resources available to that pop
ulation.

(c) Authorization of Appropriations.—
These purposes are intended to be appropriated
such sums as may be necessary to carry out
this title.

URBAN INDIAN ORGANIZATIONS.

SEC. 504. APPROPRIATIONS. “The amounts appropriated for
such purposes shall be used to
facilitate access to or provide services for
Urban Indians through grants made to urban In
dian organizations administering contracts
entered into or receiving grants under subsec
tion (a) to prevent and treat child abuse
(including sexual abuse) among Urban In
dian children.

SEC. 505. CONTRACTS WITH, AND GRANTS TO,
URBAN INDIAN ORGANIZATIONS. “(a) Requirements for Grants and Con
tracts.—Under authority of the Act of No
and to urban Indian perpetrators of child abuse (including sexual abuse).

(4) CONSIDERATIONS WHEN MAKING GRANTS.—In making grants to carry out this subsection, the Secretary shall take into consideration—

(A) the support for the urban Indian organization demonstrated by the child protection area, including the recommendations of committees or other services funded under the Indian Child Welfare Act of 1978 (25 U.S.C. 1301 et seq.), if any;

(B) the capability and expertise demonstrated by the urban Indian organization to address the complex problem of child sexual abuse in the community; and

(C) an assessment required under paragraph (2).

(5) OTHER GRANTS.—The Secretary, acting through the Service, may enter into a contract with or make grants to an urban Indian organization that provides or arranges for the provision of health care services (through satellite facilities, provider networks, or otherwise) to Urban Indians in more than 1 Urban Center.

SEC. 504. USE OF FEDERAL GOVERNMENT FUNDS AVAILABLE TO URBAN INDIAN ORGANIZATIONS.

(a) IN GENERAL.—The Secretary may permit an urban Indian organization that has entered into a contract or received a grant pursuant to this title to use existing facilities and all equipment therein or pertaining thereto and any property owned by the Secretary under such terms and conditions as may be agreed upon for their use and maintenance.

(b) CONTRACTS.—Subject to subsection (d), the Secretary may enter into contracts with, or make grants to, urban Indian organizations entered into a contract or received a grant pursuant to this title if the Secretary determines that the property is appropriate for use by the urban Indian organization for a purpose for which a contract or grant is authorized under this title.

(c) ACQUISITION OF PROPERTY.—The Secretary may acquire excess or surplus government personal or real property for donation, subject to subsection (d), to an urban Indian organization that has entered into a contract or received a grant pursuant to this title if the Secretary determines that the property is appropriate for use by the urban Indian organization for a purpose for which a contract or grant is authorized under this title.

(d) PRIORITY.—In the event that the Secretary receives a request for a specific item of personal or real property described in subsection (b) or (c) from an urban Indian organization and from an Indian Tribe or Tribal Organization if the Secretary receives the request from the Indian Tribe or Tribal Organization before the date the Secretary transfers title to the property or, if such property is transferred by the Secretary to the urban Indian organization, the Secretary shall transfer the property physically, to the urban Indian organization.

(e) EXECUTIVE AGENCY STATUS.—For purposes of section 201(a) of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 481(a) (relating to Federal sources of supply), an urban Indian organization that has entered into a contract or received a grant pursuant to this title may be deemed to be an executive agency when carrying out such contract or grant.

SEC. 505. CONTRACTS AND GRANTS FOR THE DETERMINATION OF UNMET HEALTH CARE NEEDS.

(a) GRANTS OR CONTRACTS AUTHORIZED.—Under authority of the Act of November 2, 1921 (25 U.S.C. 13) (commonly known as the ‘Snyder Act’), the Secretary, acting through the Service, may enter into contracts with or make grants to urban Indian organizations situated in Urban Centers for which urban Indian organizations and the Secretary, before entering into or making such a contract or grant, has not been made under section 503.

(b) PURPOSE.—The purpose of a contract or grant made under this section shall be the determination of the health status and health care needs of Urban Indians in the Urban Center. The determination described in subsection (c)(1) in order to assist the Secretary in assessing the health status and health care needs of Urban Indians in the Urban Center to determine whether the Secretary should enter into a contract or make a grant under section 503 with respect to the urban Indian organization. The Secretary shall give priority to entering into a contract with, or made a grant to, under this section.

(c) GRANT AND CONTRACT REQUIREMENTS.—Any contract entered into, or grant made, by the Secretary under this section shall include requirements that—

(1) the urban Indian organization successfully undertakes to—

(A) document the health care status and unmet health care needs of Urban Indians in the Urban Center involved; and

(B) with respect to urban Indians in the Urban Center involved, determine the matters described in paragraphs (2), (3), (4), and (5) of section 503(b); and

(2) the urban Indian organization complete performance of the contract, or carry out the requirements of the grant, within 1 year after the date on which the Secretary and such organization enter into such contract, or within 1 year after such organization receives such grant, whichever is applicable;

(d) NO RENEWALS.—The Secretary may not renew any contract entered into or grant made under this section.

SEC. 506. EVALUATIONS; RENEWALS.

(a) PROCEDURES FOR EVALUATIONS.—The Secretary, acting through the Service, shall develop procedures to evaluate compliance with grant requirements and compliance with and performance of contracts entered into by urban Indian organizations under this title. Such procedures shall include provisions for carrying out the requirements of this section.

(b) EVALUATIONS.—The Secretary, acting through the Service, shall evaluate the compliance of each Urban Indian Organization which has entered into a contract or received a grant under section 503 with the terms of such contract or grant. For purposes of this evaluation, the Secretary shall—

(1) acting through the Service, conduct an annual onsite evaluation of the organization; or

(2) accept in lieu of such onsite evaluation an evaluation conducted by a private independent entity recognized by the Secretary for purposes of conducting quality reviews of providers of Indian Health Service programs under title XVIII of the Social Security Act.

(c) NONCOMPLIANCE; UNSATISFACTORY PERFORMANCE.—If, as a result of the evaluations conducted under this section, the Secretary determines that an urban Indian organization has not complied with the requirements of a grant or complied with or satisfactorily performed a contract under section 503, the Secretary shall, prior to renewing such contract or grant, attempt to resolve with the urban Indian organization any deficiencies to assure the fair and uniform provision to urban Indians of services and assistance under such contracts or grants.

SEC. 508. REPORTS AND RECORDS.

(a) REPORTS.—
SEC. 510. FACILITIES.

(a) GRANTS.—The Secretary, acting through the Service, may make grants to contractors or grant recipients under this title to construct, acquire, renovate, repair, or demolish housing, health care facilities, or other public service facilities in an urban Indian population to be served.

(b) USE OF FUNDS.—Grants provided or contracts entered into under subsection (a) shall be subject to the criteria set forth in subsec- tion (e).

SEC. 511. DIVISION OF URBAN INDIAN HEALTH.

There is established within the Service a Division of Urban Indian Health, to be responsible for the planning, policy and program functions of the Division.

SEC. 512. GRANTS FOR ALCOHOL AND SUBSTANCE ABUSE-RELATED SERVICES.

(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, may make grants to Indian organizations for the provision of health-related services in prevention of, treatment of, rehabilitation of, or school- and community-based education regarding, alcohol and substance abuse in Indian Health Centers to those urban Indian organizations with which the Secretary has entered into a contract under this title or under section 502.

(b) GOALS.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished pursuant to the grant. The goals shall be specific to each grant as agreed to between the Secretary and the grantee.

(c) CRITERIA.—The Secretary shall establish criteria for the grants made under subsection (a), including criteria relating to the following:

(1) The size of the urban Indian population to be served;

(2) Capability of the organization to adequately perform the activities required under the grant;

(3) Satisfactory performance standards for the organization in meeting the goals set forth in such grant. The standards shall be negotiated and agreed to between the Secretary and the grantee in a manner consistent with subsection (a); and

(4) Identification of the need for services.

(b) ALLOCATION OF GRANTS.—The Secretary may make grants to Indian organizations or to subgrantees for the provision of alcohol and substance abuse treatment services in a residential setting.

(c) CRITERIA.—The Secretary shall establish criteria for the grants made under subsection (a), including criteria relating to the following:

(1) The size of the urban Indian population to be served;

(2) the health status of urban Indians in the Service Area);

(3) performance standards for the organization in meeting the goals set forth in such a grant. The standards shall be negotiated and agreed to between the Secretary and the grantee;

(4) Identification of the need for services.

SEC. 513. TREATMENT OF CERTAIN DEMONSTRATION PROJECTS.

(a) NOTWITHSTANDING any other provision of law, the Tulsa Clinic and Oklahoma City Clinic demonstration projects shall:

(1) be permanent programs within the Service’s direct care program;

(2) continue to be treated as Service Units and Operating Units in the allocation of resources and coordination of care; and

(3) continue to be eligible for grants or contracts under this title or under section 201.

(b) GOALS.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished pursuant to the grant. The goals shall be specific to each grant as agreed to between the Secretary and the grantee.

(c) CRITERIA.—The Secretary shall establish criteria for the grants made under subsection (a), including criteria relating to the following:

(1) the size and location of the urban Indian population to be served;

(2) the need for prevention of and treatment of, and control of the complications resulting from, diabetes among urban Indians.

(d) REPORT.—The Secretary shall evaluate and report to Congress on the activities and accomplishments of the programs funded under this section not less than every 5 years.

SEC. 515. CONFERRED WITH URBAN INDIAN ORGANIZATIONS.

(a) IN GENERAL.—The Secretary shall ensure that the Service confers or conferences, to the greatest extent practicable, with Urban Indian Organizations.

(b) DEFINITION.—For the purposes of this section, the term ‘conference’ or ‘con- ference’ mean an open and free exchange of information and opinions that:

(1) leads to mutual understanding and cooperation; and

(2) emphasizes trust, respect, and shared responsibility.

SEC. 516. URBAN YOUTH TREATMENT CENTER DEMONSTRATION.

(a) CONSTRUCTION AND OPERATION.—

(1) IN GENERAL.—The Secretary, acting through the Service, may make grants to, or enter into contracts with, Urban Indian organizations to conduct any aspect of the construction, design, planning, or operation of an urban youth treatment center in each Service Area that meets the eligibility requirements set forth in paragraphs (b) and (c).

(2) ELIGIBILITY REQUIREMENTS.—To be eligible for a grant under paragraph (1), the Service shall:

(A) confirm or confer, in each Service Area that meets the eligibility requirements set forth in paragraphs (b) and (c), the demonstration of the provision of alcohol and substance abuse treatment services to Urban Indian youth in a culturally competent residential setting.

(b) TREATMENT.—Each residential treatment center described in paragraph (1) shall:

(1) be in addition to any facilities constructed under section 707;

(2) be eligible to receive a facility under subsection (a)(1), a Service Area shall meet the following requirements:

(1) There is an Urban Indian Organization in the Service Area.

(2) There reside in the Service Area Urban Indian youth with need for alcohol and substance abuse treatment services in a residential setting.

(3) There is a significant shortage of culturally competent substance abuse treatment services for Urban Indian youth in the Service Area.

(c) ELIGIBILITY REQUIREMENTS.—The Secretary may make grants to Urban Indian organizations that have entered into a contract or grant under this title or under section 201 and have received a grant under this title for the provision of services for the prevention and treatment of, and control of the complications resulting from, diabetes among urban Indians.

(d) REPORT.—The Secretary shall evaluate and report to Congress on the activities and accomplishments of the programs funded under this section not less than every 5 years.

SEC. 517. GRANTS FOR DIABETES PREVENTION, TREATMENT, AND CONTROL.

(a) GRANTS AUTHORIZED.—The Secretary, acting through the Service, may make grants to Urban Indian organizations that have entered into a contract or grant under this title or under section 201 and have received a grant under this title for the provision of services for the prevention and treatment of, and control of the complications resulting from, diabetes among urban Indians.

(b) GOALS.—Each grant made pursuant to subsection (a) shall set forth the goals to be accomplished pursuant to the grant. The goals shall be specific to each grant as agreed to between the Secretary and the grantee.

(c) ESTABLISHMENT OF CRITERIA.—The Secretary shall establish criteria for the grants made under subsection (a), including criteria relating to:

(1) the size and location of the urban Indian population to be served;
"(5) the willingness of the organization to collaborate with the registry, if any, established by the Secretary under section 203(e)(1)(B) in the Area Office of the Service in which the organization is located.

"(d) FUNDS SUBJECT TO CRITERIA.—Any funds received by an urban Indian organization under this Act for the prevention, treatment, and control of diabetes among urban Indians shall be subject to the criteria developed by the Secretary under subsection (c).

"SEC. 518. COMMUNITY HEALTH REPRESENTATIVES.

"The Secretary, acting through the Service, may enter into contracts with, and make grants to, urban Indian organizations for the employment of Indians trained as health service providers through the Community Health Representatives Program under section 109 in the provision of health care, health promotion, and disease prevention services to urban Indians.

"SEC. 519. EFFECTIVE DATE.

"The amendments made by the Indian Health Care Improvement Act Amendments of 2009 to this title shall take effect beginning on the date of enactment of that Act, regardless of whether the Secretary has promulgated regulations implementing such amendments.

"SEC. 520. ELIGIBILITY FOR SERVICES.

"Urban Indians shall be eligible for, and the ultimate beneficiaries of, health care or referral services provided pursuant to this title.

"SEC. 521. AUTHORIZATION OF APPROPRIATIONS.

"(a) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary to carry out this title.

"(b) URBAN INDIAN ORGANIZATIONS.—The Secretary, acting through the Service, is authorized to establish programs, including programs for the training of grantee and urban Indian organizations that are identical to any programs established pursuant to section 126 (behavioral health training), section 209 (school health education), section 211 (prevention of communicable diseases), section 701 (behavioral health prevention and treatment services), and section 707(g) (multidisciplinary training).

"SEC. 522. HEALTH INFORMATION TECHNOLOGY.

"The Secretary, acting through the Service, may make grants to urban Indian organizations for the development, adoption, and implementation of health information technology (as defined in section 30005) of the American Recovery and Reinvestment Act of 2009 (12 U.S.C. 464(c) of the Health Insurance Portability and Accountability Act of 1996 or, to the extent consistent with such regulations, other Federal rules applicable to automated management information systems of a Federal agency;

"(D) a services-based cost accounting component that provides estimates of the costs associated with the provision of specific medical treatments or services in each Area office of the Service;

"(E) an interface mechanism for patient billing and accounts receivable system; and

"(F) a training component.

"(b) PROVISION OF SYSTEMS TO TRIBES AND ORGANIZATIONS.—The Secretary shall provide each Tribal Health Program automated management information systems which—

"(1) meet the management information needs of such Tribal Health Program with respect to the treatment by the Tribal Health Program of patients of the Service; and

"(2) meet the management information needs of the Service.

"(c) ACCESS TO RECORDS.—The Service shall provide access of patients to their medical health records, or on behalf of, the Service in accordance with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 or, to the extent consistent with such regulations, other Federal rules applicable to access to health care records.

"(d) AUTHORITY TO ENHANCE INFORMATION TECHNOLOGY.—The Secretary, acting through the Assistant Secretary, shall have the authority to enter into contracts, agreements, or joint ventures with other Federal agencies, States, private and nonprofit organizations, for the purpose of enhancing information technology in Indian Health Programs and facilities.

"SEC. 603. AUTHORIZATION OF APPROPRIATIONS.

"There is authorized to be appropriated such sums as may be necessary to carry out this title.

"TITLE VII—BEHAVIORAL HEALTH PROGRAMS

"SEC. 701. BEHAVIORAL HEALTH PREVENTION AND TREATMENT SERVICES.

"(a) PURPOSES.—The purposes of this section are as follows:

"(1) to authorize and direct the Secretary, acting through the Service, to develop a comprehensive behavioral health prevention and treatment program which emphasizes prevention of alcohol and substance abuse, social services, and mental health programs.

An Assistant Secretary may serve more than 1 term.

"(5) INCUMBENT.—The individual serving in the position of Director of the Service on the day an incumbent is taken by or under the direction of the individual serving as Director of the Service on that day;

"(3) INCUMBENT.—The individual serving in the position of Director of the Service on the day an incumbent is taken by or under the direction of the individual serving as Director of the Service on that day;

"(4) administer all scholarship and loan programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including programs under—

"(a) this Act;

"(b) the Act of November 2, 1921 (25 U.S.C. 135);

"(c) the Act of August 5, 1954 (42 U.S.C. 2001 et seq.);

"(d) the Act of August 16, 1957 (42 U.S.C. 2005 et seq.); and

"(e) the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.);

"(3) the willingness of the organization to be under the direction of the individual serving as Director of the Service on that day;

"(2) perform all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and provision and utilization of, health services for Indians;

"(2) perform all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and provision and utilization of, health services for Indians;

"(1) perform all functions that were, on the day before the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, under the direction of the individual serving as Director of the Service on that day;

"(1) perform all functions that were, on the day before the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, under the direction of the individual serving as Director of the Service on that day;

"(1) IN GENERAL.—There are authorized to be appropriated such sums as may be necessary to carry out this title.

An Assistant Secretary may serve more than 1 term.

"(3) INCUMBENT.—The individual serving in the position of Director of the Service on the day an incumbent is taken by or under the direction of the individual serving as Director of the Service on that day;

"(2) perform all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and provision and utilization of, health services for Indians;

"(2) perform all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and provision and utilization of, health services for Indians;

"(1) perform all functions that were, on the day before the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, under the direction of the individual serving as Director of the Service on that day;

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"(1) perform all functions that were, on the day before the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, under the direction of the individual serving as Director of the Service on that day;
“(2) To provide information, direction, and guidance relating to mental illness and dysfunction and self-destructive behavior, including child abuse and family violence, to those Indian Tribes, tribal, State, and local agencies responsible for programs in Indian communities in areas of health care, education, social services, child and family welfare, alcohol and other drug abuse, law enforcement, and judicial services.

“(3) To assist Indian Tribes to identify services and resources available to address mental illness and dysfunctional and self-destructive behavior.

“(4) To provide authority and opportunities for Indian Tribes and Tribal Organizations to develop tribal behavioral health plans, in cooperation with community-based programs which include identification, prevention, education, referral, and treatment services, including through multidisciplinary resource teams.

“(5) To ensure that Indians, as citizens of the United States and of the States in which they reside, have the same access to behavioral health services to which all citizens have access.

“(6) To modify or supplement existing programs and authorities in the areas identified in paragraph (2).

“(b) PLANS.

“(1) DEVELOPMENT.—The Secretary, acting through the Service, shall encourage Indian Tribes and Tribal Organizations to develop tribal behavioral health plans and, with community-based programs which include identification, prevention, education, referral, and treatment services, including through multidisciplinary resource teams.

“(2) TECHNICAL ASSISTANCE.—At the request of an Indian Tribe, Tribal Organization, or urban Indian organization, the Bureau of Indian Affairs and the Service shall provide technical assistance, including child abuse and family violence, alcohol and other drug abuse, law enforcement, and judicial services.

“(3) NATIONAL CLEARINGHOUSE.—The Secretary, acting through the Service, shall provide, to the extent feasible, the following components:

“(A) An assessment of the scope of alcohol or other substance abuse, mental illness, and dysfunctional and self-destructive behavior, including suicide, child abuse, and family violence, among Indians, including—

“(i) the number of Indians served who are directly or indirectly affected by such illness or behavior; or

“(ii) an estimate of the financial and human cost attributable to such illness or behavior.

“(B) An assessment of the existing and additional resources necessary for the prevention and treatment of such illness and behavior, including assessment of the progress toward achieving the availability of the full continuum of care described in subsection (c).

“(C) An estimate of the additional funding needed by the Service, Indian Tribes, Tribal Organizations, and urban Indian organizations to meet their responsibilities under the plans.

“(2) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to Indian Tribes, Tribal Organizations, and urban Indian organizations in preparation of plans under this section and in developing standards of care that may be used and adopted locally.

“(c) PROGRAMS.—The Secretary, acting through the Service, shall provide, to the extent feasible, if funding is available, programs including the following:

“(1) COMPREHENSIVE CARE.—A comprehensive continuum of behavioral health care which provides—

“(A) community-based prevention, intervention, outpatient, and behavioral health aftercare;

“(B) detoxification (social and medical);

“(C) acute hospitalization;

“(D) inpatient aftercare; and

“(E) residential treatment;

“(F) transitional living for those needing a temporary, stable, living environment that is supportive of treatment and recovery goals;

“(G) emergency shelter;

“(H) intensive case management; and

“(I) diagnostic services.

“(2) CHILD CARE.—Behavioral health services for Indians from birth through age 17, including—

“(A) preschool and school age fetal alcohol disorder services, including assessment and behavioral intervention;

“(B) mental health and substance abuse services (emotional, organic, alcohol, drug, inhalant, and tobacco);

“(C) identification and treatment of co-occurring disorders and comorbidity;

“(D) prevention of alcohol, drug, inhalant, and tobacco use;

“(E) early intervention, treatment, and aftercare;

“(F) promotion of healthy approaches to risk and safety issues; and

“(G) identification and treatment of neglect, physical, mental, and sexual abuse.

“(3) ELDER CARE.—Behavioral health services for Indians from age 18 through 55, including—

“(A) early intervention, treatment, and aftercare;

“(B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco);

“(C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;

“(D) promotion of healthy approaches for risk-related behavior;

“(E) treatment services for women at risk of giving birth to a child with a fetal alcohol disorder;

“(F) sex specific treatment for sexual assault and domestic violence.

“(4) FAMILY CARE.—Behavioral health services for Indians who are affected by behavioral health conditions of a family member, including—

“(A) early intervention, treatment, and aftercare for affected families;

“(B) treatment for sexual assault and domestic violence;

“(C) promotion of healthy approaches relating to parenting, domestic violence, and other abuse issues;

“(D) ELDER CARE.—Behavioral health services for Indians 56 years of age and older, including—

“(A) early intervention, treatment, and aftercare;

“(B) mental health and substance abuse services (emotional, alcohol, drug, inhalant, and tobacco), including sex specific services;

“(C) identification and treatment of co-occurring disorders (dual diagnosis) and comorbidity;

“(D) promotion of healthy approaches to managing conditions related to aging;

“(E) sex specific treatment for sexual assault, domestic violence, neglect, physical and mental abuse, and domestic violence.

“(5) MENTAL HEALTH CARE NEED ASSESSMENT.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary, acting through the Service, shall provide an assessment of the needs for mental health care and the availability and cost of mental health facilities which can meet such need. The Secretary shall consider such needs on a regional basis and shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

“SEC. 702. INDIAN HEALTH CARE AGREEMENT WITH THE DEPARTMENT OF THE INTERIOR.

“(a) CONTENTS.—Not later than 12 months after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary, acting through the Service, shall develop and enter into a memorandum of agreement, or review and update any existing memorandum of agreement, as required by section 428 of the Indian Health Care Improvement Act of 1986 (25 U.S.C. 2411) under which the Secretary shall coordinate the health services to be provided by the Indian Health Service to the Indian Tribe, Tribal Organization, or urban Indian organization in the development and implementation of such plan.

“(b) PROGRAMS.—The Bureau of Indian Affairs and the Service shall encourage Indian Tribes and Tribal Organizations which adopt a resolution pursuant to paragraph (1) to obtain technical assistance for the development of a community behavioral health plan and to provide administrative support in the implementation of such plan.

“(c) COORDINATION OF AVAILABILITY OF SERVICES.—The Secretary, acting through the Service, shall coordinate comprehensive behavioral health planning, to the extent feasible, with other Federal agencies and with State agencies, to encourage comprehensive behavioral health services for Indians regardless of their place of residence.

“(d) MENTAL HEALTH CARE NEED ASSESSMENT.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary, acting through the Service, shall provide an assessment of the need for mental health care among Indians and the availability and cost of mental health facilities which can meet such need. The Secretary shall consider such needs on a regional basis and shall consider the possible conversion of existing, underused Service hospital beds into psychiatric units to meet such need.

“SEC. 702. INDIAN HEALTH CARE AGREEMENT WITH THE DEPARTMENT OF THE INTERIOR.
and agency and Service Unit, Service Area, and headquarters levels to address the problems identified in paragraph (1).

(6) A strategy for the comprehensive coordination of all behavioral health services provided by the Bureau of Indian Affairs and the Service to meet the problems identified pursuant to paragraph (1), including—

(A) the coordination of alcohol and substance abuse programs of the Service, the Bureau of Indian Affairs, and Indian Tribes and Tribal Organizations (developed under the Indian Self-Determination and Education Assistance Act of 1975 (25 U.S.C. 450 et seq.), the Indian Tribes and Tribal Organizations and urban Indian organizations, and any other Indian organizations to develop and implement a comprehensive behavioral health program of prevention, intervention, treatment, and rehabilitation for both sexes on a referral basis and programs developed and implemented by Indian Tribal Organizations at the local level under the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.). Regional centers shall be integrated with the intake and rehabilitation programs based in the referring Indian community.

(B) Alcohol and Substance Abuse Treatment Centers or Facilities—

(1) Establishment.—

(A) IN GENERAL.—The Secretary, acting through the Service, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth residential treatment center or treatment network in each area under the jurisdiction of an Area Office.

(B) A LCOHOL AND SUBSTANCE ABUSE TREATMENT CENTER OR FACILITIES—

(1) Establishment.—The Secretary, acting through the Service, shall constitute, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth residential treatment center or treatment network in each area under the jurisdiction of an Area Office.

(C) Alcohol and Substance Abuse Treatment Centers or Facilities—

(1) Establishment.—

(A) IN GENERAL.—The Secretary, acting through the Service, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth residential treatment center or treatment network in each area under the jurisdiction of an Area Office.

(B) A LCOHOL AND SUBSTANCE ABUSE TREATMENT CENTER OR FACILITIES—

(1) Establishment.—

(A) IN GENERAL.—The Secretary, acting through the Service, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth residential treatment center or treatment network in each area under the jurisdiction of an Area Office.

(B) A LCOHOL AND SUBSTANCE ABUSE TREATMENT CENTER OR FACILITIES—

(1) Establishment.—

(A) IN GENERAL.—The Secretary, acting through the Service, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth residential treatment center or treatment network in each area under the jurisdiction of an Area Office.

(B) A LCOHOL AND SUBSTANCE ABUSE TREATMENT CENTER OR FACILITIES—

(1) Establishment.—

(A) IN GENERAL.—The Secretary, acting through the Service, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth residential treatment center or treatment network in each area under the jurisdiction of an Area Office.

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(A) IN GENERAL.—The Secretary, acting through the Service, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth residential treatment center or treatment network in each area under the jurisdiction of an Area Office.

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(1) Establishment.—

(A) IN GENERAL.—The Secretary, acting through the Service, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth residential treatment center or treatment network in each area under the jurisdiction of an Area Office.

(B) A LCOHOL AND SUBSTANCE ABUSE TREATMENT CENTER OR FACILITIES—

(1) Establishment.—

(A) IN GENERAL.—The Secretary, acting through the Service, shall construct, renovate, or, as necessary, purchase, and appropriately staff and operate, at least 1 youth residential treatment center or treatment network in each area under the jurisdiction of an Area Office.
[In this document, the context is focused on provisions related to the provision of mental health services to Indian youth, the development of telehealth services, and the allocation of funds for such programs. The text references various sections and paragraphs of legislation and highlights key provisions, such as the authorization to provide telemental health services, the inclusion of family and community members in the treatment process, and the support of culturally relevant programs.]

"(3) LOCATION.—A youth treatment center constructed or purchased under this subsection shall be constructed or purchased at a location within the area described in paragraph (2)(D) or (E) as may be appropriate (by appropriate tribal resolution) by a majority of the Indian Tribes to be served by such center.

"(4) SPECIFIC PROVISION OF FUNDS.—

(A) Notwithstanding any other provision of this title, the Secretary may, from amounts authorized to be appropriated, for the purposes of carrying out section 708, the Secretary, acting through the Service, may provide intermediate behavioral health services without regard to the proviso set forth in section 4(i) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 460b(i)).

(B) PROVISION OF SERVICES TO ELIGIBLE YOUTHS.—Until additional residential youth treatment facilities are established in Alaska, the following definitions shall apply...

[The text goes on to detail various provisions, including the authorization of awardees for demonstration projects, the provision of mental health services, and the inclusion of family and community members in the treatment process.]
and paraprofessionals, tribal outreach workers, and family members who work with young people receiving mental health services under this demonstration project, including with identification of suicidal tendencies, crisis intervention and suicide prevention, emergency skill development, and building and expanding networks among these individuals in both State and local health services.

‘‘(D) To develop and distribute culturally appropriate community education materials on—

‘‘(i) suicide prevention;

‘‘(ii) suicide education;

‘‘(iii) suicide screening;

‘‘(iv) suicide intervention; and

‘‘(v) ways to mobilize communities with respect to the identification of risk factors for suicide.

‘‘(E) For data collection and reporting related to Indian youth suicide prevention efforts.

‘‘(2) TRADITIONAL HEALTH CARE PRACTICES.—In carrying out the purposes described in paragraph (1), an Indian Tribe or Tribal Organization may use and promote the traditional health care practices of the Indian Tribes and for the youth to be served.

‘‘(e) APPLICATIONS.—To be eligible to receive a grant under subsection (c), an Indian Tribe or Tribal Organization shall prepare and submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require, including—

‘‘(1) a description of the project that the Indian Tribe or Tribal Organization will carry out using the funds provided under the grant;

‘‘(2) a description of the manner in which the project funded under the grant would—

(A) expand the mental health care needs of the Indian youth population to be served by the project;

(B) improve the access of the Indian youth population to be served to suicide prevention and treatment services;

(C) provide evidence of support for the project from the local community to be served by the project;

(D) a description of how the families and leadership of the communities or populations to be served by the project would be involved in the development and ongoing operations of the project;

(E) a plan to involve the tribal community of the youth who are provided services by the project in the development and evaluation of the mental health care and suicide prevention efforts provided, in order to ensure the integration of community, clinical, environmental, and cultural components of the treatment; and

(F) a plan for sustaining the project after Federal assistance for the demonstration project is terminated.

‘‘(f) COLLABORATION: REPORTING TO NATIONAL CLEARINGHOUSE.—

‘‘(1) COLLABORATION.—The Secretary, acting through the Service, shall encourage Indian Tribes and Tribal Organizations receiving grants under this section to collaborate to enable comparisons about best practices across projects.

‘‘(2) REPORTING TO NATIONAL CLEARINGHOUSE.—The Secretary, acting through the Service, shall encourage Indian Tribes and Tribal Organizations receiving grants under this section to submit relevant, declassified project information to the national clearinghouse authorized under section 701(b)(2) in order to better facilitate program performance and improve suicide prevention, intervention, and treatment services.

‘‘(g) ANNUAL REPORT.—Each grant recipient shall submit to the Secretary an annual report that—

‘‘(1) describes the number of telemental health services provided under this section;

‘‘(2) includes any other information that the Secretary may require.

‘‘(h) REPORT TO CONGRESS.—Not later than 270 days after the termination of the demonstration project, the Secretary shall submit to the Committee on Indian Affairs of the Senate and the Committee on Natural Resources and Committee on Energy and Commerce of the House of Representatives a final report, based on the annual reports provided by grant recipients under subsection (b), that—

‘‘(1) describes the results of the projects funded by grants awarded under this section, including any information which indicates the number of attempted suicides;

‘‘(2) evaluates the impact of the telemental health services funded by the grants in reducing the number of completed suicides among Indian youth;

‘‘(3) evaluates whether the demonstration project was—

(A) expanded to provide more than 5 grants; and

(B) designated a permanent program; and

(C) the cultural, spiritual, and multigenerational aspects of behavioral health services funded by the grants in relation to the transfer of cultural health values among Indian youth;

‘‘(D) improve the access of the Indian youth population to be served to suicide prevention and treatment services;

‘‘(E) provide evidence of support for the project from the local community to be served by the project;

‘‘(F) a description of how the families and leadership of the communities or populations to be served by the project would be involved in the development and ongoing operations of the project;

‘‘(G) a plan to involve the tribal community of the youth who are provided services by the project in the development and evaluation of the mental health care and suicide prevention efforts provided, in order to ensure the integration of community, clinical, environmental, and cultural components of the treatment; and

‘‘(H) a plan for sustaining the project after Federal assistance for the demonstration project is terminated.

‘‘(i) INSTRUCTION.—The Secretary, acting through the Service, shall provide instruction in the area of behavioral health issues, including prevention, intervention, treatment, and aftercare.

‘‘(j) ANNUAL REPORT.—Each grant recipient shall submit to the Secretary an annual report that—

‘‘(1) describes the number of telemental health services provided under this section;

‘‘(2) includes any other information that the Secretary may require.

‘‘(k) TRAINING MODELS.—In carrying out the education and training programs required by this section, the Secretary, in consultation with Indian Tribes, Tribal Organizations, Indian behavioral health experts, Indian alcohol and substance abuse prevention experts, shall develop and provide community-based training models. Such models shall address—

‘‘(1) the elevated risk of alcohol and behavioral health problems faced by children of alcoholics;

‘‘(2) the cultural, spiritual, and multigenerational aspects of behavioral health problem prevention and recovery; and

‘‘(3) community-based and multidisciplinary strategies, including Systems of Care, for preventing and treating behavioral health problems.

‘‘SEC. 711. BEHAVIORAL HEALTH PROGRAM.

‘‘(a) INNOVATIVE PROGRAMS.—The Secretary, acting through the Service, consistent with section 701, may plan, develop, design, implement, and carry out programs to deliver innovative community-based behavioral health services to Indians.

‘‘(b) AWARDS: CRITERIA.—The Secretary may award a grant for a project under subsection (a) to an Indian Tribe or Tribal Organization and may consider the following criteria:

‘‘(1) The project will address significant unmet behavioral health needs among Indians.

‘‘(2) The project will serve a significant number of Indians.

‘‘(3) The project has the potential to deliver services in an efficient and effective manner.

‘‘(4) The Indian Tribe or Tribal Organization has the administrative and financial capability to administer the project.

‘‘(5) The project may deliver services in a manner consistent with traditional health care practices.

‘‘(6) The project is coordinated with, and avoids duplication of, existing services.

‘‘SEC. 712. FETAL ALCOHOL DISORDER PROGRAMS.

‘‘(a) PROGRAMS.—

‘‘(1) IN GENERAL.—Funding provided pursuant to this section shall be used for the following:

‘‘(1) To develop and provide for Indians community and in-tribe alcohol and substance abuse, and prevention programs relating to fetal alcohol disorders.

‘‘(2) To identify and provide behavioral health treatment to high-risk Indian women and high-risk women pregnant with an Indian’s child.
“(iii) To identify and provide appropriate psychological services, educational and vocational training, counseling, advocacy, and information to fetal alcohol disorder affected Indian children and their families; and

“(iv) To develop and implement counseling and support programs in schools for fetal alcohol disorder affected Indian children.

“(v) To develop and implement prevention and intervention models which incorporate practitioners of traditional health care practices, cultural values, and community involvement.

“(vi) To develop, print, and disseminate education and prevention materials on fetal alcohol disorder.

“(vii) To develop and implement, in consultation with Indian Tribes, Tribal Organizations, and urban Indian organizations, culturally sensitive assessment and diagnostic tools including dysmorphology clinics and multidisciplinary fetal alcohol disorder clinics for use in Indian communities and Urban Centers.

“(B) ADDITIONAL USES.—In addition to any purpose under subparagraph (A), funding provided pursuant to this section may be used for 1 or more of the following:

“(i) Early childhood intervention projects from ages 0 to 5 that make a difference in the early development of childhood disorders among Indians.

“(ii) Community-based support services for Indians and women pregnant with child.

“(iii) Community-based housing for adult Indians with fetal alcohol disorder.

“(C) CRITERIA FOR APPLICATIONS.—The Secretary shall establish criteria for the review and approval of applications for funding under this section.

“(b) SERVICES.—The Secretary, acting through the Secretary of Health and Human Services, shall:

“(1) develop and provide services for the prevention, intervention, treatment, and aftercare for those affected by fetal alcohol disorder among Indians; and

“(2) provide supportive services, including services to meet the special educational, vocational, school-to-work transition, and independent living needs of adolescent and adult Indians with fetal alcohol disorder.

“(c) TASK FORCE.—The Secretary shall establish a task force to be known as the Fetal Alcohol Disorder Task Force to advise the Secretary in carrying out subsection (b). Such task force shall be composed of representatives from the following:

“(1) Administration for Native American Affairs.

“(2) The National Institute on Alcohol and Alcoholism.

“(3) The Office of Substance Abuse Prevention.

“(4) The National Institute of Mental Health.

“(5) The Service.


“(7) The Administration for Native Americans.

“(8) The National Institute of Child Health and Human Development (NICHD).

“(9) The Centers for Disease Control and Prevention.

“(10) The Bureau of Indian Affairs.

“(11) Indian Tribes.

“(12) Tribal Organizations.

“(13) urban Indian organizations.

“(14) Indian fetal alcohol spectrum disorder experts.

“(d) APPLIED RESEARCH PROJECTS.—The Secretary, acting through the Substance Abuse and Mental Health Services Administration, shall make grants to Indian Tribes, Tribal Organizations, and urban Indian organizations for applied research projects which propose research on proposed methods and/or models, under the direction of investigators or program specialists, in the context of methods to prevent, intervene, treat, or provide rehabilitation and behavioral health aftercare for Indians and urban Indians affected by fetal alcohol spectrum disorders.

“(e) FUNDING FOR URBAN INDIAN ORGANIZATIONS.—Ten percent of the funds appropriated under this section shall be used to make grants to urban Indian organizations funded under title V.

**SEC. 713. CHILD SEXUAL ABUSE AND PREVENTION PROGRAMS.**

“(a) ESTABLISHMENT.—The Secretary, acting through the Service, shall, after the date of enactment of the Indian Health Care Improvement Act Amendments of 2008, establish the Indian Child Sexual Abuse and Prevention Program to:

“(1) victims of sexual abuse who are Indian children or children in an Indian household; and

“(2) perpetrators of child sexual abuse who are Indian or members of an Indian household.

“(b) USE OF FUNDS.—Funding provided pursuant to this section shall be used for the following:

“(1) To develop and provide community education and prevention programs related to sexual abuse of Indian children or children in an Indian household.

“(2) To identify and provide behavioral health treatment to victims of sexual abuse who are Indian children or children in an Indian household, and to their family members who are affected by sexual abuse.

“(3) To develop prevention and intervention models to improve traditional health care practices, cultural values, and community involvement.

“(4) To develop and implement culturally sensitive assessment and diagnostic tools for use in Indian communities and Urban Centers.

“(5) To identify and provide behavioral health treatment to Indian perpetrators and perpetrators who are members of an Indian household.

“(A) making efforts to begin offender and victim therapy; and

“(B) providing treatment after the perpetrator is released, until it is determined that the perpetrator is not a threat to children.

“(c) COORDINATION.—The programs established under this section shall be carried out in coordination with programs and services authorized to be carried out under the Indian Child Protection and Family Violence Prevention Act of 2008 (25 U.S.C. 3381 et seq.).

**SEC. 714. DOMESTIC AND SEXUAL VIOLENCE PREVENTION AND TREATMENT.**

“(a) IN GENERAL.—The Secretary, in consultation with appropriate Federal agencies, shall:

“(1) in the manner consistent with the availability of funds provided under this section, establish in each Service Area programs involving the prevention and treatment of—

“(1) victims of domestic violence or sexual abuse; and

“(2) perpetrators of domestic violence or sexual abuse who are Indian or members of an Indian household.

“(B) Make efforts to begin offender and victim therapy, and to develop prevention and intervention models, which may incorporate traditional health care practices and

“(c) TRAINING AND CERTIFICATION.—

“(1) IN GENERAL.—Not later than 1 year after the date of enactment of the Indian Health Care Improvement Act Amendments of 2008, the Secretary shall submit to the Committee on Indian Affairs of the House of Representatives a report that describes the means and extent to which the Secretary has carried out paragraph (1).

“(2) COORDINATION.—

“(A) to improve domestic violence or sexual abuse responses;

“(B) to improve forensic examinations and collections;

“(C) to identify problems or obstacles in the prosecution of domestic violence or sexual abuse; and

“(D) to meet other needs or carry out other activities required to prevent, treat, and improve prosecutions of domestic violence and sexual abuse.

**SEC. 715. BEHAVIORAL HEALTH RESEARCH.**

“The Secretary, in consultation with appropriate Federal agencies, shall:

“(a) make grants to, or enter into contracts with, Indian Tribes, Tribal Organizations, and urban Indian organizations to improve, develop, evaluate, and implement models, tools, and techniques for the conduct of research on the incidence and prevalence of behavioral health problems among Indians served by the Service, Indian Tribes, or Tribal Organizations and among Indians in urban areas. Research priorities under this section shall include—

“(1) the multifactorial causes of Indian youth suicide, including—

“(A) protective and risk factors and scientific data that identifies these factors; and

“(B) the effects of loss of cultural identity and the development of scientific data on those effects;

“(2) the interrelationships and interdependence of behavioral health problems with alcoholism and other substance abuse, suicide, homicides, other injuries, and the incidence of family violence; and

“(3) the development of models of prevention techniques.

“The effect of the interrelationships and interdependencies referred to in paragraph (2) on children, and the development of prevention techniques under paragraph (3) applicable to children, shall be emphasized.

**SEC. 716. DEFINITIONS.**

“For the purpose of this title, the following definitions shall apply:
"(1) ASSESSMENT.—The term ‘assessment’ means the systematic collection, analysis, and dissemination of information on health status, health needs, and health problems.

"(2) ALCOHOL-DERIVED NEURODEVELOPMENTAL DISORDERS OR ARND.—The term ‘alcohol-related neurodevelopmental disorders or ARND’ means-without limitation-the confirmed presence of an alcohol-related neurodevelopmental disorder following inpatient, residential, and perceptual and judgment problems.

"(3) BEHAVIORAL HEALTH AFTERCARE.—The term ‘behavioral health aftercare’ includes those activities and resources used to support recovery following inpatient, residential, intensive substance abuse, or mental health outpatient or outpatient treatment. The purpose is to help prevent or deal with relapse by ensuring that by the time a client or patient is discharged from a level of care, such as aftercare treatment, an aftercare plan has been developed with the client. An aftercare plan may use such resources as a community-based therapeutic group, transitional living facilities, a 12-step sponsor, a local 12-step or other related support group, and other community-based providers.

"(4) DUAL DIAGNOSIS.—The term ‘dual diagnosis’ means coexisting substance abuse and mental illness conditions or diagnosis. Such clients are sometimes referred to as mentally ill chemical abusers (MICAs).

"(5) FETAL ALCOHOL SPECTRUM DISORDERS.—

"(A) IN GENERAL.—The term ‘fetal alcohol spectrum disorders’ includes a range of effects that are caused by maternal drinking during pregnancy, in physical, mental, behavioral, and/or learning disabilities with possible lifelong implications.

"(B) INCLUSIONS.—The term ‘fetal alcohol spectrum disorders’ may include—

(i) fetal alcohol syndrome (FAS);

(ii) fetal alcohol effect (FAE);

(iii) alcohol-related birth defects; and

(iv) alcohol-related neurodevelopmental disorders (ARND).

"(6) FETAL ALCOHOL SYNDROME OR FAS.—The term ‘fetal alcohol syndrome or FAS’ means any 1 of a spectrum of effects that may be caused by maternal drinking during pregnancy, the diagnosis of which involves the confirmed presence of the following 3 criteria:

(A) a functional impairment that is either linked to the brain damage or is caused by it;

(B) growth deficits.

"(7) Reports on safe water and sanitary waste disposal facilities as required by section 301(c)(2)(B) and 301(d).

"(8) a review of programs established or assisted under the provisions of section 201.

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"(9) A separate statement which specifies the amount of funds requested to carry out the provisions of section 301.

"(10) A report of the evaluations of health promotion and disease prevention as required in section 201.

"(11) An annual report on the status of all health care facilities as required by section 301(c)(2)(B) and 301(d).

"(12) Reports on the operations and sanitary waste disposal facilities as required by section 302(h).

"(13) An annual report on the expenditure of non-Service funds for renovation as required by section 304(b)(2).

"(14) A report identifying the backlog of maintenance and repair required at Service and tribal facilities as required by section 313(a).

"(15) A report providing an accounting of replacement funds that are to be provided to the Secretary under titles XVIII, XIX, and XXI of the Social Security Act.

"(16) A report on any arrangements for the sharing of medical facilities or services, as authorized by section 406.

"(17) A report on evaluation and renewal of urban Indian programs under section 505.

"(18) A report on the evaluation of programs as required by section 513(d).

"(19) A report on and substance abuse as required by section 701(f).

"(20) A report on Indian youth mental health services as required by section 707(h).

"(21) A report on the reallocation of base resources if required by section 807.

"(22) A report on the movement of patients between Service Units, including—

(A) a list of those Service Units that have a net increase and those that have a net decrease in the number of patients served;

(B) a list of Service Units that have an increase in the number of patients served and the number of patients served;

(C) what funding changes are necessary to maintain a consistent quality of service at Service Units that have an increase in the number of patients served.

"(23) A report on the extent to which health care facilities of the Service, Indian Tribes, Tribal Organizations, and urban Indian organizations comply with credentialing requirements of the Service or licensure requirements of States.

"(c) ADAPTATION OF PROCEDURES.—The Secretary shall transmit to Congress a report containing the following:

(1) A report on the progress made in meeting the objectives of this Act, including a review of programs established or assisted pursuant to the Act and recommendations of additional programs or additional assistance necessary to, at a minimum, provide health services and ensure a health status for Indians, which are at a parity with the health services available to the health status of the general population.

(2) A report on whether, and to what extent, new national health care programs, benefits, initiatives, or financing systems have an impact on the purposes of this Act and assert that the Secretary may have to consult with Indian Tribes, Tribal Organizations, and urban Indian organizations to address such impact, including a report on proposed changes in allocation of funding pursuant to section 807.

(3) A report on the use of health services by Indians—

(A) on a national and area or other relevant geographical basis;

(B) by gender and age;

(C) by source of payment and type of service;

(D) comparing such rates of use with rates of use among comparable non-Indian populations.

(4) Provided under contracts.

(14) A report of contractors to the Secretary on Health Care Educational Loan Repayments every 6 months required by section 110.

(15) A report providing an accounting of funds required by section 807.

(16) A report of the findings and conclusions of demonstration programs on development, implementation, and evaluation of alcohol abuse counseling as required in section 125(f).

(17) A separate statement which specifies the amount of funds requested to carry out the provisions of section 201.

(18) A report of the evaluations of health promotion and disease prevention as required in section 203(c)

(19) A biennial report to Congress on infectious diseases as required by section 212.

(20) A report on environmental and nuclear health hazards as required by section 213.

(21) An annual report on the status of all health care facilities as required by section 301(c)(2)(B) and 301(d).

(22) A report on alcohol and substance abuse as required by section 701(f).

(23) A report on Indian youth mental health services as required by section 707(h).

(24) A report on the reallocation of base resources if required by section 807.

(25) A report on Indian youth mental health services as required by section 707(h).

(26) A report on the movement of patients between Service Units, including—

(A) a list of those Service Units that have a net increase and those that have a net decrease in the number of patients served;

(B) a list of Service Units that have an increase in the number of patients served and the number of patients served;

(C) what funding changes are necessary to maintain a consistent quality of service at Service Units that have an increase in the number of patients served.

(27) A report on the extent to which health care facilities of the Service, Indian Tribes, Tribal Organizations, and urban Indian organizations comply with credentialing requirements of the Service or licensure requirements of States.

SEC. 802. REGULATIONS.

(1) BASELINE ASSESSMENTS.—Proposed regulations to implement this Act shall be published in the Federal Register by the Secretary no later than 2 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009, and the Secretary shall initiate procedures under subchapter III of chapter 5 of title 5, United States Code, and promulgate such regulations or amendments thereto that are necessary to carry out this Act.

(2) REIMBURSEMENT.—The Secretary may promulgate regulations to carry out such sections using the procedures required by chapter 5 of title 5, United States Code (commonly known as the Administrative Procedures Act).

"(2) PROPOSED REGULATIONS.—Proposed regulations to implement this Act shall be published in the Federal Register by the Secretary no later than 2 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009 and shall have no less than a 120-day comment period.

The Secretary shall publish in the Federal Register final regulations to implement this Act by not later than 3 years after the date of enactment of the Indian Health Care Improvement Act Amendments of 2009.

"(b) COMMITTEE.—A negotiated rulemaking committee established pursuant to section 505 of title 5, United States Code, to carry out this section shall have as its members only representatives of the Federal Government and representatives of Indian Tribes, Tribal Organizations, a majority of whom shall be nominated by and be representatives of Indian Tribes and Tribal Organizations from each Service Area.

"(c) CONSULTATION.—The Secretary shall adapt the negotiated rulemaking procedures to the unique context of
self-governance and the government-to-government relationship between the United States and Indian Tribes.

(d) Lack of Regulations.—The lack of promulgated regulations shall not limit the effect of this Act.

SEC. 803. PLAN OF IMPLEMENTATION.

(a) In General.—Not later than 1 year after enactment of the Indian Health Care Improvement Act Amendments of 2009, the Secretary, in consultation with Indian Tribes, Tribal Organizations, and urban Indian organizations, shall submit to Congress a plan explaining the manner and schedule, by title and section, by which the Secretary will implement the provisions of this Act. The implementation of such plan shall be conducted jointly with the annual budget consultation pursuant to the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

(b) Lack of Plan.—The lack of (or failure to submit) such a plan shall not limit the effect, or prevent the implementation, of this Act.

SEC. 804. LIMITATION ON USE OF FUNDS APPROPRIATED TO INDIAN HEALTH SERVICES.

Any limitation on the use of funds contained in an Act providing appropriations for the period with respect to the performance of abortions shall apply for that period with respect to the performance of abortions using funds contained in an Act providing appropriations for the Secretary's programs for the period.

SEC. 805. ELIGIBILITY OF CALIFORNIA INDIANS.

(a) In General.—The following California Indians shall be eligible for health services provided by the Service:

(1) Any member of a federally recognized Indian Tribe.

(2) Any descendant of an Indian who was residing in California on June 1, 1852, if such descendant—

(A) is a member of the Indian community in which such descendant lives.

(B) is regarded as an Indian by the community in which such descendant lives.

(3) Any Indian who holds trust interests in public domain, national forest, or reservation allotments in California.

(4) Any Indian in California who is listed on the plans for distribution of the assets of rancherias and reservations located within the Service area under the Act of August 18, 1958 (72 Stat. 619), and any descendant of such an Indian.

(b) Clarification.—Nothing in this section shall be construed as expanding the eligibility of California Indians for health services provided by the Service beyond the scope of eligibility for such health services that applied on May 1, 1986.

SEC. 806. HEALTH SERVICES FOR INELIGIBLE PERSONS.

(a) Children.—Any individual who—

(1) has not reached 19 years of age;

(2) is the natural or adopted child, stepchild, foster child, legal ward, or orphan of an eligible Indian; and

(3) is not eligible for health services provided by the Service, shall be eligible for all health services provided by the Service on the same basis and subject to the same rules that apply to eligible Indians until such individual attains 19 years of age.

(b) Spouses.—Any spouse of an eligible Indian who is not an Indian, or who is of Indian descent but is not otherwise eligible for the health services provided by the Service, shall be eligible for such health services if all such spouses or spouses who are married to members of the Tribe being served are made eligible, as a class, by an appropriate resolution of the governing body of the Indian Tribe or Tribes providing such services. The health needs of persons made eligible under this paragraph shall not be taken into consideration by the Service in determining whether need, or allocation, of its health resources.

(c) Provision of Services to Other Individuals.—(1) In General.—The Secretary is authorized to provide health services under this subsection through health programs operated directly by the Service to individuals who reside within the Service area of the Service Unit and who are not otherwise eligible for such health services if—

(A) the Indians served by such Service Unit request such provision of health services to such individuals; and

(B) the Secretary and the served Indian Tribes have jointly determined that—

(i) the provision of such health services will not result in a denial or diminution of health services to eligible Indians; and

(ii) there is no reasonable alternative to the provision of health services under any other subsection of this Act.

(2) ISDEAA Programs.—In the case of ISDEAA programs, the governing body of the Indian Tribe or Tribal Organization providing health services under such contract or compact shall take into account the considerations described in paragraph (1).

(d) Lack of Regulations.—The lack of (or failure to submit) such a plan shall not limit the effect, or prevent the implementation, of this Act.

(1) IN GENERAL.—The Secretary is authorized to provide health services under this subsection through health programs operated directly by the Service to individuals who reside within the Service area of the Service Unit and who are not otherwise eligible for such health services if—

(A) the Indians served by such Service Unit request such provision of health services to such individuals; and

(B) the Secretary and the served Indian Tribes have jointly determined that—

(i) the provision of such health services will not result in a denial or diminution of health services to eligible Indians; and

(ii) there is no reasonable alternative to the provision of health services under any other subsection of this Act.

(e) Provision of Services to Other Individuals.—(1) In General.—The Secretary is authorized to provide health services under this subsection through health programs operated directly by the Service to individuals who reside within the Service area of the Service Unit and who are not otherwise eligible for such health services if—

(A) the Indians served by such Service Unit request such provision of health services to such individuals; and

(B) the Secretary and the served Indian Tribes have jointly determined that—

(i) the provision of such health services will not result in a denial or diminution of health services to eligible Indians; and

(ii) there is no reasonable alternative to the provision of health services under any other subsection of this Act.

(f) Other Services.—The Service may provide health services under this subsection to individuals who are not eligible for health services provided by the Service under any other provision of law in order to—

(1) achieve stability in a medical emergency;

(2) prevent the spread of a communicable disease or otherwise deal with a public health hazard;

(3) provide care to non-Indian women pregnant with an eligible Indian’s child for the duration of the pregnancy through postpartum; or

(4) provide care to immediate family members of an eligible individual if such care was directly related to the treatment of the eligible individual.

SEC. 807. REALLOCATION OF BASE RESOURCES.

(a) Report Required.—Notwithstanding any provision of law, any allocation of Service funds for a fiscal year that reduces by 5 percent or more from the previous fiscal year the funding for any recurring program, project, or activity of a Service Unit may be submitted only if the Service has submitted to Congress, under section 801, a report on the proposed change in allocation to the Committee on Appropriations, including the reasons for the change and its likely effects.

(b) Exception.—Subsection (a) shall not apply if the total amount appropriated to the Service for a fiscal year is 5 percent less than the amount appropriated to the Service for the previous fiscal year.
The Secretary shall provide for the dissemination to Indian Tribes, Tribal Organizations, and Indian organizations of the findings and results of demonstration projects conducted under this Act.

SEC. 809. MORATORIUM.

During the period of the moratorium imposed on implementation of the final rule published in the Federal Register on September 15, 1987, by the Department of Health and Human Services, relating to eligibility for the health care services of the Indian Health Service, the Indian Health Service shall provide services pursuant to the criteria that services that were in effect on September 15, 1987, subject to the provisions of sections 805 and 806, until the Service has submitted to the Committees on Appropriations of the Senate and the House of Representatives a budget request reflecting the increased costs associated with the proposed final rule, and the request has been included in an appropriations Act and enacted into law.

SEC. 810. SEVERABILITY PROVISIONS.

If any provision of this Act, any amendment made by the Act, or the application of such provision to any person or circumstances is held to be invalid, the remainder of this Act, the remaining amendments made by this Act, and the application of such provision to other persons or circumstances other than those to which it is held invalid, shall not be affected thereby.

SEC. 811. USE OF PATIENT SAFETY ORGANIZATIONS.

The Service, an Indian Tribe, Tribal Organization, or urban Indian organization may provide for quality assurance activities through the use of a patient safety organization in accordance with title IX of the Public Health Service Act.

SEC. 812. CONFIDENTIALITY OF MEDICAL QUALITY ASSURANCE RECORDS AND IMMUNITY FOR PARTICIPANTS.

(a) Confidentiality of Records. —Medical quality assurance records created by or for any Indian Health Program or a health program of an Urban Indian Organization as part of a medical quality assurance program are confidential and privileged. Such records may not be disclosed to any person or entity, except as provided in subsection (c).

(b) Prohibition on Disclosure and Testimony.

(1) In General. —No part of any medical quality assurance record described in subsection (a) may be subject to discovery or admitted into evidence in any judicial or administrative proceeding, except as provided in subsection (c).

(2) Testimony. —A person who reviews or creates medical quality assurance records for any Indian Health Program or Urban Indian Organization who participates in any proceeding that reviews or creates such records is privileged to testify in any judicial or administrative proceeding with respect to such records or with respect to any finding, recommendation, evaluation, opinion, or action taken by such person or body in connection with such records except as provided in this section.

(c) Authorized Disclosure and Testimony.

(1) In General. —Subject to paragraph (2), a medical quality assurance record described in subsection (a) may be disclosed, and a person or body in connection with such a record, only as follows:

(A) To a Federal executive agency or private school for the medical, dental, social, mental health, or educational care of an individual if such health care provider or organization, on request has been included in an appropriations Act and enacted into law.

(B) To an administrative or judicial proceeding commenced by a present or former Indian Health Program or Urban Indian Organization for the purpose of determining termination, suspension, or limitation of clinical privileges of such health care provider.

(C) To a governmental board or agency or to an Indian Health Program or organization, if such medical quality assurance record or testimony is needed by such board, agency, health care provider, or organization, on request has been included in an appropriations Act and enacted into law.

(D) To a hospital, medical center, or other institution that provides health care services, if such medical quality assurance record or testimony is needed by such institution to assess the professional qualification of any health care provider who is or was an employee of an Indian Health Program or Urban Indian Organization.

(E) To an officer, employee, or contractor of the Indian Health Program or Urban Indian Organization who has had access to or been granted authority to perform health care services for or on behalf of such program or organization.

(F) To an administrative or judicial proceeding commenced by a Federal, State, or local governmental board or agency or professional standards society or organization.

(G) In an administrative or judicial proceeding commenced by a criminal or civil law enforcement agency or instrumentality, with respect to any finding, recommendation, evaluation, opinion, or action taken by such person or body in connection with such records, only as follows:

(i) Regulations. —The Secretary, acting through the Service, shall promulgate regulations pursuant to section 802.

(ii) Definitions. —In this section:

(1) The term ‘health care provider’ means any health care professional, including community health aides and practitioners certified under section 121, who are licensed or certified to perform health care services by a governmental board or agency or professional standards society or organization.

(2) The term ‘medical quality assurance program’ means any activity carried out before, on, or after the date of enactment of this Act by or for an Indian Health Program or Urban Indian Organization to assess the quality of medical care, including activities conducted by or on behalf of individuals, Indian Health Programs, Urban Indian Organizations, medical or dental treatment review committees, or other review bodies responsible for quality assurance, credentialing, patient care, quality assurance, and utilization control, including quality assurance, patient care assessment (including treatment procedures, blood, drugs, and therapeutic procedures, medical records, health resources management reports, and identification of medical or dental incidents and risks).

(iii) The term ‘medical quality assurance record’ means the proceedings, records, minutes, and reports that emanate from quality assurance program activities described in paragraph (2) and are produced or compiled by or for an Indian Health Program or Urban Indian Organization.

(H) In a proceeding commenced by a criminal or civil law enforcement agency or instrumentality, with respect to any finding, recommendation, evaluation, opinion, or action taken by such person or body in connection with such records, only as follows:

(1) In General. —Nothing in this section shall be construed as authorizing or requiring the use of any medical quality assurance record or testimony during a proceeding before any court or other body, or in any proceeding commenced by a governmental board or agency or professional standards society or organization.

(2) Disclosure for Certain Purposes. —

(I) In General. —Nothing in this section shall be construed as authorizing or requiring the use of any medical quality assurance record or testimony during a proceeding before any court or other body, or in any proceeding commenced by a governmental board or agency or professional standards society or organization.

(2) Withholding from Congress. —Nothing in this section shall be construed as authorizing or requiring the use of any medical quality assurance record or testimony during a proceeding before any court or other body, or in any proceeding commenced by a governmental board or agency or professional standards society or organization.

(3) In order to prevent any person or entity from offering any medical quality assurance record or testimony during a proceeding before any court or other body, or in any proceeding commenced by a governmental board or agency or professional standards society or organization.

(4) Prohibition on Disclosure of Record or Testimony. —A person or entity having possession, custody, or control of a medical quality assurance record or testimony described by this section may not disclose the contents of such record or testi-
for the purposes of section 1151 of title 18, United States Code.

**SEC. 814. SENSE OF CONGRESS REGARDING LAW ENFORCEMENT AND METHAMPHETAMINE ISSUES IN INDIAN COUNTRY.**

"It is the sense of Congress that Congress encourages State, local, and Indian tribal law enforcement agencies to consider and develop memoranda of agreement between and among those agencies for purposes of streamlining law enforcement activities and maximizing the use of limited resources—"

"(1) to improve law enforcement services provided to Indian tribal communities; and"

"(2) to increase the effectiveness of measures taken by such agencies relating to methamphetamine use in Indian country (as defined in section 1151 of title 18, United States Code).

**SEC. 815. PERMITTING IMPLEMENTATION THROUGH CONTRACTS WITH TRIBAL HEALTH PROGRAMS.**

"Nothing in this Act shall be construed as preventing the Secretary from—"

"(1) carrying out any section of this Act through contracts with Tribal Health Programs; and"

"(2) carrying out sections through 214, 701(a)(1), 701(b)(1), 701(c), 701(g), and 712(b), through contracts with urban Indian organizations.

The previous sentence shall not affect the authority the Secretary may otherwise have to carry out other provisions of this Act through such means.

**SEC. 816. AUTHORIZATION OF APPROPRIATIONS; AVAILABILITY.**

"(a) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this title.

"(b) LIMITATION ON NEW SPENDING AUTHORITY.—Any new spending authority (described in subparagraph (A) or (B) of section 401(c)(2) of the Congressional Budget Act of 1974 (Public Law 93-344; 88 Stat. 3171)) which is provided under this Act shall be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation Acts.

"(c) AVAILABILITY.—The funds appropriated pursuant to this Act shall remain available until expended."

**(d) RATE OF PAY.**

"(1) POSITIONS AT LEVEL IV.—Section 515 of title 5, United States Code, is amended by striking "Assistant Secretaries of Health and Human Services (6)", and inserting "Assistant Secretaries of Health and Human Services (7)".

"(2) POSITIONS AT LEVEL V.—Section 516 of title 5, United States Code, is amended by striking "Director, Indian Health Service, Department of Health and Human Services (8)".

"(c) AMENDMENTS TO OTHER PROVISIONS OF LAW.—"

"(1) Section 3307(b)(1)(C) of the Children's Health Act of 2000 (20 U.S.C. 1671 note; Public Law 106-310) is amended by striking "Director of the Indian Health Service" and inserting "Assistant Secretary for Indian Health".

"(2) The Indian Lands Open Dump Cleanup Act of 1994 is amended—"

"(a) in section 3 (25 U.S.C. 3902)—"

"(i) by striking paragraph (2);"

"(ii) by redesignating paragraphs (1), (3), (4), (5), and (6) as paragraphs (4), (5), (2), (6), and (1), respectively, and moving those paragraphs so as to appear in numerical order; and"

"(iii) by inserting before paragraph (4) (as redesignated by clause (ii)) the following:

"(3) ASSISTANT SECRETARY.—The term 'Assistant Secretary' means the Assistant Secretary for Indian Health.

"(b) Sections 802 (25 U.S.C. 3904), by striking the section designation and heading and inserting the following:

"(1) BOARD.—The term 'Board' means the Board of Directors of the Foundation.

"(2) COMMITTEE.—The term 'Committee' means the Committee for the Establishment of Native American Health and Wellness Foundation established under section 802.

"(3) FOUNDATION.—The term 'Foundation' means the Native American Health and Wellness Foundation established under section 802.

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

"(5) SERVICE.—The term 'Service' means the Indian Health Service of the Department of Health and Human Services.

**SEC. 801. DEFINITIONS.**

"In this title:

"(1) BOARD.—The term 'Board' means the Board of Directors of the Foundation.

"(2) COMMITTEE.—The term 'Committee' means the Committee for the Establishment of Native American Health and Wellness Foundation.

"(3) FOUNDATION.—The term 'Foundation' means the Native American Health and Wellness Foundation established under section 802.

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

"(5) SERVICE.—The term 'Service' means the Indian Health Service of the Department of Health and Human Services.

**SEC. 802. NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION.**

"(a) ESTABLISHMENT.—"

"(1) IN GENERAL.—As soon as practicable after the date of enactment of this title, the Secretary shall establish, under the laws of the District of Columbia and in accordance with section 802, the Native American Health and Wellness Foundation.

"(2) FUNDING DETERMINATIONS.—No funds, gift, property, or other item of value (including any interest accrued on such an item) acquired by the Foundation shall—"

"(A) be taken into consideration for purposes of determining Federal appropriations required by the Foundation to support health care and services to Indians; or"

"(B) otherwise limit, diminish, or affect the Federal responsibility for the provision of health care and services to Indians.

"(b) PERPETUAL EXISTENCE.—The Foundation shall have perpetual existence.

"(c) NATURE OF CORPORATION.—The Foundation shall—"

"(1) shall be a charitable and nonprofit federally chartered corporation; and"

"(2) shall not be an agency or instrumentality of the United States.

"(4) PLACE OF INCORPORATION AND DOMICILE.—The Foundation shall be incorporated and domiciled in the District of Columbia.

"(e) DUTIES.—The Foundation shall—"

"(1) encourage, accept, and administer private gifts of real and personal property, and income from such gifts, for the benefit of, or in support of, the mission of the Service;

"(2) undertake and conduct such other activities as will further the health and wellness activities and opportunities of Native Americans; and"

"(3) participate with and assist Federal, State, and tribal governments, agencies, entities, and individuals in undertaking and conducting activities that will further the health and wellness activities and opportunities of Native Americans.

"(f) COMMITTEE FOR THE ESTABLISHMENT OF NATIVE AMERICAN HEALTH AND WELLNESS FOUNDATION.—"

"(1) IN GENERAL.—The Secretary shall establish the Committee for the Establishment of Native American Health and Wellness Foundation to assist the Secretary in establishing the Foundation.

"(2) DUTIES.—Not later than 180 days after the date of enactment of this section, the Committee shall—"

"(A) carry out such activities as are necessary to incorporate the Foundation under the laws of the District of Columbia, including acting as incorporators of the Foundation;

"(B) ensure that the Foundation qualifies for and maintains the status required to carry out this section, until the Board is established;

"(C) establish the constitution and initial bylaws of the Foundation;

"(D) provide for the initial operation of the Foundation, including providing for temporary or interim quarters, equipment, and staff; and

"(E) appoint the initial members of the Board in accordance with the constitution and initial bylaws of the Foundation.

"(2) BOARD OF DIRECTORS.—"

"(1) IN GENERAL.—The Board of Directors shall be the governing body of the Foundation.

"(2) POWERS.—The Board may exercise, or perform the exercise of, the powers of the Foundation.

"(3) SELECTION.—"

"(A) IN GENERAL.—Subject to subparagraph (B), the Board of Directors shall be composed of nine members selected in the manner of selection of the members (including the filling of vacancies), and the terms of

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office of the members shall be as provided in the constitution and bylaws of the Foundation.

"(B) REQUIREMENTS.—

"(1) NUMBER OF MEMBERS.—The Board shall have at least 11 members, who shall have staggered terms.

"(ii) INITIAL VOTING MEMBERS.—The initial voting members of the Board shall be—

"(A) a secretary, elected from among the members of the Board; and

"(B) any other persons provided for in the constitution and bylaws of the Foundation.

"(2) CHIEF OPERATING OFFICER.—The secretary of the Foundation may serve, at the direction of the Board, as the chief operating officer of the Foundation, or the Board may appoint a chief operating officer, who shall serve at the direction of the Board.

"(3) STATUS.—A member of the Board shall not receive compensation for the performance of duties of the member.

"(B) OWNERS.—The Board shall not receive compensation for actual and necessary travel and subsistence expenses incurred in the performance of duties of the member.

"(B) OFFICERS.—The officers of the Foundation shall be—

"(1) a secretary, elected from among the members of the Board; and

"(2) any other persons provided for in the constitution and bylaws of the Foundation.

"(C) COMPENSATION.—A member of the Board shall not receive compensation for the performance of actual and necessary travel and subsistence expenses incurred in the performance of duties of the Foundation.

"(D) PERSONAL LIABILITY.—A member of the Board shall not be liable, except as provided in the constitution and bylaws of the Foundation, for any act or omission of the Board or any officer, employee, agent or any other person to whom such member may be subject by reason of association with the Foundation, except in the case of gross negligence in the performance of duties of the member.

"(E) POWERS.—The Foundation—

"(1) shall adopt a constitution and bylaws for the management of the property of the Foundation and the regulation of the affairs of the Foundation;

"(2) may adopt and alter a corporate seal;

"(3) may enter into contracts;

"(4) may acquire (through a gift or otherwise), own, lease, encumber, and transfer real or personal property as necessary or proper to carry out the purposes of the Foundation;

"(5) may sue and be sued; and

"(6) may perform any other act necessary and proper to carry out the purposes of the Foundation.

"(F) PRINCIPAL OFFICE.—

"(1) IN GENERAL.—The principal office of the Foundation shall be in the District of Columbia.

"(2) ACTIVITIES; OFFICERS.—The activities of the Foundation may be conducted, and offices may be maintained, throughout the United States in accordance with the constitution and bylaws of the Foundation.

"(G) SERVICE OF PROCESS.—The Foundation shall comply with the law on service of process of each State in which the Foundation is incorporated and of each State in which the Foundation carries on activities.

"(H) LIABILITY OF OFFICERS, EMPLOYEES, AND AGENTS.—

"(1) IN GENERAL.—The Foundation shall be liable for the acts of the officers, employees, and agents of the Foundation acting within the scope of their authority.

"(2) PERSONAL LIABILITY.—A member of the Board shall be personally liable only for gross negligence in the performance of duties of the member.

"(H) LIMITATION ON SPENDING.—Beginning with the fiscal year following the first full fiscal year during which the Foundation is in operation, the administrative costs of the Foundation shall not exceed the percentage described in paragraph (2) of the sum of—

"(2) PERCENTAGE.—The percentages referred to in paragraph (1) are—

"(A) for the first fiscal year described in that paragraph, 15 percent; and

"(B) for the following fiscal year, 15 percent.

"(3) APPOINTMENT AND HIRING.—The appointment of officers and employees of the Foundation shall be subject to the availability of funds.

"(B) AUDITS.—The Foundation shall comply with section 10101 of title 36, United States Code, as if the Foundation were a corporation under part B of subtitle II of that title.

"(C) FUNDING.—

"(1) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out subsection (a)(1) $500,000 for each fiscal year, as a prudent reduction in the Consumer Price Index for all-urban consumers published by the Department of Labor.

"(2) TRANSFER OF DONATED FUNDS.—The Secretary shall transfer to the Foundation funds held by the Department of Health and Human Services under the Act of August 5, 1954 (42 U.S.C. 2001 et seq.), if the transfer or use of the funds is not prohibited by any term under which the funds were donated.

"(SEC. 803. ADMINISTRATIVE SERVICES AND SUPPORT.)

"(A) PROVISION OF SUPPORT BY SECRETARY.—Subject to subsection (b), during the 5-year period beginning on the date on which the Foundation is established, the Secretary—

"(1) may provide personnel, facilities, and other administrative support services to the Foundation;

"(2) may provide funds for initial operating costs and to reimburse the travel expenses of the members of the Board;

"(3) shall require and accept reimbursements from the Foundation for—

"(A) services provided under paragraph (1); and

"(B) funds provided under paragraph (2).

"(B) REIMBURSEMENT.—Reimbursements accepted under subsection (a)(3) shall—

"(1) be deposited in the Treasury of the United States to the credit of the applicable appropriations account; and

"(2) shall be chargeable for the cost of providing services described in subsection (a)(1) and travel expenses described in subsection (a)(2).

"(C) CONTINUATION OF CERTAIN SERVICES.—The Secretary may continue to provide facilities and necessary support services to the Foundation after the termination of the 5-year period specified in subsection (a) if the services—

"(1) are available; and

"(2) are provided on reimbursable cost basis.

"(D) TECHNICAL AMENDMENTS.—The Indian Self-Determination and Education Assistance Act is amended—

"(1) by redesignating title V (25 U.S.C. 458bbb et seq.) as title VII;

"(2) by redesignating sections 501, 502, and 503 (25 U.S.C. 458bbb, 458bbb-1, 458bbb-2) as sections 7001, 7002, and 7003, respectively; and

"(3) in subsection (a)(2) of section 702 and paragraph (2) of section 703 (as redesignated by paragraph (2)), by striking ‘‘section 501’’ and inserting ‘‘section 701’’.

SEC. 3103. GAO STUDY AND REPORT ON PAYMENTS FOR CONTRACT HEALTH SERVICES.

"(a) STUDY.—

"(1) IN GENERAL.—The Comptroller General of the United States (referred to as the ‘‘Comptroller General’’) shall conduct a study on the utilization of health care furnished by health care providers under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service, an Indian Tribe, or a Tribal Organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act).

"(2) ANALYSIS.—The study conducted under paragraph (1) shall include an analysis of—

"(i) the amounts reimbursed under the contract health services program described in paragraph (1) for health care furnished by entities, individual providers, and suppliers, including a comparison of reimbursement for such health care through other public programs and in the private sector;

"(ii) barriers to access to care under such contract health services program, including, but not limited to, barriers relating to travel distances, cultural differences, and public and private sector reluctance to furnish care to patients under such program;

"(iii) the adequacy of existing Federal funding for health care under such contract health services program;

"(iv) any other items determined appropriate by the Comptroller General.

"(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a), together with recommendations regarding—

"(1) the appropriate level of Federal funding that should be established for health care furnished under the contract health services program described in subsection (a)(1); and

"(2) how to most efficiently utilize such funding.

"(c) CONSULTATION.—In conducting the study under subsection (a) and preparing the report under subsection (b), the Comptroller General shall consult with the Indian Health Service, Indian Tribes, and Tribal Organizations.

TITLE II—IMPROVEMENT OF INDIAN HEALTH CARE PROVIDED UNDER THE SOCIAL SECURITY ACT

SEC. 3201. EXPANSION OF PAYMENTS UNDER MEDICAID, MEDICARE, AND SCHIP FOR ALL COVERED SERVICES FURNISHED BY INDIAN HEALTH PROGRAMS.

"(a) MEDICAID.—

"(1) EXPANSION TO ALL COVERED SERVICES.—Section 1911 of the Social Security Act (42 U.S.C. 1396) is amended—

"(A) by amending the heading to read as follows:

``SEC. 1911. INDIAN HEALTH PROGRAMS.''; and

"(B) by amending subsection (a) to read as follows:

``(a) ELIGIBILITY FOR PAYMENT FOR MEDICAL ASSISTANCE.—An Indian Health Program service eligible for Federal financial participation provided under a State plan or under waiver authority with respect to items and services furnished by the Program if the furnishing of such items and services meets all the conditions and requirements which are applicable generally to the furnishing of items and services under such State plan or waiver authority.''.

"(2) REPEAL OF OBSOLETE PROVISION.—Subsection (b) of such section is repealed.

"(3) REIMBURSEMENT OF AUTOMATICALLY CONVERTED PLANS INTO AGREEMENTS.—Subsection (c) of such section is amended to read as follows:
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SEC. 3204. ANNUAL REPORT ON INDIANS SERVED BY SOCIAL SECURITY ACT HEALTH BENEFIT PROGRAMS.

Section 1139 of the Social Security Act (42 U.S.C. 1323b–4), as amended by the sections 3203 and 3204, is amended by redesignating subsection (e) as subsection (f), and inserting after subsection (d) the following new subsection:

"(e) ANNUAL REPORT ON INDIANS SERVED BY HEALTH BENEFIT PROGRAMS FUNDED UNDER THIS ACT.—Beginning January 1, 2011, and thereafter, the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services and the Director of the Indian Health Service, shall submit a report to Congress regarding the enrollment and health status of Indians receiving items or services under health benefit programs funded under this Act during the preceding year. Each such report shall include the following:

"(1) The total number of Indians enrolled in, or receiving items or services under, such programs, disaggregated with respect to each such program.

"(2) The number of Indians described in paragraph (1) that also receive health benefits under programs funded by the Indian Health Service.

"(3) General information regarding the health status of the Indians described in paragraph (1), including information on the extent to which such programs are effective in improving the health status of Indians.

"(4) The status of facilities of the Indian Health Service for the purpose of complying with the requirements of this section.

SEC. 3205. DEVELOPMENT OF RECOMMENDATIONS TO IMPROVE THE COORDINATION OF MEDICAID AND SCHIP COVERAGE OF INDIAN CHILDREN AND OTHER CHILDREN WHO ARE OUTSIDE OF THEIR STATE OF RESIDENCY BECAUSE OF EDUCATIONAL, OCCUPATIONAL, MILITARY, AND OTHER REASONS.

(a) STUDY.—The Secretary shall conduct a study to identify barriers to interstate coordination of enrollment and coverage under the Indian Health Service under section 1123(a)(1) of the Social Security Act and the State Children's Health Insurance Program under title XXI of such Act of children who are eligible for Indian Health Service benefits and are not residents of the State in which they reside, and recommend to the Committee on Indian Affairs of the Senate and the Committee on Energy and Natural Resources of the House of Representatives such legislative proposals as may be necessary to improve the coordination of enrollment and coverage under the Indian Health Service and the Medicaid and Children's Health Insurance Programs for such children.

SEC. 3206. AUTHORITY TO ENTER INTO AGREEMENTS.—The Secretary may enter into an agreement with a State for the purpose of reimbursing the State for medical assistance provided for Indian Health Service facilities, Tribal Health Programs, Urban Indian Health Program, or an Urban Indian Organization (as so defined), directly or through a Tribal Health Program, to enter into a special fund established under section 401(c)(1) of the Indian Health Care Improvement Act, and the requirement to use amounts paid from such fund for making improvements in accordance with subsection (b), so as to be commensurate with the conditions and requirements which are applicable generally to such funds and that may be imposed by the Secretary with respect to such funds, shall not be construed to impair the authority of the Secretary to place payments under this title into a special fund established under section 401(c)(1) of the Indian Health Care Improvement Act, and the requirement to use amounts paid from such fund for making improvements in accordance with subsection (b), so as to be commensurate with the conditions and requirements which are applicable generally to such funds and that may be imposed by the Secretary with respect to such funds.
emergency evacuations, or otherwise, frequently change their State of residency or otherwise are temporarily present outside of the State of their residency. Such school shall provide for the examination of the enrollment and coverage coordination issues faced by Indian children who are eligible for medical assistance or child health assistance under their State Medicaid programs under title XIX of the Social Security Act and directors of State Children’s Health Insurance Programs under title XXI of such Act, shall submit a report to Congress that contains recommendations for such legislative and administrative actions as the Secretary determines appropriate to address the enrollment and coverage coordination barriers identified through the study required under subsection (a).

(b) REPORT.—Not later than 18 months after the date of enactment of this Act, the Secretary shall provide for the examination of the enrollment and coverage coordination issues faced by Indian children who are eligible for medical assistance or child health assistance under their State Medicaid programs under title XIX of the Social Security Act and directors of State Children’s Health Insurance Programs under title XXI of such Act, shall submit a report to Congress that contains recommendations for such legislative and administrative actions as the Secretary determines appropriate to address the enrollment and coverage coordination barriers identified through the study required under subsection (a).

I want to thank too the Republicans who engaged in this discussion, in this debate, because it is historic, and all of us who sit in this Chamber know that it will have a great effect on our people. Some perceive that effect as not positive. More, I believe, think it is positive. I believe that it is not extraordinarily important.

Soon each one of us is going to look into his or her conscience and vote on this bill. And when the time comes, I don’t think any of us will sway any of you. But I know that the most powerful arguments for the bill won’t be spoken on this floor. They are being lived right now in our country in every one of our districts, in every one of our towns and counties and municipalities.

In the anxiety of the family that finds itself paying more and more each year for health insurance that grows weaker and weaker.

In the frustration of the small business owner weighing the choices of dropping her employee’s coverage against the threat of being driven out of business by her competitors.

And in the fury of the patient who learns that an insurance company bureaucrat has deemed him too sick for the coverage he paid for.

They are our families, our neighbors, our fellow citizens. They are waiting for health insurance reform that is more predictable, more just. Their stories will be with me and I know with each of us when we cast our vote.

Because I want to say to every American facing down illness: never again, never again will you be denied coverage because you have diabetes or asthma or some other disease or because you’re pregnant or because you have anything else your insurer decides is a preexisting condition. Never again will you and your family go bankrupt. Nor will you find the coverage you thought you had paid for was actually not there at all. And never again can insurance companies drive out competition and set premiums as high as they like, because there will be a public insurance option and a transparent marketplace to keep them honest, to keep them competitive, to bring prices down.

I want to say to our middle class families, the backbone of our country: you will have something that you can depend upon. Even if you change your job or lose your job or decide to start a business, you will be able to find affordable coverage in a competitive marketplace, an insurance exchange that offers you a choice of good policies at fair rates. In fact, according to an MIT analysis, buying coverage on the exchange will bring your premiums down by a great deal, even without the affordability credits.

If your family makes $90,000 or more, you’ll save more than $2,900. If your family makes $60,000, you’ll save more than $1,200 bucks. If your family makes $40,000, you’ll save more than $500. And if your family is making $30,000, you’ll save more than $9,000. That’s the kind of tax cut that America needs to secure its medical future.

I want to say to our seniors: you can count on Medicare, on a Federal program, for dignity and peace of mind in your golden years. And that will not change. Today we are going to protect your access to your doctor, to encourage Medicare physicians to cooperate on higher quality care, to keep your Medicare solvents for longer, and to bring an end to the doughnut hole that leaves prescription drugs unaffordable for so many.

I want to say to our small businessmen and women: I know your premiums keep going up and that each year they make it harder to stay in business, to compete with Big Business and with foreign firms. You deserve a fair playing field; and in the insurance exchange marketplace, you’ll be able to buy coverage at the low group rates you’re now being denied.

I want to say to the 35 million Americans without insurance, who are forced to skip checkups and preventative care, who are forced to turn to the ER as the first and only line of defense, who live sicker and shorter lives: you can count on what every man, woman, and child has in every other industrialized country in the world: health coverage you can afford and that you can count on.

And every American who is rightly worried about our mounting deficits and debt, I can tell you this: this bill does not add to the deficit over the next 10 years or the 10 years thereafter. This bill means health care that is more fiscally sustainable for years to come.

That is what this bill, the Affordable Care Act, can achieve for our country and for our people. It isn’t a simple bill. It isn’t a perfect bill, but it is the product of months and months of debate, sometimes animated debate, yes, even angry debate, careful scrutiny, hard work, and citizen input. And it’s the right response to this time of economic insecurity in which we have been called to lead.

If we miss this chance, or if we vote for a Republican plan that does very little to expand coverage, weakens insurance, frankly, for millions who have it, and continues to allow millions of Americans to be denied affordable coverage, we’ll find ourselves back here again.

But by then, premiums will eat up even more of our families’ budgets; health care will consume even more of our economy; and even more Americans will have died for the lack of health care.

If we miss this chance, if we miss this challenge of nearly a century’s duration, when Teddy Roosevelt, one of the greatest Presidents of this country, a Republican President, said a hundred years ago we need to have health care coverage for all Americans—this is not a new idea, but it is
America is going to be spent by the
every dollar spent on health care in
that two-thirds to three-fourths of
When fully implemented, it's my opin-
imbursement fix in the separate bill.
years if you include the physician re-
Worth, Texas; and this is something
things planned this weekend, I do want
to oppose the bill before us, H.R. 3962.
Slowly, I participated in a talk radio
program on health reform, and a gen-
tleman called in to tell me that his
health care was great, and he didn't
want me or the government to mess
I explained to him that our plan was about
choice, bringing down costs, and
providing quality care.
But the next caller got right to
the heart of the matter. She said, Of course
he likes his health insurance; it is
probably because he has never tried to
use it. She explained that she had re-
cently been diagnosed with cancer and
thought she liked her coverage until
she tried to use it. She said that when
she began to get treatment she was
dropped from her insurance coverage.
I am pleased at this time to yield 3 minutes
to give to our fellow citizens a greater sense of security.
We will vote to make Medicare stronger
for our seniors. We will vote for a
healthier economy, for affordable cov-
ence worthy of the values we profess and the principles we hold
dear. We will vote for a healthier America.
Mr. WAXMAN. Mr. Speaker, I reserve
myself 2 minutes.
Mr. BARTON of Texas. Mr. Speaker,
yield myself 1 more minute.
Mr. WAXMAN. Mr. Speaker, I am
pleased at this time to yield 3 minutes
to give to our fellow citizens a greater sense of security.
We will vote to make Medicare stronger
for our seniors. We will vote for a
healthier economy, for affordable cov-
ence worthy of the values we profess and the principles we hold
dear. We will vote for a healthier America.
I just don't think it's right, in the
guise of helping Americans, to mandate
what they have to do. I don't think it's
right that you mandate an employer to provide health
insurance or they're going to pay
all these penalties. I don't think it's
right that we set up a health choice ad-
For average Americans, this bill is a bad deal.
Mr. Speaker, today I'm thinking
about a woman from South Carolina. A
few months ago during the August run,
I participated in a talk radio
program on health reform, and a gen-
tleman called in to tell me that his
health care was great, and he didn't
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I explained to him that our plan was about
choice, bringing down costs, and
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But the next caller got right to
the heart of the matter. She said, Of course
he likes his health insurance; it is
probably because he has never tried to
use it. She explained that she had re-
cently been diagnosed with cancer and
thought she liked her coverage until
she tried to use it. She said that when
she began to get treatment she was
dropped from her insurance coverage.
I am pleased at this time to yield 3 minutes
to give to our fellow citizens a greater sense of security.
We will vote to make Medicare stronger
for our seniors. We will vote for a
healthier economy, for affordable cov-
ence worthy of the values we profess and the principles we hold
dear. We will vote for a healthier America.
I just don't think it's right, in the
guise of helping Americans, to mandate
what they have to do. I don't think it's
right that you mandate an employer to provide health
insurance or they're going to pay
all these penalties. I don't think it's
right that we set up a health choice ad-
For average Americans, this bill is a bad deal.
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government-controlled system. Don’t trust me: ask my friend, JAN SCHAKOWSKY, or ask Chairman BARNEY FRANK. Or believe President Obama who said, “I happen to be a proponent of a single-payer health care program. But I don’t think we’re going to be able to eliminate employer coverage immediately.”

Make no mistake, this bill will achieve the single-payer goal. And along with it, it will raise premiums, increase taxes, cuts billions of dollars from Medicare, and cost millions of dollars working Americans their job. And at the end, a single-payer system will force every American into a one-size-fits-all system that rations care. A government that rations care is anti-life.

Mr. WAXMAN. Mr. Speaker, at this time I am very pleased to recognize and to yield 1 minute to the gentlewoman from Connecticut (Ms. DeLAURO).

Ms. DeLAURO. Mr. Speaker, I rise at this historic moment in support of the Affordable Health Care for America Act. None of us will again have such an opportunity in our time serving in the United States Congress to do something enduring and fulfilling to make sure that every American shall have access to quality, affordable health insurance.

For more than a century, the special interests have won this moment. Presidents Theodore Roosevelt, Franklin Roosevelt, Truman, Kennedy, Nixon, and Clinton have spoken of our country’s aspiration, but only now have we come so far.

When the Democrats and the Congress passed Medicare, we lifted seniors out of poverty forever, and now we get to say to working Americans, You can no longer be broken by a health insurance system that drops you when you are sick or lose a job.

It says to women, You will no longer be denied coverage on account of a C-section or domestic violence. No longer will maternity or preventive care be ignored.

I urge my colleagues to vote for history and for America today. This is why we are here.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair will remind all persons in the gallery that they are here as guests of the House and that any manifestation of approval or disapproval of proceedings or other audible conversation of the House in violation of the rules of the House.

Mr. BARTON of Texas. Mr. Speaker, I would like to yield 1 minute to the gentleman from Georgia (Mr. DEAL), a subcommittee ranking member.

Mr. DEAL of Georgia. Mr. Speaker, I yield 2 minutes to the gentleman from Georgia (Mr. DEAL), a subcommittee ranking member.

Mr. DEAL. Mr. Speaker, I rise in opposition to this bill, and I express three major concerns.

First of all, I raise a question. The question is doctored that authority in the United States Constitution gives this Congress the right to mandate that every citizen must purchase a health insurance policy, and upon failing to do so, shall be fined and possibly imprisoned? I think the answer to that question is, there is no such congressional authority.

Secondly, make no mistake about it, illegal aliens will receive government-done health care because all they are required to show is a Social Security number and a name. There is no way to prevent the same Social Security number from being used by numerous individuals, and there is no requirement that a picture ID be produced in order to prove that the person is in fact the name that appears on the Social Security card. If you think identity theft is a problem now, just wait until this bill passes.

Thirdly, this bill requires States to increase their Medicaid rolls to 150 percent of the Federal poverty level. In an ever-increasing fashion, States will have to absorb the cost of this burden. I offered an amendment which would have allowed States to opt out from this mandate, but it has been rejected. In States like mine, where we have to balance our budget, right now schoolteachers and law enforcement officers are having to take unfunded furloughs. If this bill passes, it will have more furloughs. We are passing a bill that takes days and money out of the paychecks of teachers and law enforcement officers to pay for this piece of legislation.

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Mr. WAXMAN. Mr. Speaker, I am pleased at this time to yield 2 minutes to the gentleman from the State of Maryland, Mr. CHRIS VAN HOLLEN.

Mr. VAN HOLLEN. Mr. Speaker, today our Nation stands at an historic crossroads. We can choose the road that dead-ends in the status quo where the health industry will continue to call the shots and ration our health care or we can pass this bill and take the path that will provide every American citizen access to quality, affordable health care.

What we do in this bill is preserve what is best and fix what is broken. We will continue to face skyrocketing health care costs that are breaking our family budget, forcing businesses to drop health insurance, and will eventually bankrupt our Nation. We saw health insurance premiums more than double between 2000 and 2008, and during that period of time, health insurance profits soared by 500 percent. How did they do it? Essentially by saying “no” to people who had preexisting conditions and using the fine print in insurance policies to deny people promised benefits when they needed help the most.

This bill will end those abuses. It ends the antitrust exemption that In fact, this bill does a tremendous amount of harm and would inflict an enormous burden on current and future generations of Americans. It would raise insurance premiums, raise taxes, and create huge new government bureaucracies to stand squarely between patients and doctors.

This bill does not offer real health care reform. Rather than reduce costs and make health care more affordable and accessible, this bill will increase costs to consumers and put the government in charge of all treatment and care Americans are entitled to.

Millions of Americans have resoundingly rejected this shell game masquerading as reform. The very least we can do is listen to the American people and reject this flawed bill.

Mr. WAXMAN. Mr. Speaker, I am pleased now to yield 2 minutes to the gentleman from Connecticut (Mr. LARSON), the chairman of the Democratic Caucus.

Mr. LARSON of Connecticut. Mr. Speaker, I thank Mr. WAXMAN and Mr. RANGEL and Mr. MILLER for their help.

The growth of this great Nation cannot be achieved without caring for the health and welfare of our fellow Americans. Thirty-six million Americans await our action on the House floor today. Thirty-six million Americans watched as the feartongued stood on the steps of the Capitol this week telling them to be afraid.

Mr. WAXMAN. Mr. Speaker, at this time I am very pleased to recognize and to yield 1 minute to the gentlewoman from Connecticut (Ms. Delauro).
shields the health insurance industry from price-fixing. It establishes a health insurance exchange like a supermarket for health policies that provides more choice, including a public option.

Mr. Speaker, that’s why the Consumers Union and Consumer Reports support this legislation. That’s why the AARP, the largest organization protecting the rights of seniors, has endorsed this. And that’s why the doctors of America have endorsed this.

I understand why the insurance industry opposes this bill, but our job is not to protect the special interests of the insurance industry; our job is to do what’s right by the American people.

Let’s move this country forward.

Let’s vote “yes” for America.

Mr. BARTON of Texas. Mr. Speaker, I would like to yield 1 minute to another member of the committee, Congresswoman MARSHA BLACKBURN of Nashville, Tennessee.

Mrs. BLACKBURN. Mr. Speaker, I find it so interesting that some are so excited about voting for this bill. Quite frankly, I find it to be a very sad day that this body would take a step moving toward a single-payer system in health care.

We have all heard the horror stories of what happens in Europe and in Canada as women seek to get care for breast cancer and die before that care can be found, because care delayed is care denied. We’ve heard about heart surgeries that never came to pass because they were waiting in the queue. We have talked to mothers who sought desperately to have children treated for chronic illnesses and could not get that help. We have heard about our seniors, and we know what this bill will do to Medicare, making one-half trillion dollars worth of cuts. We have talked to mothers who have said, Mr. Speaker, you cannot even get H1N1 vaccine out there and you think you’re going to handle the health care for my children?

And today, recorded in the Wall Street Journal, Betsy McCaughey, former Lieutenant Governor of New York, cites some of the provisions and what it will do to the seniors in this Nation as it cuts into their access.

This is not the action we should take.

ANNOUNCEMENT OF THE SPEAKER PRO TEMPORE

The time of the gentlewoman has expired.

The Chair would ask all Members to adhere to the time limits and to heed the gavel.

Mr. WAXMAN. Mr. Speaker, I yield myself 3 minutes.

Today, we have a historic opportunity. Sixty-five years after Franklin Roosevelt and Social Security and 35 years after Medicare, we have an opportunity, under the leadership of President Obama and Speaker Pelosi, to reform our health care system and to last provide coverage to all Americans.

We know that health insurance today is failing our families and our economy. If we do nothing, the system will go bankrupt, premiums will keep skyrocketing, benefits will be slashed, what you get will cost more, and the deficit will increase by billions of dollars.

Today, Americans with health insurance know that they are one serious illness away from debt and bankruptcy, and millions of Americans have no insurance at all. With this legislation, we can fix these problems.

First and foremost, this bill provides health insurance security for all Americans. If you have health insurance today, you can keep it; you keep your doctor and your other health providers. But if you lose your job, you will not lose your health insurance. If you have a preexisting medical condition, you cannot be denied health insurance. If you have a serious illness, we remove the cap insurance companies have imposed to cut you out of coverage over your lifetime. Effective immediately, it will be illegal for insurance companies to put lifetime caps on your coverage. And children all the way up to age 27 can continue on their parents’ policies.

Our bill has historic reforms. It expands coverage and reduces costs. It trains doctors and supports community health centers. It provides a public health insurance option that will give Americans more choice and competition.

Our legislation strengthens Medicare. We will eliminate copayments for preventive services. We close and then eliminate the doughnut hole that makes prescription drugs unaffordable for so many of our seniors.

And this legislation is affordable. The only thing not affordable is to do nothing. The legislation is fully paid for. It will not add to the deficit over the next two decades.

Today, we have the chance of a lifetime to do something great and momentous for the American people. By passing this bill, we can reform health insurance in America and provide all Americans with the security of knowing that when they get sick, care will be available and affordable.

I urge all my colleagues to support this bill.

Mr. Speaker, I reserve the balance of my time.

Mr. BARTON of Texas. Mr. Speaker, I yield for a unanimous consent request to the former chairman of the Appropriations Committee, Mr. BILL YOUNG of Florida.

(Mr. YOUNG of Florida asked and was given permission to revise and extend his remarks.)

Mr. YOUNG of Florida. Mr. Speaker, I rise in opposition to the bill.

Mr. Speaker, this bill, H.R. 3962, does not represent good public policy. I rise to express my concerns about H.R. 3962, the Affordable Health Care for America Act.

This legislation is misnamed, as even the nonpartisan Congressional Budget Office says it will not be affordable for the American people and our nation as a whole.

The Congressional Budget Office says this legislation will cost $1.055 trillion over the next 10 years, raising taxes on American taxpayers and businesses by $729.5 billion. Of great concern, Mr. Speaker, and Medicare beneficiaries I represent, is that it will also cut Medicare payments by $500 billion. There is no possible way you can cut such a significant amount of funding out of a program that is so vital to senior citizens without compromising the availability or quality of care without disrupting the relationship they have with their current doctors and medical providers.

Within the Medicare program, H.R. 3962 also cuts the reimbursement rate for seniors enrolled in Medicare Advantage programs. In the 10th Congressional District of Florida which I represent, more than one-third of the Medicare beneficiaries, or 47,729 seniors, are currently enrolled in Medicare Advantage plans. The Chief Actuary of the Centers for Medicare and Medicaid Services estimates that if enacted, the legislation we consider today will result in 143,000 seniors losing their Advantage plans by as much as 25 percent. These are additional premiums that seniors living on fixed incomes will have to pay to keep their prescription drug coverage.

Finally, with regard to Medicare, this legislation does nothing to correct a 21 percent cut in physician reimbursement rates that is scheduled to take effect January 1st for doctors who provide care to our seniors. Having met with doctors I represent throughout the past year, I know that one of their major concerns about health care reform is that they be allowed to take larger and larger cuts in Medicare reimbursement rates. These cuts, they say, will make it more and more difficult for them to care for Medicare patients. In the end, many seniors could be forced to find new doctors.

In addition to the impact this legislation would have on senior citizens, I am concerned about the economic impact this legislation will have on those seniors, their children, their grandchildren, and their great grandchildren. H.R. 3962 creates a brand new federal entitlement program at a time when our nation is struggling to sustain those entitlement programs already on the books. While the Congressional Budget Office says that under a best case scenario the $500 billion in Medicare cuts and $729.5 billion in tax increases will pay for this legislation over its first 10 years if there are much smaller cuts, it is doubtful that this will keep the program from running up federal deficits after that and leaves no margin for error.

In fact, despite one of the goals of this legislation to make health insurance more available and affordable for uninsured Americans, we simply move an estimated 18 million people into the government Medicaid program. This is more than half of the 34 million uninsured Americans who would have been left uninsured under the Affordable Care Act.
Mr. Speaker, I have discussed here some of my concerns about provisions in this bill; however, there are glaring omissions to this legislation as well. The most significant provision that has been left out is medical liability reform. This is a top issue for doctors, hospitals and all medical providers, as it is one of the major drivers increasing the cost of health care. Tort reform would help reduce the filing of unwarranted lawsuits, decrease the number of duplicative tests such as radiology and lab medicine, and lower the cost of medical malpractice insurance rates, which would translate in lower medical costs.

Tort reform is one of the many areas that we can agree to to increase the availability and decrease the cost of health care. There are others I support, some in this bill, including requiring coverage for individuals with pre-existing conditions, preventing insurance companies from cancelling the policies of individuals when they become sick, providing for the availability of health insurance across state lines, ensuring that employees can retain access to health insurance when they change or lose their jobs, creating health insurance pools that small business owners and self-employed individuals can join to provide lower cost health insurance for their employees and themselves, and closing the so-called doughnut hole in the Medicare Part D prescription drug program.

Mr. Speaker, there is no doubt that our nation can and should do better to provide qualitative and affordable health care for the American people. Throughout my service in Congress, I have done all I could to expand health care opportunities nationally and throughout the 10th Congressional District, which I represent. By establishing the National Marrow Donor Program in 1989, I sought to provide life-saving medical options to terminally ill patients suffering from leukemia and more than 60 otherwise fatal blood disorders. Today the national registry has more than 7 million volunteers available to donate the life-saving bone marrow.

During the time that I worked to establish the national registry and as we began to find matched marrow donors for patients, I met with family after family who needed help convincing health insurance companies to cover the cost of bone marrow. From this experience, I witnessed first-hand the tragedy of families losing their health insurance coverage at their time of greatest need and of being denied coverage for a life-saving procedure.

In a similar manner, I have identified other national and local health care needs and have done something to solve the problems that include increasing the vaccination rates for our nation’s children; ensuring the availability of specialized services, facilities and equipment at our hospitals to meet the needs of children; expanding the funding for graduate medical education programs to increase the number of doctors who receive the next step of their training; increasing the Inspector General force at federal agencies to uncover waste, fraud and abuse which threaten the safety of seniors and veterans, and divert limited federal health care resources; improving the quality of health care through our investment in biomedical research by doubling the budget for the National Institutes of Health during my 6 years as Chair; creating the Access to Cancer Treatment Equity Act; expanding our research opportunities through the Department of Defense in the areas of breast cancer, prostate cancer, Parkinson’s Disease, ALS, multiple sclerosis and diabetes; and expanding the number of community health centers throughout Florida and Pinellas County.

Mr. Speaker, I take a back seat to no one when it comes to my work to improve and expand the quality and availability of health care for the American people and the people I represent. I supported the creation and expansion of the State Children’s Insurance Program, which increases access to health care for our nation’s youth, and likewise the Family and Medical Leave Act, allowing employees to take time off from work to care for a sick and remaining family member.

However, I cannot support legislation that would threaten the sanctity of the patient-doctor relationship, that would establish new federal bureaucracies that would insert themselves into the health care programs of individuals and employers, that creates a new and financially unsustainable federal entitlement program, that threatens the availability of health care for our nation’s seniors, that raises taxes substantially and threatens the viability of many small businesses at a time when we are trying to get our nation back on track, and that ultimately will not make health care insurance more affordable for the American people.

We have all heard from the American people we represent over the past few months about this legislation that has been under consideration. We have heard that they are closely following its progress. We have heard that they have many concerns about this legislation before us. And we have heard that they want us to work together in a bipartisan manner to bring down the cost and expand the availability of health care coverage.

Today, we have a historic opportunity to tell the American people we hear their voices. We can commit to them that, on this issue which will affect every single household and business in our nation, we will go back to our respective committees and work together—as Republicans and Democrats; conservatives, moderates and liberals; Blue Dogs and Progressives—to come up with a solution that the American people can support and, most importantly, that we can finally live with, providing our families the job without bankrupting our nation, jeopardizing our economic recovery and violating the free market principles upon which our nation was founded.

Mr. BARTON of Texas. Mr. Speaker, I yield a clock 3 minutes to the minority leader, Mr. Boehner. This is not his leadership imperial minute. It is the clock 3 minutes.

Mr. BOEHNER. Let me thank my colleague for yielding. I have no propensity to be surprised by any of you that I rise in opposition to this bill.

One of the issues in this bill that is of concern to Members on both sides of the aisle has to do with the sanctity of life. The Rules Committee made in order an amendment by our colleague from Michigan, Mr. Stupak, that would continue existing law that no Federal funds will be used for abortion.

While I am grateful that we’re going to have this vote in the House, I want to ask the chairman of the Energy and Commerce Committee, Mr. Waxman, if the House does vote in fact, for Mr. Stupak’s amendment, if the gentleman will guarantee me that when this bill
comes back from conference, that that language will remain in the bill.

Mr. WAXMAN. If the gentleman would yield.

Mr. BOEHNER. I would be happy to yield.

Mr. WAXMAN. As the gentleman well knows, the decision is not up to one person; it will be up to the con-

ferees. The conferees will have to be meeting with the Senate conferees and going over a number of positions.

If this amendment is adopted by the House, it will be the House position as we go into conference. We will have to
discuss it further, and then we will see what will be the result. But no guar-

antee can be made by me or any other Member at this time.

There will be an opportunity, as you know, to instruct the conferees, which reinforces, of course, a particular part of

the House bill.

Mr. BOEHNER. Reclaiming my time, the reason I stand here at this point in the debate is that, while we are grate-

ful to have this amendment and this chance to vote to make sure that tax-
payer funding is not used for abortion—which has been the policy of the land for the last 30 years—as the gen-
tleman points out, there is no guar-

antee that at the end of the day this language will be in the bill.

Now, I've been a chairman of a com-

mittee. I understand that there are no guarantees, but that's the whole point here. The only reason this amendment is allowed to be offered is in order to secure enough votes to try to move this bill through the floor today. I have my doubts about whether this lan-
guage, if it passes, has any chance of ever being in the final version of this bill.

Mr. WAXMAN. Mr. Speaker, at this
time, I am honored to yield 2 minutes
to the gentleman from New Jersey (Mr. PALLONE), the chairman of the Health Subcom-

mittee on the Energy and Com-

merce Committee.

Mr. PALLONE. Mr. Speaker, I want
to thank my chairman, Mr. WAXMAN, for all his hard work on this bill.

For far too long, our Nation has en-
dured a health care system that is cha-

otic, costly, and crippling American families. In casting our votes today, each of us must make a simple choice:

Do we want to maintain the broken system we currently have or do we want to do better?

And you should ask yourself, first, are you in favor of allowing health care premiums for American families to

to continue to spiral out of control, forc-
ing them to delay care or drop cov-

erage altogether, or are you in favor of providing every American with access to affordable and quality health insur-

ance?

Second, are you in favor of more American businesses delaying invest-

ments, closing their doors or laying off workers because of increasing health care costs, or are you in favor of mak-
ing it more affordable for those busi-

nesses to provide health care coverage for their workers?

And finally, are you in favor of allow-
ing health insurance companies to be able to discriminate against people be-

cause they are sick, women, or older, or are you in favor of putting an end to this explicit and immoral form of discrimi-
nation that insurance companies get away with today?

Mr. Speaker, there are many reasons to vote for this bill, but there is really only one reason to vote against it, and

that is to maintain the broken health care system we currently have.

If you want to change the system, vote “yes”; vote for affordable and quality health care for every Amer-
ican.

Mr. MCCARTHY of California. I yield 2 min-

utes to a member of the Republican leadership, Mr. McCAIN of California.

Mr. McCAIN of California. I thank the gentleman from Texas for yielding. Mr. Speaker, this is my second term.

Since being elected by the people of California's 22nd District, I am re-

minded about how much things have changed.

Three years ago on this date, employ-

ment was 4.5 percent. Today, the

unemployment rate has more than dou-
bled to 10.2. Three years ago on this date, the stock mar-

ket was over 12,000. Today, the stock

market has dropped by 2,000 points. Three years ago on this date the cur-

rent House majority promised to drain the swamp. Today, the swamp in Wash-

ington isn’t drained; it’s overflowing.

And 3 years ago on this date, November 7, 2006, the Democratic Party was vic-

torious in winning control of this House.

Today, we are here on the floor to vote on a $1 trillion government take-

over that can replace the health insur-

ance that millions of Americans have. This is a defining vote for this Con-

gress. We can reject tax increases on small business at a time when 2.8 mil-

lion jobs have been lost since the stim-

ulus was signed into law and say yes to helping small businesses access more affordable health insurance for their

employees. We can reject the govern-

ment takeover of our health care that will increase health insurance costs and say yes to saving American fami-

lies up to $5,000 off their current health care premiums.

I know that over the last 3 years there have been many disappoint-

ments, when the voices of Americans have been overruled by government bailouts and now a government take-

over of health care, but I urge my col-

leagues to reject the politics of the past and fight for a better direction for our country, for our children, and for our grandchildren.

I urge a “no” vote on H.R. 3962 and a

“yes” vote for the Republican bill.

Mr. WAXMAN. Mr. Speaker, this bill reflects the input and the inspiration of two Kennedys in the Congress of the United States, certainly Senator Ted Kennedy, but also Patrick Kennedy, who has been such a leader in the areas of mental health and addiction.

I yield to the gentleman from Rhode Island for a unanimous consent re-

quest.

Mr. KENNEDY asked and was given permission to revise and extend his re-

marks.

Mr. KENNEDY. I rise in support of mental health benefits in this bill to

support suicide, addiction, and depres-

sion coverage in this legislation for whole health coverage.

Mr. WAXMAN. Mr. Speaker, I ask unanimous consent that Members have

5 legislative days in which to revise and extend their remarks on H.R. 3962 and include extraneous material in the

RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gent-

dleman from California?

There was no objection.

Mr. WAXMAN. Mr. Speaker, at this

time, I am greatly honored to yield 3

minutes to the chairman of the Ways

and Means Committee, one of the crafters of this bill and one of the great leaders in health care as well as other policy areas, Mr. Gentleman from New York (Mr. RANGEL).

Mr. RANGEL asked and was given permission to revise and extend his re-

marks.

Mr. RANGEL. We have an expression in my community, “God is good,” and basically it means that it gives us all an opportunity in our lives to do some of the things that we had hoped and dreamed would be possible. Since God has been good to our country and to this Congress, it means that we have a responsibility to extend our power to make certain that people have access to health care.

It’s really surprising that the other side would believe that, as a party, their answer to this crisis that we face as a Nation in providing health care to so many millions of people that don’t have it, that their answer is “no” and their vote will reflect “no.” But a short visit to history would see that everyone, we’re talking about compassion—Social Security, Medicaid, and Medicare—their answer is going to be “no.”

I want to thank our President for recognizing that even though we have to carry this load alone, it is an honor to be working under the leadership of Speaker NANCY PELOSI, our chairmen, Chairman WAXMAN and Chairman MILLER, and all of the wonderful people that have worked together under the caucus chair of Mr. Larson so that we all trust and understand that we only have this one chance to get it right; Mr. CLYBURN, who brought our votes to-

gether so that we are able to be here on

November 7, 2009

CONGRESSIONAL RECORD — HOUSE

H12839

GENERAL LEAVE
Mr. HALL of Texas. Mr. Speaker, I rise today to urge, of course, a "no" vote with your constituents, and I say against this bill, and I believe it's a generation killer, and the targets are your grandchildren and mine. My generation will not have the luxury of determining who will live and who will not live. This bill is a proposal.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to a distinguished woman from California, ANNA ESHOO.

Ms. ESHOO. Mr. Speaker, I come to the floor today to cast one of the most important votes of my congressional career, the Affordable Health Care for America Act. This effort is historic, almost a century in the making.

For many of us, this long battle has had a singular, courageous champion who fought like a lion for the sick, the elderly, the left behind, and the left out, Senator Edward Kennedy, and this bill is a fitting memorial to him.

Most uninsured Americans want to purchase health insurance, but they simply can’t afford it. They are priced out. The most priced out, Millions more live under the crushing weight of medical bills that bankrupt households or that shutter small businesses. This bill provides access to affordable health care for every American.

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Very importantly, seniors, your Medicare will be strengthened; and it will provide you with better care.

I am proud to be part of making history. I think it is a privilege to do so.

I urge all of my colleagues to vote for this legislation.

The SPEAKER pro tempore. The Chair will note that the gentleman from Texas has 28 minutes remaining, and the gentleman from California has 22½ minutes remaining.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to a distinguished member of the Energy and Commerce Committee, the gentleman from Rockwall, Texas, Congressman RALPH HALL.

(Mr. HALL of Texas asked and was given permission to revise and extend his remarks.)

Mr. HALL of Texas. Mr. Speaker, I rise today to urge, of course, a "no" vote on the Democratic health care proposal.

I have five grandchildren, and already they will spend their entire lives paying the debts that we are accumulating in their name, and they will not be even paid. This bill is a generation killer, and the targets are your grandchildren and mine. My Fourth District of Texas is 100-1 against this bill, and I believe it's a good composite of other districts around the country.

I urge you all to please listen and to vote with your constituents, and I say to Members on both sides of this aisle: remember who sent you here, and vote their wishes. The American people have memories that will survive the actions of today’s vote. They will not forget. I ask you to vote “no.”

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to a woman from California, ANNA ESHOO.

Ms. ESHOO. Mr. Speaker, I come to the floor today to cast one of the most important votes of my congressional career, the Affordable Health Care for America Act. This effort is historic, almost a century in the making.

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place of our family doctors, mandate health insurance with jail for not complying with or for paying a tax, and ignore the voices of thousands of people who come here and who said, Listen to us. Don’t pass this bill.

Mr. Speaker—where are people in this Chamber thinking of?

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to a member of our committee, the gentleman from Texas, GENE GREEN.

Mr. GENE GREEN of Texas. Mr. Speaker, I rise in strong support of H.R. 3962, the Affordable Health Care for America Act. This is a momentous day like that day in 1935 when Social Security was created and also like that day in 1965 when Medicare was passed.

We are in desperate need of health care reform. Health insurance premiums are growing three times as fast as wages; and, last year, more than half of Americans postponed medical care or skipped their medications because they couldn’t afford them.

The 29th District in Texas, which I represent, has the highest number of uninsured individuals in the country as 40 percent of the residents are uninsured. If enacted, H.R. 3962 will provide coverage to 96 percent of all Americans and to 230,000 currently uninsured residents in our district. It will also improve the employer-based coverage for 217,000 residents in our district.

H.R. 3962 will give individuals the ability to access quality, affordable health insurance. They will no longer be denied coverage for preexisting conditions, and their coverage will not be capped or dropped when they are sick. The bill ensures no more co-pays for preventative care, no more yearly caps for what insurance companies will cover, and it provides premium subsidies for those who need it.

This is a government controlled medicine—individuals will be able to choose their own insurance plan and their physician. This bill ensures individuals will be able to have access to primary and preventative care services, which will enable the patient to see a doctor before they are sick, and be able to access quality medical services.

H.R. 3962 will rein in rising health costs for American families and small businesses—introducing competition that will drive premiums down, capping out-of-pocket spending.

The time for health reform has come and I urge my colleagues to vote in favor of H.R. 3962 not only for my constituents, but for all Americans.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to one of the distinguished ranking members of the Energy and Commerce Committee, the gentleman from Florida (Mr. CLIFF STEARNS).

(Mr. STEARNS asked and was given permission to revise and extend his remarks.)

Mr. STEARNS. I thank my colleague. Mr. Speaker, I rise against this bill. The Congressional Budget Office has said that tort reform will save the Federal Government $54 billion. Instead, we get a bill today that makes a mockery of tort reform.

The Democrats add a provision that will clearly increase costs for health care and that will make it harder to recruit doctors. The new language explicitly prevents States that accept these grant funds from capping noneconomic damages or attorneys’ fees even if it is currently capped. Said another way, the Secretary of Health and Human Services can give such sums as he deems necessary to any States that do not cap attorneys’ fees, or, sadly, the bill undoes all States’ tort reform.

This bill violates States’ rights. It undermines their efforts at real tort reform. It allows trial lawyers to begin to circumvent on our doctors and medical providers.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to a very active and important member of the Health Subcommittee and of the full Energy and Commerce Committee, my colleague from California, LOIS CAPPS.

Mrs. CAPPS. Mr. Speaker, I am honored to rise in emphatic support of H.R. 3962. As we pass this historic legislation today, which improves health care for all Americans, let us focus on the benefits for women’s health.

When this bill becomes law, a woman will no longer be discriminated against by an insurance company simply for being a woman. Women will no longer be discriminated against by insurance companies for being victims of domestic violence. Women will automatically be covered for maternity care. Women will not have to pay co-pays for important preventative screenings like mammograms and cervical cancer.

Most importantly, women who make the bulk of the health care decisions for their families will have access to quality, affordable health care for their families.

This is an excellent bill, and I am humbled by the fact that, as a Representative of the 23rd Congressional District in California—a nurse, a mother and a grandmother—I am privileged to vote today in favor of this bill. I urge all of my colleagues to do the same.

Mr. BARTON of Texas. I yield 1 minute to another of my distinguished ranking members on the Energy and Commerce Committee, the gentleman from the Bluegrass State of Kentucky (Mr. WHITFIELD).

Mr. WHITFIELD. Mr. Speaker, there are many provisions of this 2,000-page Affordable Health Care for America Act that we can support on this side. Yet we do not support the establishment of a Federal health care board to control health care in America. We do not support establishing civil penalties of up to $10,000 a day for violating health regulations. We do not support reducing Medicare funding by $500 billion. We do not support cutting funding for hospitals by $155 billion and rural hospitals by $8 billion between 2017 and 2019. We do not support increasing taxes on small business owners, particularly at a time when we have an unemployment rate of 10.2 percent.

If we had a surplus, we could support spending billions of dollars for the sovereign states of Micronesia, the Marshall Islands and Palau. Since we have a $11 trillion debt, why should we be spending money for health care in those countries? We are also increasing by $100 billion health care for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa in this bill.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentleman from Pennsylvania (Mr. DOYLE).

Mr. DOYLE. Mr. Speaker, my colleagues on the other side of the aisle are trying to scare our seniors. They are telling tall tales, saying that passing health care reform will destroy Medicare.

For Americans watching this debate, I want to make this clear: This bill will strengthen Medicare. My good friend from Michigan, JOHN DINGELL, helped write the law that created Medicare, and he authored this health care reform bill we will vote on today.

This bill protects seniors and gives all Americans access to affordable health insurance. This bill will start to close the Medicare prescription drug doughnut hole and ban insurance companies from dropping people for having the audacity to get sick. This bill makes sure that preventative services are free to seniors in Medicare and all Americans with insurance.

This bill extends the Medicare’s solvency by at least 5 years, it pays for itself and it will reduce the national deficit. Finally, this bill is endorsed by doctors, nurses, patients, the Autism Society of America and the AARP.

Mr. BARTON of Texas. I would like to yield 1 minute to the gentlelady who has the privilege of representing Key West, Florida, the Honorable ILEANA ROS-LEHTINEN.

Ms. ROS-LEHTINEN. Mr. Speaker, I am blessed that even though my elderly mother has Alzheimer’s, we are able to provide her with high quality health care, but I am worried. I am worried about the families who, like mine, have an elderly parent who needs care and assistance. It’s not easy for any family to support a loved one through hard times, and there is no doubt that these are hard times.

Employment in the state of south Florida is over 11 percent. In the midst of this, the Pelosi bill takes away from seniors. Yes, it does. The Pelosi bill makes sure that preventive services are free to seniors in Medicare and all Americans with insurance.

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Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentleman from Pennsylvania (Mr. DOYLE).
State of Washington, a very important member of the Energy and Commerce Committee, Mr. INSLEE.

Mr. INSLEE. Mr. Speaker, I just want to relate one call from a small businessman who told me we needed health care reform so that his wife can finally start a small business of her own and be freed from the insurance industry that stopped her from getting insurance.

I would like to enter into a colloquy with Mr. WAXMAN.

Mr. Chairman, I would like to clarify section 1188, the generic fill provision in the bill. This section allows Medicare Part D plans to waive copays for generic, bioequivalent and biosimilar drugs. I believe that absent explicit approval from the patient’s doctor, this inducement should only apply to those biosimilars that have been rated “interchangeable” by the FDA, meaning that they can be expected to produce the same clinical result in a given patient and switching medicines poses no greater risk than not switching. With respect to biosimilars that have not been rated as interchangeable, is it your intent that under this provision patients could not be switched from a non-interchangeable biosimilar drug without an explicit request by a patient and approval by their doctor?

Mr. WAXMAN. Congressmen INSLEE, you are correct. It’s our intent that the patient would not be switched from a reference product to a non-interchangeable biosimilar without approval from the doctor.

Mr. WAXMAN. I yield the gentleman an additional 30 seconds.

Our intent is also that a patient could not be financially induced by their plan to switch to a non-interchangeable biosimilar without the consent of the patient. I am happy to work with the gentleman to clarify the language in conference.

Mr. INSLEE. Today we should pass this bill.

Mr. BARTON of Texas. Mr. Speaker, I would like to yield 2 minutes now to the leader of the Republican Health Care Task Force and a member of our committee, the deputy ranking member, Mr. ROY BLUNT.

Mr. BLUNT. Thank you, Mr. BARTON. Mr. Speaker, there are so many things that I am for in health care. In our Health Care Solutions Group, I am sponsoring a dozen bills. The core of those bills we will talk about later when we get to the Republican substitute.

But if those bills cost $1 trillion, the bills I am for, I would be against those bills. We can’t afford this bill. It cuts Medicare $505 billion. It raises taxes.

There is no estimate I see of people who have estimated the job impact who don’t say that it cuts jobs. Instead, it’s a 2,000-page roadmap to a government takeover of health care.

We could be here today talking about real reforms, medical liability reform, access for everybody regardless of pre-existing conditions. We think you can do that by expanding a risk pool concept. It costs a little money, but it doesn’t cost billions and billions and billions of dollars.

If we could find Medicare savings, Mr. Speaker, we should use those Medicare savings to save Medicare. Only the government would have made a commitment to a program like Medicare, and we know that the Medicare fund is in huge trouble beginning in about 2017, and be here today saying we should make savings from that program to fund a new program. If there are savings in Medicare, we should be using them to save Medicare, Mr. Speaker.

I hope we reject this bill. Even if this bill passes today and doesn’t go further than this, I hope we can work together to do the things we really need to do to reform the system.

Mr. WAXMAN. Mr. Speaker, at this time I yield 1 minute to the gentleman from the State of North Carolina, an important member of our committee, Mr. BUTTERFIELD.

Mr. BUTTERFIELD. Mr. BUTTERFIELD, I thank the gentleman for the time.

Mr. Speaker, later today we will have an opportunity to fix a broken health care system. I have listened to both sides of this debate, I have read everything available, and I have prayed for guidance.

We have an obligation, constitutional and moral, to provide for the general welfare of every American citizen. Allowing a broken health care system to continue to bankrupt families, businesses and hospitals and deny coverage to millions is a failure of duty.

We must act now. Reject the false rhetoric surrounding this debate. Reject the false claims about Medicare coverage reductions. The bill strengthens the Medicare program.

The bill provides healthy and needed competition.

Reject the claim that this legislation will increase the debt. Doing nothing will increase the debt by billions. We should not delay any longer.

I urge my colleagues to vote “yes” on this legislation.

Mr. BARTON of Texas. Mr. Speaker, I see that we have changed from the Jets and the Giants to the Green Bay Packers in the chair.

I would like to yield 1 minute to a Ramblin’ Wreck from Georgia Tech, a member of the Committee on Energy and Commerce, Dr. GINGREY.

Mr. GINGREY of Georgia. Mr. Speaker, having spent most of my life in medicine and healing the sick, I rise in strong opposition to this bill. With double-digit unemployment at 10.2 percent, this so-called reform, which will destroy an additional 5.5 million jobs, is not what the American people want.

Yet their opposition and protests have fallen on deaf ears as this majority has fallen on deaf ears as this majority.

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Yet their opposition and protests have fallen on deaf ears as this majority simply does not seem to care.

One can perhaps see why. Democrats have the White House, 60 votes in the Senate and an 81-seat majority in this House. They have all the power. They can pass government-run health care without one single Republican vote. Mr. Speaker, just because they can doesn’t mean that they do not make it right. With $750 billion in tax increases, $500 billion cuts in Medicare, Mr. Speaker, if the House proceeds down this precarious path, I have no doubt that though the American people may forget what you said here, they will never forget what was done here and who did it to them.

Mr. WAXMAN. Mr. Speaker, I yield for the purpose of a colloquy to the chairman of the subcommittee, Mr. PALLONE, 1 minute.

Mr. PALLONE. Thank you, Chairman WAXMAN.

The bill we are debating today includes the CLASS Act, a bill I sponsored, along with Representative Dingell, which would encourage individuals to plan ahead for future long-term care needs. But there are other things we can do to help increase the availability of home and community-based services. The Empowered at Home Act, H.R. 2688, which I sponsored with Representative DeGette, helps encourage States to improve and increase access to home and community-based services under their Medicaid programs.

While we were not able to include these other provisions from the Empowered at Home Act in H.R. 3962, I hope that we can consider their inclusion in the final health reform bill that emerges from the conference with our Senate colleagues.

Mr. WAXMAN. Mr. Speaker, I want to thank the gentleman from New Jersey for his leadership on the bill before us today and for his tireless efforts on behalf of low-income Americans who need long-term care. I support the elimination of barriers to the provision of home and community-based services under Medicaid, a result that the gentleman’s Empowered at Home Act would achieve.

The SPEAKER pro tempore (Mr. WAXMAN). Mr. Speaker, I yield the gentleman an additional 30 seconds.

Mr. WAXMAN. I yield the gentleman an additional 30 seconds.

I will continue to work with you and other Members to enact legislation that gives State Medicaid programs a robust option for offering low-income Americans the choice of receiving long-term care services in the community rather than in a nursing home.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the gentlewoman from Missouri, who represents the hometown of Rush Limbaugh, Cape Girardeau, Missouri, Congresswoman Jo Ann EMERSON.

Mrs. EMERSON. Mr. Speaker, this couple have been a great day in the House of Representatives, but we have missed an opportunity for consensus, to improve access and save money for
taxpayers and patients alike. Americans pay the highest prices for prescription drugs in the world and this bill binds us to that fate.

For every Member of Congress, there are two and a half pharmaceutical lobbyists. In the first half of 2009, drug companies spent $609 million every day on lobbying. We have missed an opportunity to tell the drug companies that they no longer set the agenda in Congress.

We have missed an opportunity to put the interests of Americans ahead of special interests. We have missed an opportunity to end the pill-splitting, skipped doses and unfilled prescriptions that plague Americans who can’t afford the medicine their doctor prescribes.

This bill shifts those costs from patients to taxpayers, from this generation to the next. It trades affordable generics for pricey name-brand name drugs. It intentionally makes quality care more expensive for our Nation, and it is wrong to leave hundreds of billions in savings on the table.

Mr. WAXMAN. Mr. Speaker, I am pleased to yield 1 minute to a very important member of our committee, the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN).

Mrs. CHRISTENSEN. Thank you, Mr. Chairman.

Mr. Speaker, as a family physician who practiced for more than 20 years, a mother and an American, I am proud to stand here in support of the Affordable Health Care for America Act. This bill is for the many patients I know who put off health care until it was too late because they couldn’t afford it and the tens of millions like them who will now have access to full health care.

This year and every year past, over 80,000 African Americans died, whose deaths were preventable, because they were unable to get health care. This bill is for all people of color, those in our rural areas, the territories and the poor, because beyond insurance, this bill will provide the services some of them never had.

H.R. 3962 will give young people for whom a health care professional is out of the reach the opportunity to help heal their communities. It will cover 36 million uninsured people, making insurance secure and affordable, strengthening prevention and public health, improve Medicare and Medicaid, help poor communities, create an environment that supports good health, and finally begin to eliminate health disparities.

Today we have the opportunity to vote for health and a better life for everyone in this country and for a better country where life, liberty and the pursuit of happiness is truly a right for all.

Let’s make history together. Vote “yes” for affordable health care for America.

Mr. BARTON of Texas. Mr. Speaker, I recognize one of my ranking subcommittee members, Mr. RADANOVICH, who represents Fresno, California, for 1 minute.

Mr. RADANOVICH. Mr. Speaker, we are standing on the precipice of a major shift in this country’s history. In less than a year, the President and Congress, with the Pelosi Congress, has recklessly spent taxpayer funds to expand government to a level never before seen in history.

The government is now more involved in our lives than I think any of us could have imagined. The result has been double-digit unemployment for the first time since the early 1980s. And now we are going to vote on whether the government should take over the Nation’s health care system at a cost of $1.3 trillion and up to 5.5 million jobs.

Despite all this, the leadership of this Congress has chosen to ignore the will of the people and say, America, you are wrong. We know what’s best for you. Well, this is not what the American people want, and it certainly is not what the doctor ordered for health care improvement.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentlewoman from Illinois (Ms. SCHAKOWSKY), a senior member of the Energy and Commerce Committee.

Ms. SCHAKOWSKY. This is a great moment in history because today we act to guarantee affordable health care for this and future generations. It is a great day for women. Our bill stops gender rating, preventing insurance companies from charging women 48 percent more than men for the same coverage.

We eliminate preexisting conditions. Being a breast cancer survivor or domestic violence victim will no longer prevent access to care. We require coverage of maternity and well-baby care. We ensure that older women not yet eligible for Medicare can buy affordable coverage.

We improve Medicare. Senior women will be able to afford preventive services like cancer screenings because we eliminate cost-sharing. We close the doughnut hole, so they can afford their medications.

Women need health care reform. They need H.R. 3962.

Mr. BARTON of Texas. Mr. Speaker, I am proud to yield 1 minute to the honorable gentlewoman from North Carolina (Mrs. MYRICK), a cancer survivor.

Mrs. MYRICK. Mr. Speaker, Americans are struggling with health care costs. We all know that. Too many families can’t afford coverage, and small businesses are struggling to find coverage for their employees.

However, this bill does not fix the underlying problem, the cost of health insurance. It is an unprecedented expansion of Federal Government spending that will only dig a deeper hole of debt for generations to come.
In each of these meetings, these men and women have expressed deep concern about the so-called health care reform that has been sponsored by the House majority, the Pelosi bill, and most are opposed. They are worried about the massive federal into large bills, over 2,000 pages long, will affect their doctor-patient relationship, their personal care, and their ability to afford their health insurance. And they are worried with good reason.

H.R. 3962 is a toxic-mixture of job-killing higher taxes, rampant new mandates on businesses and individuals of all ages and damaging Medicare cuts, combined with a government takeover of health care.

It demands opposition on so many grounds: First, according to the Congressional Budget Office, H.R. 3962 will cost at least $1.2 trillion over the next ten years! This is mind-boggling, on top of earlier borrowing and deficits!

To pay for this massive new spending, Speaker Pelosi wants to raise taxes and cut Medicare, the older Americans depend on.

My colleagues, we heard the grim news yesterday that unemployment currently is at a 26-year high—10.2 percent. (And we know it’s actually higher.) And yet, this bill contains $735 billion in new taxes!

Using the formula developed by the chief White House economic advisor, 5.5 million Americans could lose their jobs as a result of enactment of the Pelosi Health Care bill.

$735 billion in new taxes

Among the new taxes is a new “surtax” on high-income filers—many of whom are small business men and women.

While this tax is intended to target “high-income” couples, it is not indexed for inflation, meaning it will reach millions more New Jersey residents over time just like the Alternative Minimum Tax.

H.R. 3962 also includes taxes on individuals who do not purchase government-mandated health insurance.

Think about this! You do not make enough money to afford health insurance and this bill will be able to contract with entities such as commercial fishing organizations or others to facilitate the dissemination of information?

Mr. WAXMAN, the answer is yes.

Mr. FRANK of Massachusetts. I thank the gentleman. I assume this bill is in line with our concern to work with the Small Business Administration on this sort of outreach and education?

Mr. WAXMAN. Yes. The bill ensures the commissioner will work with the Small Business Administration.

Mr. FRANK of Massachusetts. I thank the chairman for clarifying these points.

Section 2229 of the Senate bill recognizes the unique health care educational outreach needs of commercial fishermen, farmers and ranchers, and I hope that that will be accepted in the final bill.

Mr. BARTON of Texas. Mr. Speaker, I am proud to yield 1 minute to the gentlewoman from Pennsylvania (Mr. Pritzl), one of the strong pro-life leaders in the U.S. Congress, a combat veteran of Vietnam, and a member of the Energy and Commerce Committee.

Mr. PITTS. Mr. Speaker, there has been some recent confusion surrounding the inclusion of abortion coverage in H.R. 3962, but the issue is actually quite clear. The Capps amendment in the bill, which some have argued is neutral on abortion, explicitly authorizes the Federal Government to directly fund elective abortions using Federal funds drawn from a Federal Treasury account. The provision has been billed as a so-called compromise amendment. But this bill will radically expand current and longstanding Federal policy with respect to abortion.

Currently, there is not a single government health care program that provides coverage for elective abortion; not SCHIP, not Medicaid, not DOD, Indian Health or the Federal Employee Health Benefit Program, all because of congressional action to explicitly prohibit coverage of abortion under each of these programs. But such an explicit exclusion is missing from this bill.

Therefore, I urge my colleagues to support, when it comes up later, the Stupak-Pitts-Smith-Ellsworth-Dahlkemper-Kaptur amendment that would prevent Federal funding of abortion in this bill.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentlewoman from Florida (Ms. CASTOR), a member of our committee.

Ms. CASTOR of Florida. Mr. Speaker, Democrats will now deliver on what American families and businesses have been asking for when it comes to their health: one, meaningful, secure and stable insurance; two, improved Medicare for seniors; and, three, vital consumer protections.

For families with health insurance, health reform will provide you with coverage you can count on. Families will no longer have to worry about insurance companies canceling their coverage because someone in their family gets sick. Health insurance companies will no longer be able to bar you from insurance just because you have diabetes or cancer or some other chronic condition.

American families have been doing everything right. They have been paying their copays and paying their premiums, even as those costs have risen dramatically. Our health bill says that in return, that coverage must be meaningful, stable and secure. And for our family members who rely on Medicare, you will see immediate improvements, in your prescriptions, your checkups, and a provision I worked on, to penalize unscrupulous practices of private Medicare insurance sales agents.

The meaningful health reform that will pass the House today builds on the great legacies of Social Security and Medicare, and I am proud to represent from the families and small business owners.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the gentlewoman from Wyoming (Mrs. LUMMIS), who represents the entire State.

Mrs. LUMMIS. Mr. Speaker, I stand before you today on behalf of the people of Wyoming, where individual freedom and personal responsibility are hallmark values.

This $1 trillion tax-everybody-right-down-the-wheelchair, debacle will impact every person in Wyoming. This bill will force my constituents to buy insurance, whether it makes sense for them or not. This bill will dump some of my constituents into a government-run health care program to which Members of Congress will not even subject themselves.

I sought an amendment that would allow States to shield their citizens from government-forced insurance, from unfunded mandates on States. But my amendment and dozens of others were swept away by the majority, and American freedoms right along with it.

Our Constitution was designed to empower the American people and shackles the Federal Government. This bill will shackle the American people while empowering the Federal Government. It is a sad day for Wyoming, Mr. Speaker.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

THE SPEAKER pro tempore. The Chair will remind all persons in the gallery that they are guests of the House and that any manifestation of approval or disapproval of proceedings or other audible conversation is in violation of the rules of the House.

Mr. WAXMAN. Mr. Speaker, I am pleased to yield 1 minute to the gentleman from Pennsylvania (Mr. PATRICK J. MURPHY), who has been a leader in our efforts to lower growth in premiums through measures such as immediate review and justification of insurance rate increases.

Mr. PATRICK J. MURPHY of Pennsylvania. Colleagues, voting “yes”
today means tax incentives for Joe Frederick, a small business owner in Bucks County, Pennsylvania, who struggles with skyrocketing health care costs for his employees. It is a vote for Mrs. St. Clair, whose niece died because she couldn't get insurance for; or for Jay Dobrow, who was kicked off his plan after being diagnosed with Lou Gehrig's disease.

I urge a "yes" vote for our fellow Americans who want to secure affordable health insurance which can't be taken away from them when they need it most.

Sixteen years have passed since we last tried to reform health care. Premiums have more than doubled. Every day in the State of Pennsylvania, 510 families are kicked off their coverage. That is every single day.

Mr. Speaker, as I said, I am a proud Blue Dog Democrat, and there is universal agreement that to get our country's fiscal house back in order, we must first get our health care spending under control. And this bill does just that. It actually reduces our deficit by $129 billion, taking important steps to rein in health care costs.

But there is more work to be done, and I look forward to working with you and our leadership to accomplish this goal.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. WAXMAN. Mr. Speaker, I yield the gentleman an additional 10 seconds.

Mr. BARTON of Texas. If the gentleman would permit, I want to thank you for your leadership, and assure you we are going to continue to work in conference to do everything we can to make coverage affordable for the American people.

Mr. PATRICK J. MURPHY of Pennsylvania. Mr. Speaker, I rise in opposition to this bill.

Mr. BARTON of Texas. I would like to recognize the gentleman from Virginia, Congressman FRANK WOLF, for a unanimous consent request.

Mr. WOLF asked and was given permission to revise and extend his remarks.

Mr. WOLF. I rise in strong opposition to the bill because our Nation is going broke.

We must carefully weigh the implications of a costly new government spending program at a time when the country already owes more than $56 trillion in entitlement obligations.

I am also deeply concerned about the national debt, which has increased since 2000 and is nearing $12 trillion for the first time in our history.

Any plan put forward must control costs, not add billions of dollars to an already ballooning deficit.

America is going broke. Is this the legacy this Congress wants to leave our children and grandchildren?

"Health care is a very personal issue and there are very real consequences to what Congress does on this issue. Congress must be committed to offering affordable, accessible, and portable health care choices with the goal of fixing what's broken and keeping what works. I know there are good and reasonable people with deeply held views on every side of the health care reform issue. That's why I believe all sides need an opportunity to be heard and offer ideas so that a bipartisan consensus can be reached."

"I believe every fair-minded person would agree that Congress needs to find a way for those millions without health insurance to be assured of quality, affordable health care when they need it and to address
deficit; how to ensure that U.S. taxpayers are not subsidizing health insurance for those illegally in our country; how to ensure that the self-employed and small business owners have insurance, and how to ensure that young adults can continue to be carried under their parents’ health plan until they reach age 25.

There are concerns about a government-run insurance option and what that will mean in the way of costly mandates for small businesses and employers during a time when unemployment is teetering near 10 percent. I am also concerned about how Americans will pay for a $900 billion plan as our country heads out of an economic recession and faces trillions of dollars in debt and a growing annual deficit that could be near $2 trillion. I also have questions about the half trillion dollars in savings in Medicare and Medicaid costs. What will that mean for senior citizens today?

I must carefully weigh the implications of a costly new government spending program at a time when the country already owes more than $56 trillion in promised entitlement obligations through Medicare and Social Security. I am also concerned about the national debt, which has doubled since 2000 and is nearing $12 trillion for the 118th time in our history, and unprecedented federal deficits, which could result in increased interest rates for consumers if we continue to finance government by borrowing from foreign lenders. I have the leading bill in the House to establish a bipartisan commission to review entitlement spending with tax policy on the table to ensure that Congress addresses these spending issues, which if left unchecked, will be disastrous for future generations. (For more information about the SAFER Act, please go to www.wolf.house.gov/SAFE.)

I again want to emphasize: it is important for Congress to fix what’s broken with our nation’s health insurance system. But we have to do it the right way without changing what is working. We need a plan that controls costs without adding billions of dollars to an already ballooning deficit; ensures competition and choice; provides that patients and their doctors make the decisions on medical care rather than a government-run agency; addresses skycracking medical liability costs and tort reform.

I believe that the legislation in the House falls short of these goals and that Congress has a lot more work to do to provide the kind of health reforms Americans want and need.

Mr. BURGESS. I thank the gentleman from Texas, Mr. Speaker, I yield 1 minute to the former FBI man from the great State of Michigan (Mr. ROGERS), a member of the committee.

Mr. ROGERS of Michigan. Mr. Speaker, there are huge consequences to the 85 percent of Americans who have government health care. This bill. Not only will they get longer wait times and more expensive premiums, but at the end of that, with new debts, some $1.5 trillion in new spending, 18 million Americans won’t have coverage. But more importantly, there will be discrimination.

There is nothing more sacred than the bond between a mother and a child, that trust, that love, that nurturing when that child is sick. And when a mother goes to the doctor under that $2,000 in bills the relation can suffering, they enjoy between their patient and their doctor and what that mother wants for that child is no longer assured, because now, through the 118 different boards and commissions, their comparative effectiveness research allows the Federal Government, through forced government insurance, to ration and deny care. You have violated the most important trust, the most important thing that have in the building block and the foundation of the values of this country. That mother, that doctor knows what’s best for that child. You will find no compassion in a Federal bureaucracy.

Mr. Speaker, I would urge the strong rejection and the protection of that bond between doctor and patient and mother and child.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentleman from Colorado (Mr. SALAZAR).

Mr. SALAZAR. Mr. Speaker, I am especially pleased that this bill will help rural America. Currently, physicians in rural areas are reimbursed less from Medicare than their urban counterparts. It makes rural care physicians in rural areas 10 percent more than the urban physicians not only to equalize the disparity, but to make rural communities more attractive to physicians.

Most of the care that is considered a health professional shortage area. In my district in Colorado, we have three counties with only one practicing physician. We have one county with none at all. This bill will increase the number of physicians in my counties and improve access for 106,000 Medicare beneficiaries.

This bill will expand insurance coverage to 111,000 currently uninsured residents in my district. In my district, it will protect 900 families from going bankrupt due to excessive health care costs. It will help 184,000 low-income families pay for their insurance.

Our current system is broken, and it is time to fix it now. Mr. Speaker, I thank the gentleman from Texas, Mr. Speaker, I yield 1 minute to the gentleman from the Pelican State, Congressman SCALISE from New Orleans, a member of the committee.

Mr. SCALISE. I want to thank the ranking member from Texas for yielding.

I rise in opposition to Speaker PELOSI’s 1,990-page government take-over of health care. Weighing in at nearly 20 pounds, this bill comes out to a cost of over $2,000 for each American per page. And where does this bill spend that money? Well, first of all, it falls the American people. It falls those small businesses and families that are going to have to pay the $730 billion in new taxes in this bill. It falls our seniors who have to deal with over $500 billion in cuts to Medicare. And it falls many of President Obama’s own pledges and promises he made right here on this floor, like when he said, If you make less than $250,000 a year, you won’t pay any new taxes. In this bill, there is over $20 billion of new taxes just on people who have no insurance. The President has said multiple times, If you like what you have, you can keep it. Unfortunately, this bill fails the President’s promise because it allows the health care czar to take away your insurance even if you like it. It’s so bad, that even when we brought our amendment to say all doctors, nurses, and other health professionals would be able to opt out of this bill, they actually refused to allow a vote on that amendment.

We need to defeat this legislation and do real reform.

The SPEAKER pro tempore. The Chair would announce that the gentleman from Texas has 11½ minutes remaining, and the gentleman from California has 6½ minutes.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentlewoman from Ohio, BETTY SUTTON, a member of our committee.

Ms. SUTTON. Mr. Speaker, the American people have been waiting for this day, a day that we will finally pass a health care bill that will work for us. I was not listening with access to more affordable quality care, care that they can count on.

Mr. Speaker, they have been waiting for us to put an end to the egregious discriminatory practices of insurance companies who deny them coverage on preexisting conditions and place caps on coverage to prevent people from accessing the care they need just when they need it the most.

Today we act to improve the employment-based coverage for 200,000 residents in my district, to improve Medicare for 107,000 beneficiaries, and to move to close the prescription drug doughnut hole for seniors across this country.

Yes, Mr. Speaker, the American people have been waiting, and today we act for a health care system that will work for and with them.

Mr. BARTON of Texas. Mr. Speaker, could I ask how much time. You said it a minute ago, but I was not listening.

The SPEAKER pro tempore. The gentleman from Texas has 5⅕ minutes remaining.

Mr. BARTON of Texas. Thank you, Mr. Speaker. I was listening to my distinguished friends on the majority rapidly.

I now yield 1 minute to one of our doctors, physicians, the gentleman from Lewisville, Texas, the Honorable MICHAEL BURGESS, also a member of the committee.

Mr. BURGESS. I thank the gentleman for yielding.

Last spring and summer, as we got into this debate, America’s doctors were pretty clear of what they wanted to see if Congress was going to undertake health care reform. They wanted to see some relief in the medical justice system. They wanted to see some medical liability reform. They desperately needed a fix to the payment formula in Medicare, bearing reductions in Medicare reimbursement rates every year for as far as the eye could see, and they wanted a little help with
Mr. BOUCHER. Mr. Speaker, I rise in opposition to the bill. Health care reform is needed. More than 36 million American citizens do not have health insurance, and millions more are underinsured and cannot afford to pay for the medical care they need. As those without insurance are treated in emergency rooms, the high cost of that care is borne by those who have insurance and, driving up insurance costs for everyone. The typical family pays an extra $1,100 each year in health insurance premiums as a cost of treating the uninsured. Health insurance premiums are increasing 3.5 times as fast as the rate of increase in family incomes.

This status quo is unsustainable, and finding a way for everyone to afford health insurance is necessary to benefit both the uninsured and those who have insurance. I hope that following a House-Senate conference on the legislation, we will be able to send to the White House the needed reform measure.

But reform legislation must ensure that Southwest Virginia residents continue to have access to the high quality health care services now delivered locally.

I oppose the health care reform legislation now before the House for several reasons including the continued existence of disparities in Medicare reimbursements between urban and rural areas under the House bill. Rural areas have traditionally received less under Medicare than urban areas, and while the bill makes some improvements in this regard, I would like to see more done to increase the payments to rural health care providers. Higher Medicare reimbursements would enable the attraction of more doctors to serve our medically underserved region.

I also oppose the bill because of my concern that a government operated health insurance plan could place at risk the survival of our region’s hospitals. Most of our hospitals are operated on a non-profit basis for the benefit of the community. While most of their receipts are from Medicare and Medicaid payments, they lose money on each Medicare or Medicaid patient they treat. These programs reimburse hospitals at rates below the actual cost of providing patient care.

The financial viability of our hospitals comes from the payments they receive from privately insured patients. A government operated health insurance plan competing with private insurance will attract patients who are privately insured today, with the result that the hospitals lose money on each of their patients insured under the government plan.

A government operated insurance plan would reimburse health care providers at rates approximating Medicare rates, and hospitals would lose money on each of their patients insured under the government plan. I am concerned that for these reasons the creation of a government operated insurance plan as envisioned in the House bill could result in the closure of hospitals in our region. Families depend on our community hospitals for health care services, and financially healthy hospitals are essential to the health of Southwest Virginians.

Many of our hospitals are financially stressed in normal times, and two hospitals in...
I am proud to yield 1 minute to the gentleman from the State of Maryland (Mr. SARBANES), a member of our committee.

Mr. SARBANES. Mr. Speaker, every day thousands of people wake up with a knot in their stomach because they have anxiety and fear that they may lose their health care coverage or they don’t have it to begin with. They need this health care bill. We in this Chamber are conscious of the sweep of history, but the people in my district and millions more across the country have a much less ambitious perspective. They just want to know is this a good bill, does it make sense, and will it help them and their families.

Well, if you are a senior, the answer is yes. To begin closing the doughnut hole. If you are a young person, the answer is yes. You can now stay on your parents’ policy through age 26. If you are a working adult, the answer is yes, because we’re going to curb the abusive practices of the health insurance industry.

So what I want to say to people in my district and to others is this is a good bill, it makes sense, and it will help millions of Americans across this country.

I urge its passage.

Mr. BARTON of Texas. Mr. Speaker, I am proud to yield 1 minute to the gentleman from the Hoosier State of Indiana, Mr. STEVE BUYER, another member of the Energy and Commerce Committee, and the ranking member on the ‘Veterans’ Affairs Committee.

Mr. BUYER. Mr. Speaker, in a few days, all of us are going to be going back to our districts. We are going to be celebrating Veterans Day. Many of you are going to be giving speeches. You are going to be throwing your arms around the soldier, the marine, the sailor, the airman, the coast-guardman. Do you throw your arm around them in this bill? You don’t.

And when you go home and you give that speech, you can tap into the American character and you can say, Americans go to a land where they’ve never been to fight for a people that they’ve never met. They do so at no bounty of their own, and they leave freedom in their footsteps. Yet when they get to come home, how does our Congress right now treat them? In this 2,000-page bill, we deny them their rights of choice with regard to the health system which they can go to. Can you imagine that?

Now, I received a pledge not only from the Speaker, but also from the leadership, that veterans would be taken care of in this bill. My amendments were denied last night in the Rules Committee. How do you deny veterans their choice in this bill?

Shame on this institution.

Mr. WAXMAN. At this time, I yield 1 minute to the gentleman from Iowa has the floor.

Mr. BARTON of Texas. Mr. Speaker, I yield myself 1 minute. Before I yield to another very important member of our committee, I just want to set the record straight. We keep faith with the veterans in this bill. We allow them to keep their veterans benefits. We allow them to keep their benefits. They may, if they choose to, go into the exchange; but if they don’t, they keep their benefits.

Mr. BUYER. Will the gentleman yield?

Mr. WAXMAN. I yield 1 minute to the gentleman from Iowa (Mr. BRALEY), a member of the Energy and Commerce Committee.

Mr. BUYER. We do not. Mr. Speaker, we don’t protect veterans’ rights.

The SPEAKER pro tempore. The gentleman from Iowa has the floor.

Mr. BRALEY of Iowa. We thank the chairman for his extraordinary leadership on this bill.

Mr. Speaker, I rise today on the third anniversary of my election to Congress to urge my colleagues to speak truth to fear and vote for the Affordable Choices for America Health Care Act.

We were elected, my class, to come and change the direction of this country. That’s exactly what this bill does.

We just saw a beautiful young child. I want to tell you about another beautiful young child, Tucker Wright, my nephew’s son, who at age 18 months was diagnosed with liver cancer, had two-thirds of his liver removed, and faces a lifetime of expensive medical care. Tucker was lucky because both of his parents work full time. Both of them have health care. And yet he still has tens of thousands of uninsured medical costs that his parents have to pay for.

That is what’s wrong with health care delivery in this country. That’s why we need to reform health care. And that’s why this bill will do for America what we should have done 100 years ago: provide health care for all Americans as a matter of right, not as a matter of privilege. And that’s why I support this bill.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the distinguished ranking member of the Financial Services Committee from the great State of Alabama, Mr. SPENCER BACHUS.

Mr. BACHUS. Mr. Speaker, when I joined the Army, they sent me to Fort Lewis, Washington; and one of the first things we did there was get in line to get our hair cut.

We noticed on the wall there were pictures of four different haircuts, and they told us to choose one of those haircuts, get a number, and give it to the barber.

We thought this was going to be pretty good. So we all gave him that number for the longest haircut. We all gave our numbers to the barber, and he cut all our hair off, every one of us. The numbers meant absolutely nothing.

When we got back to the barracks, we knew who was in charge. We knew who was making the decisions, and it wasn’t us. The Army was making all the decisions.

Just like thinking you’re going to get the haircut you choose, we’re promised the right to choose under this bill. But the reality is, just like the Army, when the government’s in...
charge, you’re not. This bill is about a new government bureaucracy making all the choices for us. We’re Americans. America is about freedom. Freedom is about making choices. And given the choice, I’ll always put my faith in the individual, not the government.

Mr. WAXMAN. Mr. Speaker, I yield 1 minute to the gentleman from the State of California (Mrs. Davis) for the purposes of a colloquy.

Mrs. DAVIS of California. Mr. Speaker, I appreciate the opportunity to raise this issue also on behalf of my colleague from California, Congresswoman SPEIER.

Unfortunately, the provisions in section 309 allowing States to enter health insurance compacts may bring unintended consequences that could threaten long-established patient protections, and I know that that is not the intention.

I certainly plan on supporting this legislation today; but I would ask you for the commitment, Mr. Chairman, to continue working on the language in section 309 to ensure it does not impact strong State consumer safeguards such as we have in California.

Mr. WAXMAN. The gentlewoman would yield, I thank you and I’m encouraged you and your staff have committed to further working on these provisions and not allowing health insurers to find loopholes in State laws.

Mrs. DAVIS of California. Mr. Chairman, I thank you, Mr. Chairman. I look forward to that.

Mr. BARTON of Texas. Mr. Speaker, it is my privilege to yield 1 minute to Congressman FORTENBERRY of Lincoln, Nebraska, which today, since Oklahoma is playing Nebraska at Lincoln, is the largest city in Nebraska.

Mr. FORTENBERRY. I thank the gentleman for the insight.

Mr. Speaker, our health care system must be strengthened. No one disputes the diagnosis. We need to improve health care outcomes for all Americans and reduce costs, especially for small businesses and families, while we protect vulnerable persons.

But this bill is a massive, risky re-structuring of our health care system. Why could there not be agreement on reasonable reforms such as portability of insurance, buying insurance across State lines, and creating new insurance association models for farmers and families, providing affordable options just like corporations have?

I agree we should promote a health care culture that focuses on wellness and prevention, removes lifetime caps, and expands high-risk pools to help those with preexisting conditions. However, I fear that this 2,000-page bill at $1.3 trillion will fail to reduce costs, would simply shift the costs to more government-run health care and reduce health care choices.

Mr. Speaker, what is at issue now is winning and power, not effective, reasonable reforms. We’ve missed an opportunity. I cannot support this bill.

Mr. WAXMAN. Mr. Speaker, I reserve the balance of my time.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the gentleman from Lubbock, Texas, a recent beneficiary of the best health care system in the world, Congressman RANDY NEUGEBAUER.

Mr. NEUGEBAUER. Mr. Speaker, I rise today as a proud cancer survivor. August 1 of this year, I was diagnosed with the early stages of prostate cancer. No one could have known that I live in America and I was able to sit down with my doctor and work out a treatment plan that would help me be cancer free and stand before you today. Thank goodness that I live in a country where I could go and see my doctor and make choices. Thank goodness I live in America where I didn’t have to get on a list to determine when I was going to be able to have the surgery so that I could get rid of this cancer. Thank goodness I’m not living in Canada.
Supermajorities, more than 67 percent, oppose public funding of abortion. Protecting vulnerable unborn children and women from the insidious violence of abortion is the human rights cause of our time.

So please let’s not gloss over or trivialize the fact that abortion dismembers, decapitates, starves to death, or chemically poisons innocent babies, and that the abortion act itself, euphemistically called “choice,” can in no way be construed to be compassionate, benign, nurturing, or health care. Abortion is violence against women and children. It is neither health care nor reform.

Support the Stupak-Pitts amendment.

Mr. WAXMAN. Mr. Speaker, I continue to reserve the balance of my time.

PARLIAMENTARY INQUIRY

Mr. BARTON of Texas. Mr. Speaker, I have a parliamentary inquiry.

The SPEAKER pro tempore. The gentleman from New York (Mr. RANGEL) has 40 minutes and the gentleman from Michigan (Mr. CAMP) has 40 minutes.

The Chair recognizes the gentleman from New York.

Mr. RANGEL. Mr. Speaker, I would like to take this time to recognize the gentlewoman from Florida (Ms. WASSERMAN SCHULTZ) for 1 minute.

Ms. WASSERMAN SCHULTZ. Mr. Speaker, 37 million Americans do not have health insurance because they can’t afford it, their employers do not offer it to them, or they have a preexisting condition and the insurance companies deny it to them. We want them to buy the same policies that politicians and the lawmakers have talked about in such glowing terms, available to them and their families. Don’t say “no” to 37 million Americans and tell them they have freedom. They don’t have freedom to go bankrupt. In a country where people should not be forced into bankruptcy when they get sick, let’s let people buy private insurance or a public option and get coverage.

The SPEAKER pro tempore. The gentleman from New York (Mr. RANGEL) has 40 minutes and the gentleman from Michigan (Mr. CAMP) has 40 minutes.

Mr. BARTON. Mr. Speaker, Mr. Speaker, since I have been age 5, I have spent at least 90 days in Canada, there might never have been a chest pain; 48 hours later, he was given permission to revise and extend his remarks.

Mr. BARTON. Mr. Speaker, first of all, I am proud to be a member of the Energy and Commerce Committee.

Mr. WAXMAN. Mr. Speaker, I yield myself the balance of the Energy and Commerce time.

(Mr. BARTON of Texas asked and was given permission to revise and extend his remarks.)

Mr. BARTON. Mr. Speaker, first of all, I am proud to be a member of the Energy and Commerce Committee on both sides of the aisle who have participated in this debate since January, and who have participated on the floor debate today. It makes me proud to be a member of that committee.

Mr. Speaker, we have heard all of the policy arguments pro and con for this bill. I am going to end the Republican side of the Energy and Commerce debate simply by saying that I think this bill should be defeated because it is an imposition on personal freedom here in America. I just simply don’t think that it is right to tell people that they have to have insurance, tells employers they have to provide insurance, to set up a bureaucracy that advises a bureaucracy that what that insurance should be, that then determines what the insurance itself should be, what the minimum premium should be, what has to be covered, and then over time almost guarantees that everybody, except the richest people in America, are in some version of the public option.

I just think that is wrong in America, Mr. Speaker, and for that reason alone I am against this bill.

There is an alternative. The Republican alternative covers many of the things that my friends on the majority side say they are for. We simply do it without mandating and imposing government on the American people. Please vote “no” on the majority bill, and vote “yes” on the minority substitute.

Mr. BARTON of Texas. Mr. Speaker, I would like to recognize a Member from the great State of Georgia (Mr. KINeSTON) for 1 minute.

Mr. KINGSTON. Mr. Speaker, in January, with unemployment at 8.5 percent, Speaker PELOSI passed an $800 billion pork-laden stimulus bill that was supposed to create jobs. In May, with unemployment up to 9.5 percent, Speaker PELOSI passed an energy tax of $1,500 billion in taxes. The American people that was supposed to create green jobs. Now in November, unemployment is up to 10.5 percent, we have the highest deficit in the history of the country, a $12 trillion national debt, and Speaker PELOSI wants to impose a government takeover of insurance.

This bill raises premiums. It raises taxes. It cuts Medicare, and it forces you to surrender your current health care coverage and puts a thousand bureaucrats in between you and your doctor.

The government couldn’t even run cash for clunkers, and now it wants to take over 17 percent of the economy. Let’s vote “no” on the Pelosi plan and support the Bipartisan alternative.

Mr. BARTON. Mr. Speaker, I yield myself the balance of the Energy and Commerce time.

Mr. WAXMAN. Mr. Speaker, I yield myself the balance of the Energy and Commerce time.

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Mr. KINGSTON. Mr. Speaker, in January, with unemployment at 8.5 percent, Speaker PELOSI passed an $800 billion pork-laden stimulus bill that was supposed to create jobs. In May, with unemployment up to 9.5 percent, Speaker PELOSI passed an energy tax of $1,500 billion in taxes. The American people that was supposed to create green jobs. Now in November, unemployment is up to 10.5 percent, we have the highest deficit in the history of the country, a $12 trillion national debt, and Speaker PELOSI wants to impose a government takeover of insurance.

This bill raises premiums. It raises taxes. It cuts Medicare, and it forces you to surrender your current health care coverage and puts a thousand bureaucrats in between you and your doctor.

The government couldn’t even run cash for clunkers, and now it wants to take over 17 percent of the economy. Let’s vote “no” on the Pelosi plan and support the Bipartisan alternative.

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force millions of Americans to give up their current health care coverage.

With the national unemployment rate spiking to 10.2 percent, it should be unthinkable to pass this bill which contains more than $730 billion in taxes that will deny millions more American jobs. The Democrats’ bill cuts Medicare by one-half trillion dollars, slashing health care benefits for seniors, a direct violation of the President’s pledge that Americans could keep what they have if they like it.

This bill, laden with an unpaid-for SGR fix, increases the deficit, a violation of the President’s pledge that health care reform would not add one dime to the debt. The Democrats’ bill drives up the cost of health care and increases Federal spending on health care by $600 billion, a violation of the President’s pledge that health care reform would bend down the cost curve.

So you can keep what you like if you like it. The bill spends over $1 trillion while raising taxes, cutting Medicare and increasing the deficit, and it drives up the cost of health care. The Democrat majority has not listened to the American people. Vote “no” on this bill.

Mr. RANGEL. Mr. Speaker, I would like to recognize the distinguished gentleman from Georgia (Mr. SCOTT) for 1 minute.

Mr. SCOTT of Georgia. Mr. Speaker, today the arc of history will hover over this House of Representatives, and the question facing each and every one of us today as 14,600 of our American citizens are losing their insurance every day is: where are we going to stand on this arc of history today? I ask you, are you going to stand with the negative forces of “no” or “kill the bill” or “I object”? Or are we going to stand with the hope of America that has been expressed all of the way down from Teddy Roosevelt to Dolan to Harry Truman to Lyndon Johnson to Ted Kennedy, and to John Dingell?

I say to you today, this House of Representatives, stand up and say I am not afraid of the future because the key to our future is to make sure that all Americans have access and have affordable health care insurance. That’s what the American people are expecting us to do, to stand up for America.

Mr. CAMP. I yield to the gentleman from California for a unanimous consent request.

(Mr. ROHRABACHER asked and was given permission to revise and extend his remarks.)

Mr. ROHRABACHER. Mr. Speaker, I oppose this bill that will take hundreds of billions of dollars out of Medicare and give billions of dollars of health care to illegal immigrants.

Mr. Speaker, this attempt at siding Americans into dependence on a government-controlled health care system brings bait and switch to a new low.

We have heard about the flaws of our current health care system, high costs, lack of portability, lose a job—lose health insurance, discrimination of those with preexisting conditions. Yes, many of the heart-wrenching stories we are hearing to justify this legislation are real. But correcting those maladies requires specific reform, not transforming the health care system into a bureaucratically-managed system that will cost hundreds of billions, including billions to provide healthcare for illegal aliens, while at the same time cutting Medicare by hundreds of billions of dollars. This so-called reform will destroy the freedom of the American people to make health decisions with a doctor of their choice. It will transform our system, rather than reform it. And what will we end up with is a system that is massively more expensive, less effective, and will be based on government controls and rationing, rather than the patient-doctor relationship.

You can touch our hearts with the stories of suffering brought about by defects in our current system, but it doesn’t follow that we have to buy into this monstrous federal power grab. It is too benign to call this scheme bait and switch.

Wake up America!! This bill cuts health care for our seniors by hundreds of billions of dollars while providing subsidized health care of illegal immigrants, which will draw in more illegals into our country.

Wake up America!! This bill is structured so that private companies will find it profitable to dump employees into the government-run option, rather than continuing to offer private health insurance.

Wake up America!! This ill-conceived power grab will bankrupt our country as it destroys our freedom.

Mr. CAMP. Mr. Speaker, I yield 2 minutes to a distinguished member of the Ways and Means Committee, a true American hero, the gentleman from Texas (Mr. SAM JOHNSON).

(Mr. SAM JOHNSON of Texas asked and was given permission to revise and extend his remarks.)

Mr. SAM JOHNSON of Texas. Mr. Speaker, today we are voting on Speaker Pelosi’s $1 trillion Wash-ington takeover of health care. This bill bulldozes individual liberty and puts the government just where it doesn’t belong, right smack dab in the middle of your personal health care decisions. This bill forces every single person in this country to purchase government-approved health care or go to jail. Businesses must also offer government-approved health care or face huge fines.

Unfortunately, government-approved health care will be defined by a handful of bureaucrats around a conference table in Washington. This unprecedented Washington power grab eliminates an individual’s right to choose what kind of health care is best for them and their families.

Speaker Pelosi’s 20-page bill costs $2.2 million per word. The American public have made their voices heard. They are sick and tired of the government sticking its nose where it does not belong. They are fed up with Washington’s trillion-dollar bailouts, free handouts and special interest paybacks.

The Democrats in Congress need to listen and come up with a bipartisan, patient-centered plan. We can do better with a targeted, fiscally responsible approach that makes health insurance more affordable, more accessible, and available. Real health reform protects our right to buy into their own care. Real health reform gives doctors the freedom to do what is best for their patients. We can do all of this without piling trillions of dollars of debt onto our children and grandchildren.

Wake up America!! This bill forces millions of Americans to give up their current health care coverage.

Mr. RANGEL. Mr. Speaker, I would like to recognize my friend and colleague, the outspoken Member from New York, Mr. NADLER, for 1 minute.

Mr. NADLER of New York. Mr. Speaker, I have spent much of my adult life fighting for greater health care rights and for universal health care coverage. This historic bill goes a long way toward achieving those goals.

Around the country, we see millions of people with inadequate or no coverage. Families go to sleep at night knowing that they are one serious illness away from bankruptcy. And the unemployed are people who face going it alone in the prohibitively expensive individual coverage market or, worse, going without insurance at all.

While I would have preferred a single-payer system, I am happy to support a bill that contains a public health insurance option that will provide competition to the private insurance companies and will drive down rates.

This bill will end discrimination against people with preexisting health conditions, will end the practice of dropping patients when they are sick, and will strengthen and enhance Medicare by ending the doughnut hole and extending the solvency of the Medicare Trust Fund.

Mr. Speaker, the status quo is not an option. We have an opportunity to get universal health care coverage in this country to implement the competitive public health insurance option that puts the patient before the quarterly financial report, and to ensure that just because you lose your job, you won’t lose your health insurance.

This is monumental and historic, and I am proud to support the Affordable Health Care for America Act.

Mr. Speaker, I have spent much of my adult life fighting for greater health care rights and universal health coverage. This historic bill, H.R. 3962, makes great strides toward achieving those goals.

Around the country, we see millions of people with inadequate or no coverage, with another 14.6 million joining the ranks of the uninsured each day. We see families who go to sleep at night knowing they are one serious illness away from bankruptcy, the reason...
for 55 percent of all bankruptcies filed last year. We see the rising ranks of the unemployed who face going it alone in the prohibitively expensive individual coverage market—or worse, going without insurance at all. And we see 20,000 people die every year because they have no health insurance.

At the same time that this stark reality hits hardworking Americans, insurance companies have conspired to keep costs high. These costs, upward of 15–35 percent squandered on outrageously high administrative costs, do nothing to make people healthier but do much to line the pockets of insurance companies and help their corporate bottom line.

This is unacceptable. We must take action. That's why I support the Affordable Health Care for America Act.

As with any legislation, there have been some compromises made along the way. I would have preferred a single payer system, the most effective and least costly way to implement a health delivery system. But I, like so many of my colleagues, have come to see a competitive public option as the best available way to bring needed health care reform.

A public option will put patients and doctors, not corporate bottom lines, at the forefront. This public option will add much needed competition into an insurance market that must be kept honest, and it will work to end game playing and saw the public option for what it is—an option, not a mandate, that will help stem the cost of ever-rising health care costs.

In addition to the public option, this national health reform bill implements key insurance industry reforms, strengthens Medicare, and immediately gives hope to the millions of Americans currently living without health insurance. It will end discrimination against pre-existing conditions, and end the cruel practice of rescission, which allows insurance companies to drop people from coverage if their illness is considered too expensive. This bill also guarantees that people with insurance will not face devastating costs when they get sick by placing limits on out-of-pocket medical expenses, and for the first time ever by mandating long-term care.

H.R. 3962 would end the blanket exemption insurance companies currently enjoy from anti-trust laws. With this change, we can now bring anti-trust enforcement against the egregious practices of price fixing, market dominance, and all.

H.R. 3962 contains numerous provisions that help our seniors by strengthening and enhancing the Medicare program. This bill reduces the donut hole to $500 immediately and eliminates it entirely by 2019. It allows the HHS secretary to negotiate prescription drug costs, which I have long advocated for. It eliminates out-of-pocket expenses for preventive care for seniors, and extends the solvency of the Medicare trust fund for at least five years.

Small businesses also receive desperately needed assistance from this bill. Initially, businesses with up to 25 employees, then growing to businesses with up to 100 employees by 2015, will be able to join the health exchange, which will allow small business employers to take advantage of group rates and a broader range of insurance options. For small businesses, this policy change that will go a long way toward helping small businesses keep down their number one expense, which is the cost of providing health care coverage.

For America's young people, who make up 29 percent of the uninsured in America, H.R. 3962 will permit parents to extend coverage to their children until their 27th birthday. To help American families defray the costs of health coverage, this bill extends assistance on a sliding scale to families earning up to $88,000 per year. This will go a long way toward ending the cruel choice between health care coverage and other necessities.

Mr. Speaker, there are some who have said that health care reform is too hard. There are those who have allowed misinformation and politics to push them to root against helping their fellow Americans to have access to quality, affordable health care. There are even those who, for reasons I fail to grasp, want to continue with the status quo.

To those people, Mr. Speaker, I say—the public option weathered the storms of misinformation, slander, and downright lies because the American people saw through the political game playing and saw the public option for what it is—an option, not a mandate, that will help stem the cost of ever-rising health care costs.

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and impact. It will help pay for care in hospitals. If hospitalization is unnecessary, it will help pay for care in nursing homes or in the home. And wherever illness is treated—in home or hospital—it will also help all Americans.

My friends we can all say that about this sweeping legislation. Madam Speaker, while some of us have heard the story of patients and their families. Oppose this bill I know otherwise. Today, I met with dozens including physicians, medical students, patients, and advocates. This group included representatives from Doctors for America, National Physicians Alliance, American Medical Student Association, US PIRG, Disciples of Christ, Episcopal Church, NETWORK—a Catholic Social Justice Lobby, United Church of Christ, and United Methodist Church along with a nationally renowned cardiologist Dr. Salim Aziz of the George Washington University Medical Center.

The health providers with whom I met are on the front lines of the health care debate every day. As such, it is no surprise that they enthusiastically endorse this bill, while holding out hope for progressive changes to health care reform legislation before it becomes law. These health professionals see the pain and frustration of hardworking Americans who face financial collapse, physical suffering, and sometimes the loss of their life simply because they do not have health coverage.

Allow me to share with you some of the stories that I’ve heard from these care givers. One story was that of Dr. “Alex,” a pediatrician and Health and Evidence Policy Fellow at Mt. Sinai School of Medicine. Dr. Alex told me of an eight-year-old boy who had a swollen face, a rash on his forehead and cheeks, and raw in his neck folds. He sat before him and scratched his arms, trunk, and face uncontrollably to the point of bleeding. Because of his constant scratching his skin had started to harden. He inquired how his mother told him in tears how she had not been able to obtain a referral to a dermatologist. The county pediatric dermatologist’s one afternoon a month clinic time was that same day. To prevent the patient’s mother from receiving a large medical bill, Dr. Alex did what he normally did; he got on the phone to her private insurance company and asked the insurance bureaucrats to agree to pay for the visit. As his other patients had to wait for him, he wasted time on the phone trying to solicit preapproval from her insurance company. But he could not succeed. He inquired what his patient does not have to worry whether their insurance company will pay for it. An insurance bureaucrat sitting in their cubicle should play no part in the relationship between me and my patient. We need to reform our system.

Today is a historic day not only for the 39 million uninsured Americans, but also for our great Nation. As Speaker PELOSI remarked earlier today, we, Members of Congress, are “humbled to stand here at a time when we can associate ourselves with the work of those who passed Social Security, those who passed Medicare, and now we will pass health care reform.” Many parallels exist between that history and today. Today, we listened to a parade of Republicans warn that this bill will bring the downfall of American society, of the American way of life. This is not the first time that the Republicans have been on the wrong side of history. In an interview in 1975, David L. Kopelman, who played a prominent role in the early administration of the Medicare Program, remarked that his colleagues were often critical of the system and termed these proposals “communist schemes.” He called them “false designations all too liberally applied to anyone with a progressive idea. Well, after all, when we went around making contact with employers in those early years that was the designation not delicately applied by many, if not most of them, to the social security program. As it became conscious scheme foisted on the American people.” Alf Landon, the Republican candidate for President in 1936, even campaigned on the fact that not a dollar in social security benefits would ever be paid.

Mr. Speaker, unfortunately, such ad hominem attacks are as prevalent as ever. The Republicans want you to believe that our country is descending into an abyss of socialism, but nothing could be further from the truth. Today, I am proud to support a bill that is distinctly American. We the people, Thomas Jefferson wrote in the Declaration of Independence are endowed “with certain unalienable Rights that among these are Life, Liberty and the pursuit of Happiness.” That to secure these rights our forefathers are instituted among Men, deriving their just powers from the consent of the governed. I believe that it is no coincidence that life is listed first—for without it, the Founders realized, no other rights can be realized. Over years, the millions of Americans who could not access medical services were deprived of their basic right. The value of life is echoed in the Universal Declaration of Human Rights as well as in the Hippocratic Oath taken by every physician.

True, health insurance is not a human right by itself, but consider the following: according to the National Academy of Sciences, Institute of Medicine, there is a “consistent and statistically significant relationship between health insurance coverage and health outcomes for adults. Those factors, in turn, improve the likelihood of disease screening and early detection, the management of chronic illness, and the treatment of acute conditions.” This study published in the Journal of Public Health by researchers at Harvard University Medical School concluded that nearly 45,000 excess deaths of Americans can be linked each year to lack of health insurance. Forty-five thousand is fifteen times the death toll at the World Trade Center; 45,000 people are approximately equal to the population of Texas A&M University; 45,000 is almost thirty times the number of American soldiers killed in Iraqi since 2001. The lives lost at the World Trade Center and in Iraq will never be forgotten. Why then, do we pretend that a far greater loss of life every year does not exist? Make no mistake about it, health insurance can be a direct determinant of wheth-er somebody lives or dies.

According to the U.S. Census Bureau, 27 million American live without health insurance, and an additional 1.1 million part-time workers lost their health insurance in 2008. Implementing this legislation will instantly improve the expectancy of millions of Americans of all ages. It is impossible to put a price on that. When we talk about the right to healthcare, we are actually talking about the right to access healthcare. In our current system people do not choose to be uninsured but, instead, are priced out of insurance. These people cannot, as free market proponents often argue, “Pull themselves up by their bootstraps.” Instead, they and their families are too often cyclically and systemically trapped in their economic situation. Texas, in particular, with 6 million uninsured persons and 26 percent in the 18th Congressional—H.R. 3962 must pass.

I am committed to working with the Speaker’s office and Senatorial leadership now that we are taking the first step in stemming the rising tide of the many uninsured. The protection of physician-owned hospitals is an issue of national interest. We have a lot of work to do as we move towards the Senate and to the conference. I was grateful to meet with the Speaker today to discuss the continued protection of the very viable physician-owned hospitals.
I will continue to work to save physician-owned hospitals that are currently treating patients or under significant development, to ensure that Americans can continue to receive health care at the local hospitals they have come to depend upon. Physician-owned hospitals take care of patients covered by Medicare and Medicaid, as well as patients who are uninsured or cannot pay for their care. They also provide emergency departments access for their communities. At a time when we are concerned about the shortage of hospital beds and the impact of disease like the swine flu, my amendment to this landmark bill will make sure no hospital is forced to shut its doors or turn away Medicare or Medicaid patients. The benefits that will come from our efforts to protect physician-owned hospitals are far reaching and will prevent any further losses to local economies. Not only do physician hospitals deliver high quality medical care to the patients they serve, they also provide much needed jobs, pay taxes, and generate significant economic activity for local businesses and communities. Existing physician-owned hospitals employ approximately 51,700 individuals, have over 27,000 physicians on staff, pay approximately $2,421,579,312 in payroll taxes, and pay approximately $1.9 billion in trade payables. Hospitals currently under development would employ approximately 21,700 more individuals. With approximately 50 physician-owned hospitals, Texas leads the nation in the number of physician-owned hospitals. The Texas economy could lose more than $2.3 billion and more than 22,000 jobs.

In my district, the 18th Congressional District of Houston, Texas, St. Joseph Medical Center is a general acute care hospital that treats many of the medically disadvantaged in and around the City of Houston. It’s 40 percent Medicaid, 25 percent uninsured, and it is one of the most significant hospitals in the city of Houston. It would be a shame if we were to allow 40 percent of the population to be turned away. The hospital was offered a for-profit and not-for-profit hospital systems but no one would accept responsibility for operating St. Joseph’s. A plan was developed to convert the hospital into a community hospital. A joint venture model was used to create a new community hospital that would be able to continue to provide care to the patients. The hospital was developed to provide care to the patients in the city of Houston. It would be a shame if we were to allow 40 percent of the population to be turned away. The hospital was developed to provide care to the patients in the city of Houston. It would be a shame if we were to allow 40 percent of the population to be turned away. The hospital was developed to provide care to the patients in the city of Houston. It would be a shame if we were to allow 40 percent of the population to be turned away.

In Congresswoman Jackson-Lee’s district, the Affordable Health Care for America Act will: Improve employer-based coverage for 279,000 residents. Provide credits to help pay for coverage for up to 196,000 households. Improve Medicare for 70,000 beneficiaries, including closing the prescription drug donut hole for 5,300 seniors. Allow 16,600 small businesses to obtain affordable health care coverage and provide tax credits to help reduce health insurance costs up to $14,000 for small businesses. Provide coverage for 187,000 uninsured residents. Protect up to 500 families from bankruptcy due to health care costs. Reduce the cost of uncompensated care for hospitals and health care providers by $49 million.

Better health care coverage for the uninsured. Approximately 41% of the district’s population, 279,000 residents, receive health care coverage through employer-based care with legislation, individuals and families with employer-based coverage can keep the health insurance coverage they have now, and it will get better. As a result of the insurance reforms in the bill, there will be no co-pays or deductibles for preventive care; no more rate increases or coverage denials for pre-existing conditions, whether employment, occupation, or guaranteed oral, vision, and hearing benefits for children.

Affordable health care for the uninsured. Those with low-income and high-risk health care coverage through their employer will be able to purchase coverage at group rates through a health insurance exchange. Individuals and families with income of up to four times the federal poverty level—an income of up to $88,000 for a family of four—will receive affordability credits to help cover the cost of coverage. There are 186,000 households in the district that could qualify for these affordability credits if they need to purchase their own coverage.

Coverage for individuals with pre-existing conditions. There are 27,600 individuals in the district who have pre-existing medical conditions who are denied from buying insurance. Under the bill’s insurance reforms, they will now be able to purchase affordable coverage.

Rate increases and financial security. There were 500 health care-related bankruptcies in the district in 2008, caused primarily by the health care costs not covered by insurance. The bill caps annual out-of-pocket expenses.

Mr. CAMP. Mr. Speaker, at this time, I yield 2 minutes to the distinguished ranking member of the Budget Committee and distinguished member of the Ways and Means Committee, the gentleman from Wisconsin (Mr. RYAN).

Mr. RYAN of Wisconsin. Mr. Speaker, I would like to place in the RECORD a statement commending the people at CBO for their long hours and hard work.

Mr. Speaker, I firmly believe that this is probably the most consequential vote each of us will take in our service here, whether you’ve been here for 40 years or for 1 year.

When you evaluate this bill’s budget gimmicks, does it increase the debt and deficit? Yes. Will it take coverage away from seniors, raise premiums for families, and decrease health care innovation? Yes. Will it raise taxes on small businesses and cost us nearly 5.5 million jobs when our unemployment rate is 10.2 percent? Yes. Does this bill mean the government will take over running our health care system? Yes.

But what is worse is this bill replaces the American idea with a European-style social welfare state. This bill, more than any other decision we are going to make in this body, will do more to put millions of Americans as dependent on government as opposed to becoming and being dependent upon themselves.

This is not about health care policy. If it were, we could pass a bipartisan bill to fix what’s broken in health care without breaking what’s working in health care. This is about ideology.

My friends, the choice is not whether you’re going to stick with your party leaders. The choice here is what side of history do you want to be on? Will you be on the side of history where you stuck with your principles that built this exceptional Nation? That is the choice we are going to make with this bill, and I encourage you to think it through.

It is unusual for the House to be in session on a Saturday. That has not been the case for the Congressional Budget Office’s staff that has been working on health care legislation. For the past several months, CBO has worked non-stop to analyze health care legislation. This legislation is enormously complex and far-reaching and CBO is doing their best to provide objective non-partisan analysis to the Congress. That analysis is critically important to us and I want to acknowledge the hard work of Director Doug Elmendorf and the following CBO staff in that endeavor:

Alexandra Minicozzi, Allison Percy, Andrea Noda, Anna Cook, April Grady, Athiphat Muthitacharoen, Ben Page, Bruce Vrincek, Assistant Director for Health and Human Resources.

Carla Tieghe Murray, Chapin White, Christi Harvey-Arntz, Colin Baker, Daniel Kao, David Auerbach, David Asch, David Weiner, Doug Elmendorf, Director, Elizabeth Bess, Ellen Werble, Heidi Grogg, Holly Harvey, Deputy Assistant Director for Budget Analysis, Jamease Kowalczyk, James Baumgardner, Deputy Assistant Director for Health, Janet Heblatt, Jean Hanson.


Phil Ellis, Unit Chief, Health Policy Analysis, Rebecca Yip, Robert Stewart, Sarah Jennings, Sean Dunbar, Sheila Campbell, Stephanie Cameron, Stuart Hagen, Sunita D’Monte, Susan Labovich, Tom Bradley, Unit Chief, Health Systems and Medicare Cost Estimates.

Mr. RANGEL. Mr. Speaker, I couldn’t agree with the last speaker more. This is an historic moment, and I certainly hope you, your friends, and colleagues think this through for the American people.

At this time, I have the pleasure to present to the body the Mr. Lacy Clay, the gentleman from Missouri, and yield him 1 minute.

Mr. CLAY. I thank the distinguished chairman for yielding.

Mr. Speaker, I rise today to support a monumental piece of legislation that will expand health care coverage and reduce cost. Currently, 46 million Americans are uninsured, and by 2019 the number could reach over 65 million. Too many are denied access to care, often when they need it most. No one should be denied coverage based on pre-existing conditions, and no one should have to fear losing their coverage after they get sick. Even individuals who have health insurance suffer. Millions of underinsured Americans pay exorbitant fees for procedures and treatments that their insurance plan should cover.

The status quo is not working for Americans. It is time to take action. Each Member in this body should ask themselves one question before they vote, and that is: Am I my brother’s keeper? And my answer is Yes, I am.

Mr. CAMP. I yield 2 minutes, Mr. Speaker, to the distinguished member of the Ways and Means, the gentleman from California (Mr. HERGER).

Mr. HERGER. Mr. Speaker, today I rise not only on behalf of my constituents in northern California, but on behalf of all Americans. They have made...
their opposition to government-run health care known. They have come out by the thousands to town halls, called our offices, and held peaceful rallies, but, unfortunately, congressional Democrats have refused to listen.

The legislation being considered today is one of the most damaging, destructive bills ever to come before this Chamber. A government takeover of health care won't bring down cost, but it will bring down quality of care. It will transfer additional debt at the expense of future generations. It raises taxes by $750 billion and guarantees middle class tax increases down the road.

We all agree that we need health care reform, but we don't need to put the government in charge. Mr. Speaker, I believe in the free market, I believe in choice and competition, and I believe in freedom to choose your doctor and to get the treatments you need. America will work with these principles, and the Pelosi health care plan will take us in the opposite direction.

I urge every Member of the House to live up to our obligation, listen to the people and say “no” to government-run health care.

Mr. RANGEL. I yield myself 30 seconds, Mr. Speaker, because the gentleman who just spoke said that the Democrats didn’t listen to the Republicans. Having had the honor to serve with outstanding Republicans on the Ways and Means Committee and having, as chairman, had hearings last year and throughout, quite frankly, there wasn’t much to listen to until last Tuesday when, for the first time, you presented a bill. In any event, I appreciate the gentleman’s contribution.

The SPEAKER pro tempore. The time of the gentleman has expired.

Mr. RANGEL. I yield myself such time as I may consume.

We have been designated as one of the three committees to work on this bill for the President and for the House of Representatives. And we were privileged to work with Chairman WAXMAN as well as Chairman MILLER. I don’t think in the history of the Congress we have found three separate committees working in such cooperation. But as I said earlier, we had such hardworking, dedicated members and such a strong support staff that it’s almost embarrassing for me to be sharing with you the work and the time and support that they’ve given to this important issue for the Congress and for our country.

In any event, I have to admit, as Chair, there was one member that I felt lied to a little bit. He is the gentleman from California who since 1984 served and continues to serve as the chairman of the Health Committee. And so it is with a great deal of pride that I yield 3 minutes to the gentleman from California (Mr. PETE)

Mr. STARK, Mr. Speaker, today’s vote will be the most important of our careers. History will mark which side we’re on: providing quality, affordable coverage for all Americans, or the status quo.

I would remind my friend from Wisconsin that former Senator Bob Dole voted against Medicare, and that vote has haunted him ever since. It probably prevented him from becoming President.

Since my first election, I have worked to see that government serves our people. My top priority for 37 years has been to provide quality, affordable health care. If I hadn’t done it, sooner, but at my age, you learn to take what you can when you can get it.

The bill is not the bill that many of us would have created on our own. That is the legislative process. The compromise before us today is the right thing to do for the American people.

The bill guarantees health coverage to 96 percent of Americans. It’s fully paid for. People who like their coverage can keep it. Your fellow Americans want health insurance regulation and requires shared responsibility by individuals, businesses, and government. It assures that health care is affordable for lower- and middle-income families.

It fills the Medicare prescription drug doughnut hole, and it provides free preventive services in Medicare.

It has the support of consumers, doctors, nurses, senior citizens, children, people with disabilities, farmers, and small business owners—organizations that represent virtually every segment.

In my district, like every other district, Republican or Democrat, I’ve got 67,000 uninsured people who will be helped; 8,000 people with preexisting conditions; 14,000 businesses will get tax credits; 8,300 seniors will have the doughnut holes filled. And every district in the country has similar numbers. I defy you to go home and tell those people you voted to deny them quality, affordable health care.

I am proud to have helped author this legislation. I encourage each of my colleagues to join me in voting “yes.” I can assure you, these guys aren’t going to have to pay for it in the future.

Mr. CAMP. Mr. Speaker, I yield 2 minutes to the distinguished member of the Ways and Means Committee, the gentleman from Georgia (Mr. LINDER).

Mr. LINDER. I thank the gentleman for yielding.

Mr. Speaker, we have been listening ad nauseam for months from the Democrats, who have been saying that anybody who doesn’t support a government takeover of health care is supporting insurance companies or their friends in the pharmaceutical industry. Guess who contributes to political campaigns? Lawyers contribute more than all the rest together. To who do they give their money? Surprise. Surprise. Ninety-six percent was given to Democrats in this year. Is that why they are left out of the health care reform bill?

Everyone who has looked at this issue for years has said to start with tort reform. Start with tort reform. The three most recent studies all this year said that Americans are spending $200 billion a year on tests and procedures that are unnecessary, defensive medicine. If they are not done, the doctors will be sued. That’s $2 trillion over 10 years. That would pay for this $1.5 trillion behemoth.

It is ignored except in one fashion: there is mention in this bill that, if your State has already reduced jury awards and has gotten control over tort reform, you will be punished.

Ladies and gentlemen, this is not about health care. This is about rewarding your friends and about punishment. It has been going on all year, and it is a huge mistake.

Mr. RANGEL. Mr. Speaker, it is my pleasure to yield 1½ minutes to the gentleman from Michigan (Mr. LEVIN). If there is a moral issue, I would like to be on his side.

Mr. LEVIN asked and was given permission to revise and extend his remarks.)

Mr. LEVIN. Mr. Speaker, most Americans—and I emphasize that—most Americans want the insurance companies to keep the insurance they have and do not want to lose it because of skyrocketing costs; to be sure they are not denied coverage because of preexisting conditions; and to be sure if they have major illnesses, they are not bankrupted by unaffordable costs. Most Americans also want other citizens to have their health care needs covered by insurance.

Democratic health care reform responds to these concerns, and like Social Security and Medicare, it is as American as apple pie.

Consider this letter from a constituent of mine from Fraser, Michigan: “I am ashamed to let my family and friends know that I have no health insurance. I have refused hospital treatment I know I needed because I could not afford to pay for any type of medical procedure.”

She closes her letter with this simple message: “Please don’t let anything or anyone stop you from forming health care. I hope you will think of me. I need you to do the right thing. Health care for all Americans now.”

That’s what we are doing: health care for all Americans now.

Mr. CAMP. Mr. Speaker, I yield 2 minutes to a distinguished member of the Ways and Means Committee from California (Mr. NUNES).

Mr. NUNES. Mr. Speaker, as we consider this super-government-run health care bill currently before the House, I would like to remind my colleagues of a few things that have happened over the last year.

Mr. Speaker, we have been listening ad nauseam for months from the Democrats, who have been saying that anybody who doesn’t support a government takeover of health care is supporting insurance companies or their friends in the pharmaceutical industry.
We spend $1 trillion to bail out banks, investment companies and car companies. We spent another $1 trillion on a stimulus bill that has yet to produce any jobs as promised. This record spending doesn’t count the omnibus spending bills that we had and the fact that we grew our budget to $3.6 trillion all in one year.

If this weren’t enough, we are being asked now to create a new trillion-dollar, government-run health care program that we can’t pay for the two existing government programs that we have today—Medicare and Medicaid. These two programs have at least $22 trillion in debt that this Congress refuses to recognize. Let me repeat that again: $22 trillion in debt that we face with our two existing government-run health care programs. Mr. Speaker, with $1 trillion here and $1 trillion there, pretty soon, you are talking about real money.

What is worst of all, despite all of this spending during record times of high unemployment, this bill will kill American jobs, exporting them overseas. In the meantime, our government leaders continue to run over and grovel to the Chinese to borrow more money to finance the spending.

Mr. Speaker, Rome is burning while this Congress fiddles. This Congress is so irresponsible, so reckless, it’s like watching a broke, drunk gambler continuing to double down, just trying to break even.

Vote “no.”

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair recognizes Mr. LEWIS of Georgia, for yielding.

Mr. LEWIS. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. CARTER).

Mr. CARTER. Mr. Speaker, a couple of weeks ago, I was doing a town hall meeting and I got a small email from a friend. He said, ‘There’s an old saying: control a man’s purse, and you control half the man. Control a man’s health, and you control all the man.’

We are talking about a massive change in the lives of every human being in America today. That massive change is because we’ve already turned over to the Federal Government most of our financial system for them to manage it, so they control our purse. Now we have to ask ourselves: Well, what’s going to happen when we do? When we create this great system, how do we know what it’s going to look like?

Maybe there’s a lot of talk here. I think we’ve got a fairly independent vision. I want to use this vision. Quite frankly, but it’s not fair because it’s one-sided, and this document is two-sided, but this document printed in smaller font is two-sided. So here is what we have in the way of what the government needs to create for a health care plan.

These are government ideas. This is the substitute: the people’s ideas. It’s the difference, ladies and gentlemen, between liberty and government. You know, this week, a whole lot of people came an awful long way so that they could express their opinions, and they were called radicals.

Vote against this bill.

Mr. RANGEL. Mr. Speaker, I yield 90 seconds to the gentleman from Massachusetts (Mr. NEAL), the true voice of justice in this Congress.

Mr. NEAL of Massachusetts. Thank you, Chairman RANGEL.

Mr. Speaker, let me stand in support of this health care bill today. Reforming this health care system has not been easy, but we come here today after deliberating for countless years, weeks, months—and as recently as this morning more hours added—because we are building a system of health care for the American family.

We’ve worked hard to reform this health care system because, if we do nothing, family premiums will increase $1,800 a year; and by 2020, 61 million Americans will be uninsured. We have analyzed, and we have debated the details of the bill line by line and section by section.

To the critics, yes, we’ve read the bill. For all of the misinformation that has surrounded this legislation, there is a great deal that we all here today agree upon: this bill ends discrimination based on preexisting medical conditions; it limits out-of-pocket expenses for families; baseline lifetime limits on health care coverage that a family with a critically ill child can bump up against in no time at all.

Limiting out-of-pocket expenses is something we do all agree on. Half the bankruptcies in America are health care-related. This bill deals with the uncertainties of our health care system for families and for businesses, for young adults who are no longer eligible for their parents’ insurance coverage, and for senior citizens in the Medicare part D doughnut hole. This is a solid piece of legislation.

As I close, remember the party that stood with Social Security, and remember the party that stood with Medicare as we proceed to this vote this evening.

Mr. CAMP. Mr. Speaker, I yield 3 minutes to the distinguished minority leader, the gentleman from Ohio (Mr. BOEHNER).

Mr. BOEHNER. I thank my colleague for yielding.

Mr. Speaker, one of the issues in the underlying bill allows for the taxpayer funding of abortion, and the leadership of the majority party did see fit to allow Mr. STUPAK of Michigan and others to offer an amendment that would restore what has been a 30-year effort, that no taxpayer funds should be used for abortion.

If that amendment were to pass, Mr. RANGEL, and when this bill comes back from committee and if the House does, in fact, pass the Stupak language of outlawing taxpayer funding for abortion, will you guarantee me, when it comes back, it will be in the bill? I would be happy to yield.

Mr. RANGEL. Mr. Leader, you’ve been here long enough to truly understand how this system works.

As soon as we pass this bill, then we would expect the Democratic-controlled Senate to pass their bill. Then we will go into conference, and we will work the will of the majority in the House.

We had no idea that you would expect that a Member, especially one that you spoke in such glowing terms of as you have about me—that you would expect me on this floor, in front of all of my friends and colleagues, to guarantee you anything. I think any Member who gives a guarantee might be in violation of our ethics laws, so I wish you would kind of take a look at this before you would ask these questions.

Mr. BOEHNER. In reclaiming my time, Mr. RANGEL, if the House does, in fact, vote for the Stupak language, in
Mr. RANGEL. Well, I haven't normally cut any deals with you as a Republican, but why don't you talk to someone on your level in the House leadership and ask for help in the past?

Mr. BOEHNER. Reclaiming my time, Mr. Speaker.

Mr. RANGEL. You asked me a question.

Mr. BOEHNER. This is exactly the point I've been trying to make.

While the House is expected to take up the Stupak language later on this evening, language which would outlaw the taxpayer funding of abortion, it's pretty clear that this could be a shell game that's underway, that it gets to pass here in the House, helping to ensure that this bill passes; but we have no guarantees that when it comes back from conference that that language stopping the taxpayer funding of abortion will be in the bill.

Mr. RANGEL. All I am asking, as long as you have been here, have you ever even voted?

Mr. CAMP. Regular order, Mr. Speaker. Regular order. No time has been yielded.

The SPEAKER pro tempore. The Chair recognizes the gentleman from New York.

Mr. RANGEL. Have you ever gotten a guarantee like that from anybody since you have been here? No.

ANNOUNCEMENT BY THE SPEAKER pro tempore

The SPEAKER pro tempore. Members will please direct their remarks to the Chair.

Mr. RANGEL. Mr. Speaker, it is my pleasure to yield 1%2⁄5 minutes to Mr. THOMPSON of California. I thank him for the great contribution he has made to this bill that we present.

Mr. THOMPSON of California. Thank you, Mr. Chairman, for yielding.

Mr. Speaker and Members, for far too long too many Americans have had access to quality, affordable health care. Because of this legislation, the millions of Americans who don't have health care or who are struggling to pay their health care bills will be able to get the care they need when they need it. Families, small businesses, and individuals will save money.

There will be no copays or deductibles for preventive care services. If you change jobs, you can take your coverage with you. You will not be denied coverage for preexisting conditions and families won't be bankrupted by high medical bills.

Mr. RANGEL. I yield 1%2⁄5 minutes to the gentlewoman from Nevada (Ms. BERKLEY) and thank her for her kind words and her leadership.

Ms. BERKLEY. Thank you, Mr. Chairman. I thank the gentleman. I supported health care reform. It will make health care more affordable for all Americans.

Mr. RANGEL. I yield 1%2⁄5 minutes to a distinguished member of the Ways and Means Committee, the gentleman from Ohio (Mr. TIBERI).

Mr. TIBERI. Mr. Speaker, the American people do not want their health care replaced by government-run health care.

This bill is flawed in many ways. It cuts benefits to seniors. It increases taxes. It's the largest expansion of Medicaid ever at a time when State governments across our land are cutting services. It creates and extends 43 entitlement programs and 111 new offices, bureaus, commissions.

The Ohio State Medical Association that represents doctors in my district is opposed to the bill. They write, "Medicaid eligibility expansion is a troubling trend for the physician community as payment for these services often fails to cover the cost of providing care."

They go on to say, the legislation "lacks many of the critical elements necessary for successfully reforming Americans' health care delivery system and strengthening the physician-patient relationship."

The bill does not address medical liability reform, which causes defensive medicine to flourish. Medicare is cut by over $500 billion. Five million seniors could lose the coverage they have today. It turns out that you can't keep what you have if you like it. In fact, one of three seniors in my district could lose the benefits they enjoy today.

I am also concerned about the negative impacts on small businesses and employers. Under the "pay or play" mandate in this bill, Mr. Speaker, $335 billion will be taken out of those businesses. This could cause over 5.5 million Americans to lose their jobs.

Mr. Speaker, we have a better way, a better alternative that will lower health care premiums, guarantee health care to affordable health care for those with preexisting conditions, allow States flexibility to provide more coverage, and protect the benefits of our seniors.

Americans deserve better. Mr. Speaker, there is a better way. Let's reject this bill and start over.

Mr. RANGEL. Mr. Speaker, I yield 1%2⁄5 minutes to the gentlewoman from Nevada (Ms. BERKLEY) and thank her publicly for the great contribution she has made to this bill.

Ms. BERKLEY. I thank the chairman for his kind words and his leadership on this issue.

Mr. Speaker, I rise today in support of this historic piece of legislation that will expand health care coverage to millions of my fellow Americans.

The way we provide health care in this country is unsustainable. In Nevada, the cost of a private family health insurance plan is expected to grow from over $11,000 in 2009 to more than $19,000 10 years from now. If we do nothing, we will reach a point in this country where hardly anyone will be able to afford health insurance.

This bill is good for Nevada. Over 400,000 uninsured Nevadans will be able to get health insurance because of this bill. This bill is good for Nevada's seniors. It closes the doughnut hole, eliminates copays for preventive services and extends the life of Medicare over 5 years.

The bill isn't perfect. It doesn't contain a provision to protect bone density tests that I fought for, and it doesn't fix the Medicare physician payment system, and we must do both. But I support this bill today for the needed reforms that are included. They are very important. It's a great first step.

Faye Schwartz in Las Vegas, Nevada, this vote is for you.

Mr. CAMP. At this time I yield 2 minutes to a distinguished member of the Ways and Means Committee, the gentlewoman from Florida (Ms. GINNY BROWN-WAITE).

Ms. GINNY BROWN-WAITE of Florida. I thank the gentleman.

Mr. Speaker, the bill before us creates 111 different offices, bureaus, commissions, programs and entitlements, but it only cuts one—Medicare. This bill steals more than 500 billion from our Nation's seniors to fund new entitlement programs for the young, the wealthy.

My colleagues in the majority have boldly decided that cutting $500 billion from Medicare is a good idea. They actually are telling seniors that these cuts will improve Medicare in the future.

Well, Grandpa and Grandma might be old, but they are not stupid. You are not going to cut Medicare and tell them that it's a good thing.

Mr. Speaker, the bill before us is not real reform. Congress should be strengthening Medicare, not weakening the program. Just look at how bad the Federal Government has been historically in predicting health care costs. This bill will increase health care costs for all Americans and cut Medicare funding. Americans don't believe that yet another trillion-dollar program will cost them nothing.

Mr. Speaker, we all hear Speaker Pelosi say that she is a grandmother. Like Speaker Pelosi, I too am a mother and a grandmother. I can tell you that my constituents believe that this bill is bad for the middle class, bad for parents and grandparents and, even worse, for future generations. I urge my colleagues to reject it as well so that we can work together truly on a bipartisan solution.

The President's own economic advisors have said that this bill will kill 5.5 million jobs. Americans back home are watching this and saying, What is Congress thinking? Why would they want to further sabotage our economy? This bill clearly is
Mr. RANGEL. I yield 1 1/2 minutes to my friend and leader Mr. CROWLEY.

Mr. CROWLEY asked and was given permission to revise and extend his remarks.

Mr. CROWLEY. I thank my good friend, the gentleman from New York, for yielding me this time.

I rise today in support of the Affordable Health Care for America Act, which will provide millions of hard-working American families the quality, affordable health care they deserve. In the past decade, the cost of health care for American families has skyrocketed. Premiums have doubled, yet wages remain stagnant at best. Last year, more than half of Americans postponed care or skipped their medications because they simply could not afford them. The status quo is no longer acceptable nor affordable, and the status quo is changing today. Today I take action, and delivering to the American people real change, a better, safer, more affordable way of life.

The Affordable Health Care for America Act will give American families peace of mind and peace of mind that health care is not just a luxury for some but an affordable, accessible benefit for all of us.

I urge all of my colleagues to make history today and vote "yes" on this bill to make health insurance affordable and accessible for each and every American.
give the American people true health care reform that will carry our country through for generations.

This is the same choice that was laid before the Members of the 89th Congress when they voted on the creation of Medicare and Medicaid. Do we want our 89th Congress to be looked at in the mirror and ask, we would be today as a nation had those Members simply succumbed to the difficulty of making real change? Where would we be today? Where would we be in mortality? Where would we be with the seniors who were sick and poor at that time without those two programs?

We are now 40th among the industrial nations in infant mortality. When will we wait to have our consensus? We need this reform. Let us not leave another generation to wonder what we could have been.

Let’s pass historic legislation that provides the promise of affordable health care for every American today and the generations to come.

Mr. CAMP. Mr. Speaker, I yield 2 minutes to the distinguished member of the Ways and Means Committee, the gentleman from Louisiana (Dr. Boustany).

Mr. BOUSTANY. Mr. Speaker, today we will have a vote on a flawed, massive bill that would push by Speaker Pelosi and House Democrats, that will cost more than $1 trillion. This bill will increase health care costs for seniors, increase, increases while Americans struggle to find work, and hurt seniors’ quality care.

Mr. Speaker, as a heart surgeon, I saw the amazing innovation in my 20 years in practice in our system. In fact, in the early 1950s, an American surgeon, hopefully observing the death of a patient from blood clots to the lungs, was inspired and invented the first heart-lung machine that made open heart surgery possible. Many thousands of patients worldwide have benefited from this innovation, this innovation right here in the United States, innovation that will be stifled by the Pelosi health care bill.

There is another way. We can do better. House Republicans have solutions that will lower costs by creating real choice and competition. We will help those with preexisting conditions to get meaningful health care coverage, we will preserve U.S. leadership in medical research and education, and we will reduce frivolous lawsuits in medicine that needlessly drive up the costs for families.

As a heart surgeon, I know that we can achieve real health care reforms to bring down costs. But this Democrats’ current bill will only lead to higher costs for millions of Americans and destroy what is currently working in our system.

There is a better way. There is a different way. There is a way to lower health care costs, help more people achieve a high quality doctor-patient relationship in this country and improve health care for all Americans.

Vote down this bill and support the Republican plan.

Mr. RANGEL. Mr. Speaker, I now yield 1½ minutes to the gentleman from Illinois (Mr. DAVIS).

Mr. DAVIS of Illinois. Mr. Speaker, pass the Pelosi health care bill will move us closer to the realization that all men, women, and children in this country can have access to quality health care. It will reduce the waiting time in emergency rooms and shorten the length of time you have to wait to see a doctor. It makes it possible for people to have health insurance who have never had any before in their lifetime and to see a doctor on a regular basis. It recognizes the needs of people with disabilities. It seriously increases the number of community health centers, protects disproportionate share and teaching hospitals, and promotes health awareness and education. But, most importantly, it prolongs and enhances life, as well as its quality.

This is the most significant health legislation passed in this country since Medicare and Medicaid. Residents of my district have been calling all day asking that I would vote for them, that I would vote for Illinois, that I would vote for America, yes, I will, because I believe that health care ought to be a right and not a privilege. I wanted a single-payer system, but I will vote for H.R. 3962 because it is good for Illinois, it is good for me, it is good for you, and it is good for America.

Mr. CAMP. Mr. Speaker, I yield 2 minutes to the distinguished member of the Ways and Means Committee, the gentleman from Nevada (Mr. HIGGINS).

Mr. HIGGINS. Mr. Speaker, the American health care industry is a $2.5 trillion industry. It represents 17 percent of the American economy, as measured by the gross domestic product. Yet our outcomes, according to the World Health Organization, are pathetically falling behind. We are 37th in overall quality. Unacceptable in America. We are 41st in infant mortality. That means in 40 other countries, from birth to 1 year of age, kids live by a higher percentage than they do in the United States. Unacceptable in America. We are dead last of any industrialized country in preventable deaths. Unacceptable in a good and generous Nation.

This is a uniquely American problem with a uniquely American solution. We look to not-for-profit plans, like the Cleveland Clinic, the Mayo Clinic and Johns Hopkins. They are early adapters of new innovation, and they are providing the highest quality health care not only in the Nation, but throughout the world, at the lowest possible cost. That is the health care that I want for my family, that is the health care that I want for my community, and that is the health care I want for my Nation.

We have been debating this issue not for seven months, but for seven decades. It is time for change. I understand that reform is tough. The reform I have said has dynamics in all those who profit by the older order, and only lukewarm defenders in all those who would profit in the new order. On health care, most Americans are rooting for the reformer.

Mr. CAMP. Mr. Speaker, at this time I yield 2 minutes to a distinguished Member of the Ways and Means Committee, the gentleman from Illinois (Mr. ROSKAM).

Mr. ROSKAM. I thank the gentlema for yielding.

Mr. Speaker, if you are at home and you are sort of flipping channels between the football games and C-SPAN,
and you flipped on and only heard the majority party, you would think, wow, what a great plan. I mean, really, you would think people are just going to fall all over themselves, and all these adjectives and declarative statements just sounded wonderful. Until you look inside that bill and you find handcuffs.

Now, I am not talking about figurative handcuffs. I am talking about criminal penalties; criminal penalties that have been mentioned by the gentleman from Texas, criminal penalties that have been mentioned time and again on this floor. We have heard from the best and the brightest all afternoon, and not a one of them have answered why it is you have to criminalize people to coax them into a plan that is fabulous. It makes no sense.

And these aren’t my words. This is actually coming from the Joint Committee on Taxation, in a letter that was written, ironically, with Chairman CHARLIE RANGEL as the chairman of that committee, released 48 hours ago, that says in fact if you don’t comply with the individual mandate, what happens? You can be subject to 5 years in prison and you can be subject to a quarter of a million dollars in fines.

And the other side, with all due respect, with all the adjectives and all the flourishing speech, has failed to answer that question.

I submit to you, if we listen today, if we listen to the remainder of this debate, they will be silent in terms of a good answer as to why it is you need to criminalize people to coax them into a plan. It’s a failure, and we ought not stand for it.

The small businesses, the entrepreneurs, and the self-employed that this would have an impact on, they say, “Look, don’t criminalize us. Give us relief.” Let us purchase across State lines. “Not in the Democrats’ bill.” “Give us real tort reform, real liability reform.” Not in the Democrat bill in any substantive way. “Let us purchase and work together to pool to lower costs down.” The right to remain silent shouldn’t be the word from the government.

Mr. RANGEL. At this time, I yield 90 seconds to the gentleman from Kentucky (Mr. YARMUTH).

Mr. YARMUTH. Mr. Speaker, 3 years ago today, the citizens of Louisville, Kentucky, sent me to this body. They sent me here largely to help bring us to this historic day, and I am also very proud for the all-too-patient citizens of Michigan who sent me here, along with many of my colleagues, in 2006 to cast votes for the Affordable Health Care for Americans Act.

Mr. CAMP. Mr. Speaker, at this time, I yield 1 minute to the gentlewoman from Michigan (Mrs. MILLER).

Mrs. MILLER of Michigan. Mr. Speaker, during the past year, the Democratic majority has passed so many bills that have done absolutely nothing to help our economy. Instead, they’ve raised taxes, they’ve expanded the Department of Health and Human Services, they’ve actually killed off jobs. Then, yesterday, the national unemployment rate went up past 10 percent—actually, to 10.2 percent, with no end in sight.

So it is incredible that today this House may pass a job-killing, tax-hiking, deficit-exploding government takeover of our health care. And one of the most disingenuous things that has been said is that if you like your current health care, that you can keep it. Well, not so.

In my county, Macomb County, Michigan, the Chamber of Commerce just did a survey of all of their members. They asked them that if, rather than continuing to provide good health care to their workers, they would instead take the 8 percent penalty that is included in this bill, and guess what? No surprise. The overwhelming majority said they would of course dump their employees out into the public plan.

Mr. Speaker, we are going to have a complete government takeover of our health care system faster than you can say, “This is making me sick.” Vote “no.”

The SPEAKER pro tempore. The gentleman from Michigan has 8 minutes remaining. The gentleman from New York has 14½ minutes remaining.

Mr. RANGEL. Mr. Speaker, I would like to yield 1 minute to the Congresswoman from California (Ms. LEE), who is the chairperson of the Congressional Black Caucus and has done such a great job on the question of diversity as well as other parts of the bill for women.

Ms. LEE of California. Mr. Speaker, on behalf of the Congressional Black Caucus, I rise in strong support of this bill. Known historically as the cornerstone of the Congress, we recognize that it is our moral responsibility to pass this today.

I want to thank the gentleman and commend him and the other Chairs of the tri-committees as well as our leadership and our Speaker for bringing us to this point today.

The strong public option in this bill will provide our constituents with the choice and competition they want. It will help improve our health care and help eliminate health disparities and this bill recognizes that an ounce of prevention is worth a pound of cure. It will help people who choose to keep their private plans by limiting annual rate increases by insurance companies. It’s a win-win. It’s your historic vote is another step forward in our quest for social justice. It really is about life and death, but it’s not the end of the process. The Congressional Black Caucus will keep fighting until a final bill is on the President’s desk.

Today, finally, health care will become a basic human right for all, rather than a privilege for the few. We all have been called today for such as this. Let us rise to the occasion and vote yes on affordable health care for all.

Mr. CAMP. At this time, Mr. Speaker, I yield 1 minute to the gentlewoman from Oklahoma (Ms. FALLIN).

Ms. FALLIN. Mr. Speaker, the American people understand the need for health care reform. They don’t want socialized medicine. They don’t want the Federal Government taking over our health care decisions, taking away our freedoms of choice about health care. They don’t want more Federal deficit spending on the backs of our children and future generations of our children, and they don’t want more taxes upon small business, especially in this recession.

They don’t like the Federal Government taking away our freedoms guaranteed under this Constitution, and they don’t want the Federal Government interfering in our States’ rights. They don’t want unfunded mandates upon the States, and they don’t want government-funded taxpayer abortions upon our families.

Mr. Speaker, men and women have fought for our freedoms for this Nation for generations, but this health care bill will change the face of our Nation and put our Nation on a trajectory of a Federal Government takeover in so many areas of our freedoms and our lives.

Let’s reject this health care bill, and let’s start all over and pass real, meaningful health care reform.

Mr. RANGEL. I yield 1 minute to the gentlewoman from New York, Congresswoman VELAZQUEZ.

(Ms. VELAZQUEZ asked and was given permission to revise and extend her remarks.)

Ms. VELAZQUEZ. For too long, millions of Americans have suffered without access to the medical treatment they need. Right now, as we debate this measure, too many Americans are worrying about how they will find health care coverage if they lose their jobs. On this day alone, 14,000 Americans will lose their coverage, and millions of other citizens, including one in every
three Hispanics, lack health insurance coverage.

Today all of that changes. This is the moment. No longer will insurance companies abandon Americans when they most need help. This bill will end the practice of preexisting conditions coverage because of preexisting conditions. The 36 million uninsured Americans will finally have coverage. Choice, competition, and transparency will be brought to the insurance market, meaning at lower costs. I say this to my colleagues: It has been too long. Let us pass this bill.

Mr. CAMP. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. Crenshaw).

Mr. CRENSHAW. Mr. Speaker, a lot of the men and women that I represent in northeast Florida are members of the military, and we’ve been working for 15 years to make sure they have adequate health care. They deserve it. They defend us every day.

They asked me, How is this new Democratic plan going to affect my TRICARE and my TRICARE for life? The only real question that this slippery slope with the public option is going to do to existing coverage. If you take this Democratic plan, you will see it’s complicated, 2,000 pages long. It’s unproven. It’s untested. It’s filled with uncertainty. At the end of the day, this Democratic plan is a dangerous experiment on the backs of the American people without their consent. If this were the medical field, that would be unethical. It would be malpractice. There is a better way. Mr. Speaker. There is a better way.

Mr. RANGEL. I yield 1 minute to the gentlewoman from Michigan, Congresswoman Kilpatrick.

Ms. KILPATRICK of Michigan. I thank the gentleman for yielding.

Mr. Speaker, this is a historic day. Choice, competition, quality, and peace of mind. I want to commend the Speaker for her leadership and our chairman in our outstanding to propose a bill that will help American families.

The 36 million Americans who do not now have insurance will be insured. Your premium costs will go down. The quality of all insurance will be increased. No longer will insurance companies be able to examine and cut you off when you get ill. Prescription drugs will be cheaper. The AARP supports this bill. Medical doctors and nurses support this bill. The Consumers Union supports this bill. The UAW supports this bill.

It’s a great historical day for our country. I predict it will be, as we go forward, as strong and as popular as Social Security, Medicare, and now our new national health care program.

Thank you. Thank you, Madam Speaker. Thank you, Democrats, for standing strong.

Mr. CAMP. Mr. Speaker, at this time, I yield 1 minute to the gentlewoman from West Virginia (Mrs. Capito).

Mrs. CAPITO. Mr. Speaker, I rise today to voice the concerns of my constituents who believe the Speaker’s trillion-dollar 1,990-page bill is simply the wrong solution for West Virginia’s families. We were told that under the President’s plans, those who like their health care would be able to keep it. Well, we’ve discovered that is simply not true. It is certainly not true for the 72,000 West Virginians on Medicare Advantage who will see the program slashed by $170 billion under this plan.

Consider one of my elderly constituents from Dunbar, West Virginia, who called us this week on the enhanced benefits of Medicare Advantage to cover her rheumatoid arthritis and her diabetes. She suffered a stroke, a brain aneurysm, and she is on more than a dozen prescriptions. She relies on these services, and she fears that this bill will put them at risk. Sadly, she is right, because this bill will change her health care.

Mr. Speaker, we need health care reform, but we can do better than this.

The SPEAKER. The gentleman from Michigan has 5 minutes remaining. The gentleman from New York has 11½ minutes remaining.

Mr. RANGEL. Thank you. I yield 1 minute of that to the gentleman from the great State of New York, Gregory Meeks.

Mr. MEEEKS of New York. The camera of history is rolling, and I am so happy to play a part in it, because just as we created history in the thirties by Social Security and in the sixties with Medicare, we will create history tonight in passing H.R. 3962.

Dr. King once asked the question, How long? Well, because of H.R. 3962, how long before all Americans have access to affordable and quality health care? Not long. How long before we end discrimination for preexisting conditions? Not long. How long before we ensure that no Americans fear bankruptcy or financial ruin due to illness? Not long. How close do we close the doughnut hole, helping all of our senior citizens? Not long. How long before we begin to control the escalating prices of insurance and health care? Not long. How long before all Americans, all of us, can have access to quality health care not long.

Mr. CAMP. At this time, Mr. Speaker, I yield 1 minute to the gentleman from Virginia (Mr. Goodlatte).

Mr. GOODLATTE. Mr. Speaker, what’s in the 2,000-page monstrosity that’s costing the taxpayers over $1 trillion in costs? Well, we’re going to see tax increases of $800 billion, and $500 billion in cuts from Medicare.

Well, take a look on page 94. Section 202(c) prohibits the sale of private health insurance policies beginning in 2013, forcing individuals to purchase coverage through the Federal Government.

On page 225, however, section 330 permits, but does not require, Members of Congress to enroll in government-run health care.

Page 122, section 233(a)(3) requires the commissioner, a new health insurance czar, to issue guidance on best practices of plain language writing. This from the same people who wrote this 2,000-page health care bill.

Page 183, section 305(a) gives the commissioner the power to enlist appropriate entities, like Planned Parenthood and ACORN, to engage in outreach to specific vulnerable populations on the bill’s new programs.

Oppose this bill.

Mr. RANGEL. Mr. Speaker, at this time, I yield 1 minute to Congressman Conyers, the distinguished dean of the Congressional Black Caucus, senior Member of this great House of Representatives, and someone that had indicated his concern about health care from many, many years ago.

Mr. CONYERS. Thank you, Chairman Rangel, and all of our colleagues that have supported single-payer health care. Eighty-six other Members are now working to make sure that we get this bill passed. I single out my colleagues Dennis Kucinich and Anthony Weiner for their particularly effective work.

But I want to say that this is the same battle that some people went through when we passed Social Security. We had the same naysayers. The same people when we passed Medicare, the same naysayers. The same people when we passed Medicaid, the same naysayers. And now we try to reform health care today, and what do we get? The same people saying “no” again.

So I’m proud to have all of the support that I can to make sure that this bill becomes law, that more people are covered, and that preexisting conditions no longer will be an excuse to get rid of people.

Mr. CAMP. Madam Speaker, at this time I yield 1 minute to the gentleman from Georgia (Mr. Kingston).

Mr. KINGSTON. I thank the gentleman for yielding.

Madam Speaker, what we have today is another Pelosi plan for America.

But let’s remember the Pelosi plan for jobs: an $800 billion stimulus plan that caused unemployment to go from 8.5 percent to over 10 percent.

Let’s remember the Pelosi plan for automobiles: Cash for Clunkers, a $3 billion program that even the Democrats agreed did not work and was killed after 3 weeks.

The Pelosi plan for fiscal discipline: a $1.4 trillion debt this year, the highest in history.

And let’s not forget the Pelosi plan for national security: dithering in Afghanistan.

Now we have the Pelosi plan for health care: it kills small businesses and jobs. It raises taxes. It raises premiums. It cuts Medicare. It takes away your current health care coverage and sends $1 trillion “away.”

Let’s look at the Pelosi plan for a government takeover of health care and join the bipartisan Members of this Congress who plan to promote an alternative which is far better.
Mr. RANGEL. Madam Speaker, I yield for the purpose of making a unanimous consent request to Mr. FALEOMAVAEGA, my friend from Samoa. (Mr. FALEOMAVAEGA asked and was given permission to revise and extend his remarks.)

Mr. FALEOMAVAEGA. Madam Speaker, God is good. I rise in full support of the health care needs of all our fellow Americans. God bless America.

Madam Speaker, I rise in strong support of H.R. 3962, legislation to provide affordable, quality health care for all Americans and reduce the growth in health care spending, and for other purposes. This bill will control rising medical costs and also extend health care coverage to uninsured American citizens throughout the United States and its Territories.

I want to thank Speaker NANCY PELOSI for her leadership and my colleagues in Congress for their support on this important bill. Especially, I extend my gratitude to the Chairman of the House Committee on Energy and Commerce, Congressman HENRY Waxman; and the House Committee on Ways and Means, Congressman CHARLES RANGEL for listening to the concerns of the Territories and for their willingness to work with the Territorial delegates on resolving the issues.

I also want to commend my fellow Territorial delegates for their hard work and efforts, in working hand-in-hand to reduce health disparity facing the Territories. I especially want to recognize Congresswoman DONNA CHRISTENSEN for her work in the House Committee on Energy and Commerce, Congressman PEDRO PIERLUSI and Congresswoman GREGORIO SABLAN for their advocacy in the House Committee on Education and Labor and to Congresswoman MADELEINE BORDALLO for her leadership as the Chairwoman of the Congressional Asian Pacific American Caucus Healthcare Task Force.

Madam Speaker, the Affordable Health Care for America Act, or H.R. 3962, will improve health care for Americans living in the insular areas. Under the provisions of this legislation, from FY2009 to FY2019 American Samoa will receive additional Medicaid funding in the amount of $239.5 million. Moreover, its Federal Medical Assistance Percentage (FMAP) will be raised to the highest FMAP applicable to any of the 50 States and District of Columbia. As a result American Samoa will assume an FMAP no less than 75 percent, the FMAP for Mississippi which has the highest among the 50 States.

American Samoa will also work together with the Secretary of Health and Human Services to improve the Territory’s Health and Human Services delivery system by 2020. And to make this transition, the Secretary will also assist to make appropriate modifications to the Territory’s existing Medicaid programs. This will require comprehensive assessment of the existing Medicaid program and health care services in American Samoa.

I am pleased that American Samoa and the insular areas will have the opportunity to become part of the Exchange program, the centerpiece of the Health Care Reform legislation. Again I thank my Territorial delegates for their hard work to ensure that Congress continues to recognize the need and unique set of circumstances we have in the Territories. To help carry out the Exchange program, $300 million is to be allocated among American Samoa, the CNMI, Guam, and the USVI, based on consultation with the Secretary of Health and Human Services. If American Samoa or any Territorial government chooses not to join the Exchange, its allocation will be added instead to that Territory’s Medicaid funding.

Madam Speaker, H.R. 3962 will bring much needed improvement to the health care system in American Samoa. The fact of the matter is rising medical costs and limited health care resources in American Samoa’s remote location and exponential rate of chronic diseases, have led to a high number of people in the Territory with minimal or no access to quality health services. Indeed, findings from the American Samoa Health Survey conducted in 2005 of $1.2 million 25 percent of the population have insurance. Subsequently, there is a tremendous need to address these concerns in a viable health care policy for the Territory.

For this reason, in a letter sent June 22, 2009, I wrote members of the Fono (American Samoa Legislature) to address the need to improve the health care system in the Territory. I specifically requested that the Fono should take advantage of the report from the Government for All American Samoa (CAAS) project, which includes policy recommendations on ways to improve the Territory’s health care system.

I commend the American Samoa Government, especially the Office of the Lieutenant Governor and staff for their dedication and commitment to the CAAS project that was completed in 2007. I also want to commend the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (DHHS) for committing the resources from 2004 to 2007 to complete the CAAS project. My hope is for the American Samoa Government to follow through on the policy recommendations in the CAAS report and adopt the framework for health care reform that is now in place and supported by H.R. 3962.

The Affordable Health Care for America Act, H.R. 3962, carries with it our expectations and hopes for quality and affordable health care for our people and with it a commitment; a commitment that every American is provided quality health care that they are entitled to and to receive health services that they so critically need. I urge my friends and colleagues to support H.R. 3962 and pass this historical health care reform legislation.

Mr. RANGEL. I yield myself 2 minutes.

This is it for the members on the Ways and Means Committee and others that have demonstrated such outstanding leadership to be a part of history.

It’s unfortunate that we were unable to create an atmosphere of bipartisan-ship because, certainly, the 40 million people without health insurance, we can’t distinguish between those who are Republicans and those who are Democrats. Clearly, we had enough information of the number of people that were in the congressional districts, all of our congressional districts, that had no insurance at all.

I am more than certain that my colleague on the other side of the aisle have heard the very same stories we have: people who thought they were insured and they were not; people who wanted insurance and they would not insure them because they had some condition; other people who worked hard every day of their lives, but were not given insurance and they can’t afford to buy it.

No, this isn’t the Pelosi plan. This is a plan for all America, a plan to make us proud to know that our country is concerned about us and our children and our grandchildren. And, yes, the American Medical Association, AARP, and everyone is throwing papers around. But these are the groups, the national groups, that have asked America and this Congress to step up and fulfill our responsibility.

And it’s not just for our constituents. It’s for our great country, to have her as strong as she can be, to be able to know that we can compete with any other nation no matter what part of the world that we’re in; and that our workforce will not only be educated and talented in order to compete, but we will be healthy.

Every industrialized country takes care of their people. It’s not a political thing. Certainly being a Republican or a Democratic thing. It’s, Are we going to be healthy? Are we going to be strong? Are we going to be certain that when you count America, count her among the healthy.

Madam Speaker, I want to bring to the floor an outstanding Member of Congress who is the subcommittee Chair on the Education and Labor Committee. As you know, three committees had jurisdiction and Education and Labor had jurisdiction. We had three chairmen. But we had one subcommittee chairman who has just been outstanding. He’s been a friend of those without insurance, a friend of those who look forward to this bill’s being passed.

So it is with great distinction that I yield the balance of my time to Mr. ROBERT ANDREWS from New Jersey, and I ask unanimous consent that he be allowed to control that time.

The SPEAKER pro tempore (Ms. EDWARDS of Maryland). Without objection, the gentleman from New Jersey will control the balance of the time.

There was no objection.

Mr. CAMP, Madam Speaker, at this time I yield 1 minute to the gentleman from Texas (Mr. GOHMERT).

Mr. GOHMERT. Madam Speaker, this is well intended. But you read section 501, and it basically says if you make too much to get free health care but you make too little to be able to buy it, you’re going to get taxed under this bill. It means well. But it does damage.

For those who have paid into Medicare for 40 years or so, who expected to have it, they get cut hundreds of billions of dollars, but illegals are going to get covered.

In the 1960s they meant well with the Great Society, but they offered a check for every child a woman could have out
of wedlock. Meaning well, wanting to help them, but they lured them into a rut with no way out, and they came to my court to be sentenced.

We hurt people when we do the wrong things. For the Declaration of Independence to stand, all must be equal in its promises. The lives, their fortunes, their sacred honor. This is a "declaration of dependence" that pledges Americas' lives, Americans' fortunes, and there is no honor in that.

Mr. ANDREWS. Madam Speaker, I yield myself 3 minutes.

Madam Speaker, the people of the country and Members of the House deserve a vigorous debate. They also deserve an accurate record. And I think the time has come to begin to clarify and correct some of the series of assertions that have been made here that are simply not correct.

There was an assertion made from the minority side a few minutes ago that, somehow, the provision happens to those who are on TRICARE or veterans health benefits. The gentleman may not know, but we do. Nothing will change for a person under TRICARE or veterans benefits if they do not wish to have their insurance changed.

There was a statement made on the other side that the bill will "cover illegal aliens." That is incorrect. There is no subsidy and there is no coverage for an undocumented person.

There have been numerous statements made on the other side that there will be massive tax increases on the American people. Here is the fact: the fact is that there is a surtax in this bill that helps to pay for coverage of uninsured people and for better quality care. It affects the top 3 percent of households in this country. If you're an individual and you make more than $500,000 a year adjusted gross income, if you're a couple and you make more than $1 million a year adjusted gross income, if you get you.

The statement has been made repeatedly, the bill will add to the deficit. That's not the truth. That's not what the Congressional Budget Office says. They say the contrary. They say that the net effect of this bill is it will reduce the deficit in the first 10 years by in excess of $100 billion and that in the second 10 years, the bill will reduce the deficit by somewhere in the neighborhood of one-quarter of 1 percent of GDP.

The statement has been repeatedly made that it is a crime not to have health insurance. Here's the accurate statement: because there is a penalty imposed on individuals who don't meet the individual mandate, and, by the way, that individual mandate has within it very generous subsidies and it has a hardship exemption, but it has been said it is a crime not to have health care. That is not accurate. It is a crime to willfully and intentionally evade taxation, just as it is with every other tax.

It has been said this is a government takeover of health care. That is false. This is a consumer takeover of health care. And those who would be apologists for the insurance industry don't like that. The American people do and will.

Madam Speaker, I reserve the balance of my time.

Mr. CAMP. Madam Speaker, at this time I will place in the RECORD a letter from the Joint Committee on Taxation, which on page 3 indicates that both misdemeanor and felony penalties with imprisonment of up to 5 years will be imposed.

CONGRESS OF THE UNITED STATES,
J OINT COMMITTEE ON TAXATION,
Hon. DAVE CAMP,
Chairman, House of Representatives,
Washington, D.C.

Dear Mr. Camp: This is in response to your request for an explanation of enforcement through the Internal Revenue Code ("Code") of the individual mandate of H.R. 3962, as amended, the "Affordable Health Care for America Act." You specifically inquired about penalties for a willful failure to comply.

TAX ON INDIVIDUALS WITHOUT ACCEPTABLE HEALTH INSURANCE

H.R. 3962 provides that an individual (or a husband and wife in the case of a joint return) who does not, at any time during the taxable year, maintain acceptable health insurance coverage for himself or herself and each of his or her qualifying children is subject to an additional tax. The tax is equal to the lesser of (a) the national average premium for single or family coverage, as applicable, as determined by the Secretary of Treasury in coordination with the Health Choices Commissioner, or (b) 2.5 percent of the excess of the taxpayer's modified adjusted gross income over the threshold amount of income required for the income tax return filing for that taxpayer. This tax is in addition to both regular income taxes and the alternative minimum tax, and is proportioned for periods in which the failure exists for only part of the year.

In general, the additional tax applies only to United States citizens and residents aliens. The additional tax does not apply to those who are residents of the possessions or who are dependent or does not apply to those whose liability in coverage are de minimis or those with religious conscience exemptions. The additional tax does not apply if the maintenance of acceptable coverage is a legal duty and that the taxpayer had the legal duty and that the taxpayer had the legal duty and that the taxpayer had the legal duty and that the taxpayer had the legal duty and that the taxpayer had the legal duty and that the taxpayer had the legal duty and that the taxpayer had the legal duty and that the taxpayer had the legal duty and that the taxpayer had the legal duty and that the taxpayer had the legal duty and that the taxpayer had the legal duty and that the taxpayer had the legal duty.

The IRS attempts to collect most unpaid liabilities through the civil procedures described above. A number of factors distinguish civil from criminal penalties, in addition to the potential for incarceration if found guilty of a crime. Unlike the standard in civil cases, successful criminal prosecution requires that the government bear the burden of proof beyond a reasonable doubt of all elements of the offense. Most criminal offenses require proof that the offense was willful, which is a degree of culpability greater than that required in a civil penalty cases. For example, a prosecution for willful failure to pay under section 7203 requires proof that the taxpayer intentionally violated a known legal duty and that the taxpayer had the ability to pay. In contrast, in applying the civil penalty for failure to pay under section 6651, the burden is on the taxpayer: the penalty applies unless the taxpayer can establish reasonable cause and lack of willful neglect with respect to his failure to pay.

Criminal prosecution is not authorized without careful review by both the IRS and the Department of Justice. In practice the application of criminal penalties is infrequent. In fiscal year 2008, the total cases referred for prosecution of legal source tax crimes were as follows. Investigations initiated—1,581. Indictments and informations—737. Convictions—666.
Mr. POE of Texas. Madam Speaker, in my prior life I was a judge for 22 years. I tried only criminal cases.

The bill forces everyone that can to buy insurance whether they want to or not. If they don’t, they’re taxed. But that tax is really a fine. Be that as it may, if they don’t pay the fine, they’re in violation of the IRS Code and they can pay another $250,000 fine and go to jail.

That is government oppression of the people, forcing them to buy insurance whether they want to or not. That is repressive government control, and that’s the way that I see it. If they don’t submit, they are forced to go to jail.

You know, this bill is about government control. It’s not about choice. It’s oppression. It’s not about liberty. The Constitution starts out with “We the people.” If this bill passes, especially that section, let’s scratch out “We the people” and write in the phrase “We the subjects of Big Government.”

And that’s just the way it is.

Mr. ANDREWS. Madam Speaker, I’m pleased at this time to yield 1½ minutes to the gentlewoman from Ohio (Ms. FUDGE), who’s one of the authors of the small business provisions in the bill.

Ms. FUDGE. There comes a time, Madam Speaker, when we must choose that which benefits the greater good or that which benefits the greater good or that which benefits the greater good or that which benefits the greater good or that which benefits the greater good or that which benefits the greater good or that which benefits the greater good.

When I go home, Madam Speaker, I will have to tell everyone that I was asked to make health care more affordable and I said “yes.” This bill makes health care affordable for 36 million more Americans by ensuring that working-class citizens will never have to pay more than 12 percent of their income on health care premiums and that people whose incomes are 400 percent of poverty or less will receive their premiums in the form of subsidies. More than 163,000 households in my district alone will benefit from these subsidies.

When I ask people to increase their access to care, I said “yes.” “Yes” to the people of America who will no longer worry about being denied coverage because of preexisting conditions. “Yes” to the people of America whose families can now have regular checkups and free preventative care. Madam Speaker, I said “yes” to those who for the first time will have a family doctor instead of using the emergency room for routine medical care.

When asked to help the laid-off worker, the small business owner, the working poor, and those who can’t make ends meet in this very struggling economy, I said “yes.” When asked to ensure that those who have health care today but may be dropped tomorrow are taken care of, I said “yes.” When asked to exhibit the courage needed to fight for change, I said “yes.”

When the history of the 111th Congress is written, I choose to be in that number that said “yes” to the people of America.

Mr. CAMP. Madam Speaker, I yield 1 minute to the gentlewoman from California (Mr. ROHRABACHER).

Mr. ROHRABACHER. Madam Speaker, this attempt at sliding Americans into dependence on a government-controlled health care system was rejected for 5 years. For the first time, we have heard about the flaws of our current health care system: high cost; lack of portability; lose a job, lose insurance; and discrimination against those with preexisting conditions. Yes, many of the heart-wrenching stories we are hearing to justify this legislation are real. But correcting those maladies only requires specific reform. It doesn’t require transforming health care in America into a bureaucratically managed health care system that will cost hundreds of billions of dollars more, including billions to provide health care for illegal aliens while at the same time cutting Medicare by hundreds of billions of dollars.

This bill will reform destroy the freedom of the American people to make health decisions with their doctor and the doctor of their choice. It will transform our system rather than reform it, and what we will end up with is a system that is massively more expensive, less effective, and will be based on government controls and rationing, rather than the patient-doctor relationship.

Mr. ANDREWS. Madam Speaker, nurses make a great contribution to our health care system, and a gentlewoman who is a nurse has made a great contribution to this bill. I yield 2 minutes to the gentlewoman from New York (Mrs. McCarthy).

Mrs. McCarthy. Yes. Madam Speaker, I thank my colleagues, Mr. Andrews, and I also thank George Miller for also working with us.

We have known for years that we have a shortage of doctors, especially primary care doctors, and we have had a shortage of nurses. This bill is going to help that.

You know, when we talk and I hear some of the charges coming from the other side, I am wondering where have I been all of these months when I sat through the committee hearings and heard what we are doing.

I want to say with the Education and Labor Committee, the Nurse Training and Retention Act and the School Nurse Ratio Improvement Act is in this bill, H.R. 3962. The Nurse Training and Retention Act will provide grants so we can have more new nurses, but to have more new nurses, we have to have those who are educated; we teach those nurses. We have that in this bill, too.

I also want to say that for years I have been fighting with the insurance companies to make sure that children who are born with disfigurements on their face can have corrections so long term they won’t have those scars, physically and mentally, and to help those families adjust to the child. In this bill, we will be able to say that the plastic surgeons can work on these children.

Think about a child who is born without an ear. The insurance companies say that is cosmetic. That is not cosmetic. The ear is actually part of the body so you can actually hear better. The emotional scars that happen to the children that are born with these deformities, that is wrong.

If we can’t take care of our children in this country, if we can’t make sure our seniors on Medicare get the kind of care that they need—I will tell you, I just went through surgery. I went to get my prescriptions filled, and my pharmacist said to me, How lucky you don’t have to pay anymore for your prescriptions until January 1. Why? Because I have coverage, because I have health care from the Federal Government. We can do better, and we should.

The SPEAKER pro tempore. The Chair recognizes the gentleman from Minnesota (Mr. Kline) for 40 minutes.

Mr. KLINE of Minnesota. Madam Speaker, I yield myself such time as I may consume.

Madam Speaker, we have before us today more than 2,000 pages of legislation text that will give us public policy that costs more than $1 trillion and creates a huge morass of government bureaucracies. Over a hundred new offices, bureaus, commissions, and programs. Let’s look briefly at just one of these new offices.

The Democrats empower a new super bureaucrat with unprecedented authority over personal health care decisions, the health choices commissioner, heading up the Orwellian health choices administration.

In the short time we have had since this legislation was made public, we have combed these pages—in the first part of these 2,000 pages—to see if we could get a picture of the responsibilities, authorities, and powers that were granted to this individual. As you can see, Madam Speaker, we actually had to go back to the supply store to get enough of these tabs.
Madam Speaker, our health care system is the envy of much of the world. That does not mean it is perfect. Major challenges such as pre-existing conditions and portability can be dealt with by breaking down barriers between states and through nationwide underwriting.

California-style liability reform provides a model to reduce the cost of defensive medicine and can significantly reduce the cost of health care.

Tax incentives can be used to encourage broader participation by families, without federal mandates.

The Speaker and her congressional advisors are committed to government-run health care. We can solve existing problems without adding a trillion dollars on the backs of average American taxpayers.

Vote "no" H.R. 3962. Help save us from single payer healthcare.

Mr. KLINE of Minnesota. I reserve the balance of my time.

Mr. ANDREWS. Madam Speaker, at this time it is my honor to yield 4 minutes to a person who has spent a distinguished career in this House fighting for health care reform, the gentlewoman from Oregon (Mr. Wu) for 1/2 minutes.

Mr. Wu. Madam Speaker, I rise today in strong support of health insurance reform. In 20, 40, 60 years, this legislation will stand beside Social Security, the GI bill, and Medicare as a pillar of American health care and humane values.

We need a new health insurance exchange or marketplace to expand access and provide people with a menu of quality health insurance options so they can choose the plan that best meets their own needs.

We need to create affordability credits to ensure that all Americans have more affordable health care coverage.

The bill will set a yearly limit on how much money you can be charged for out-of-pocket expenses because no one should go broke because you get sick.

In short, what health insurance reform means for Americans is more security and stability. Americans should not have to wait any longer for these reforms. We have been waiting since Theodore Roosevelt. We have been waiting since Franklin Roosevelt. We have been waiting since Harry Truman. We have been waiting since Lyndon Johnson. We have been waiting since Jimmy Carter. We have been waiting since Bill Clinton. It is time to stop the waiting and it is time to act.

The SPEAKER pro tempore. The time of the gentleman from New Jersey has expired.

Mr. KLINE of Minnesota. Madam Speaker, I yield for the purpose of a unanimous consent request to the gentleman from California (Mr. Lewis).

(Mr. Lewis of California asked and was given permission to revise and extend his remarks.)

Mr. Lewis of California. Madam Speaker, I rise to oppose H.R. 3962.

This super bureaucrat, this health choices commissioner, it turns out will have powers to define, deny, deem, determine, assess, administer, and establish our health care benefits for all Americans.

It is no wonder that millions of Americans are afraid of a government takeover of our health care. How can they not fear such a thing? This is unprecedented, this amount of power granted to one bureaucrat. And, of course, there are other bureaucrats in this bill.

I don’t believe that this bill should see the light of day. It certainly should not pass. It is a recipe for job losses. It is a clear power grab by Washington bureaucrats. It is a power grab by Washington bureaucrats.

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But in America today, because of the absence of this policy, because of the absence of a comprehensive health care bill that provides universal access, because of the failure of a bill that will help families that are struggling to meet the health care costs that are presented within the medical system, because of the failure as The Wall Street Journal said, we pay a huge price in innovation because people know they will be penalized if they try to seek quality insurance or they try to have health care. If they start a new business, if they try to switch work, if they take a risk, and most importantly if they ever have to seek medical care because of a pre-existing condition, they will be penalized. And this simply is not right.

Let’s give America for the first time health care security for their families, their friends, their kids, and their neighbors.

Madam Speaker, I rise in support of this historic legislation to fix our broken health insurance system and finally bring affordable health care coverage to every American. We are truly on the verge of making history. Never before has the House or Senate approved a bill to guarantee every American access to affordable health care. Never.

Not that we haven’t tried.

The fight to reform this Nation’s health care system has spanned nearly 100 years, across generations and many great leaders, from Teddy Roosevelt to Franklin Roosevelt to John F. Kennedy to President Clinton to my own personal hero, Ted Kennedy.

But time and again these efforts were stymied by special interests. The need for reform is dire. Hundreds of thousands of people are losing insurance each month.

At least 36 million Americans have no coverage at all—including nearly 50,000 people in my district in Northern California. Over half of all personal bankruptcies are due to a medical incident.

Businesses are choking on bloated health care costs. Innovation is being stifled. Our competitive-ness is undermined.

But this year is different. This time is different.

The American people literally cannot afford to wait any longer, and today we will cast a history-making vote to guarantee all Americans access to quality, affordable health insurance.

We must not fail again.

An unprecedented effort by the House led us to this milestone.

Three committees and our diverse Caucus worked together in an extensive and coordinated fashion, with one purpose—to fulfill a decades-old and yet still urgent promise.

We engaged the public in one of the most transparent debates of federal legislation in history, including over 2,000 events across the U.S. since July alone.

The result is a bill that reflects what we have heard from workers and families, from small business owners and economists, from seniors and college students, from doctors and nurses.

The Affordable Care Act will directly meet the needs of Americans and the goals that President Obama set for reform:

It lowers costs for families and businesses, protects people’s choices of doctors and health plans, reduces the deficit, and ensures access to quality, affordable health insurance for all Americans.

For the first time in U.S. history, all uninsured Americans will be able to purchase quality, affordable coverage through a new Health Insurance Exchange, where they will be able to choose from a menu of options: a public health insurance option or several private plans.

And for those that already have insurance, our bill will grant them the security of knowing that their coverage will always be there.

Never again will Americans worry about losing their health care if they change or lose their job.

Never again will someone be denied health care coverage because of a pre-existing condition.

Never again will a patient have to worry about their insurance company rescinding their policy when they need coverage the most.

Never again will a small business owner have to worry about unpredictable and unaffordable premiums.

Our bill, H.R. 3962, will end the many injustices that workers, families, and businesses face in today’s system.

It will finally make health insurance work for consumers—not insurance CEOs.

Let me be specific about what our reforms will mean for the American people:

No more co-pays or deductibles for preventative care;

No more rates increases because of a pre-existing condition, gender, or occupation;

An annual cap on out-of-pocket expenses;

Guaranteed affordable dental, hearing and vision care for children;

Lower prescription drug costs for seniors;

Young people will be able to stay on their parents’ insurance through their 27th birthday; and

A ban on lifetime caps on what insurance companies will pay, so patients will never again be one treatment away from medical bankruptcy.

As I mentioned earlier, this legislation meets our commitment to fiscal responsibility.

Every penny paid for through a combination of revenue raised by placing a surcharge on the wealthiest Americans and savings generated by making Medicare and Medicaid more efficient.

These reforms will strengthen Medicare for seniors and shift our system’s focus from quantity of health procedures to quality of care and producing healthier outcomes for patients.

The Congressional Budget Office reports that our bill will reduce the deficit by more than $100 billion over the next decade and slow the growth of health spending, leading 11 chief health care economists to declare our legislation “vital to the Nation’s fiscal and economic future.”

As with previous efforts to reform health care, this bill received an enormous amount of public scrutiny.

In the last few months, opponents of health reform have conjured up every falsehood imaginable about this bill in an effort to scare the American people and once again try to stymie reform.

But as I said, I believe that this year is different. Our legislation has been tested in public and the momentum continues to grow in support of the bill.

The American people have been through the lies and distortions. And they are not fooled by the hoax of an 11th hour Republican bill that is nothing more than a cruel rebuke to the needs of the American people.

Their bill would do nothing but maintain the status quo and guarantee insurance profits at the expense of tens of millions of hard working Americans.

The public understands the true meaning of our bill.

They know it will cover 96 percent of Americans.

They know that, under our bill, if they lose their job they will continue to have health coverage for their children, spouses and families.

They know that this bill means that if they have cancer, the insurance company can no longer pull the rug out from under them while they’re in the middle of treatment.

They know that this bill will protect them, through any economic cycle.

Nearly 50 years ago, as he was fighting to expand health care benefits, President Kennedy said, “All of the great revolutionary movements of the Franklin Roosevelt Administration we take for granted. But I refuse to see us live on the accomplishments of another generation. I refuse to see this country and all of us shrink from the struggles which are our responsibility in our time.”

We must not shrink from the struggle for health reform, which is our responsibility in our time.

This is our moment to revolutionize health care in this country.

We have arrived at this historic moment thanks to the hard work of so many people.

I would like to thank my good friends and colleagues, Chairman Rangel and Chairman Waxman, and our three subcommittee chairs, Rob Andrews, Frank Pallone and Pete Stark, and especially Dean Dingell. We could not have had better teammates in this journey.

I would also like to thank the Democratic Leadership, our Speaker, Ms. Pelosi, the Majority Leader, Mr. Hoyer, our Whip, Mr. Clyburn, and all the members of leadership for the countless hours they spent working with the committee chairs to arrive at this point today.

And of course we could not have completed the work on this bill without the work of our incredibly talented staff, who worked long nights and weekends for months on end. They are the unsung heroes of this process, and I know all our colleagues join me in thanking them for their extraordinary work.

From my staff I would like to thank Mark Zuckerman, Alex Nock, Danny Weiss, Michele Vamhagen, Megan O’Reilly, Jody Calemine, Tico Almeida, Meredith Regine, James Schroll, Rachel Racusen, Aaron Albright, Amy Peake, Courtney Rochelle, and Mike Kruger.

Finally, I’d like to pay tribute to my mentor and friend, Sen. Edward M. Kennedy.

Health care was the cause of Ted’s lifetime. Our effort would have been impossible had he not carried the torch of justice and equality for all those years.

I know I am not alone when I say that I sincerely wish Ted Kennedy could be with us today to see his dream of quality, affordable health care for all become a reality.

Madam Speaker, this is the most important bill I have ever worked on during my many years of service in Congress.
I could not be prouder to have helped to write this bill, to encourage each of my colleagues to support it, and to cast my vote in favor of the Affordable Health Care for America Act.

We stand at the doorstep of history. Let us go in.

Mr. KLINE of Minnesota. Madam Speaker, at this time, I yield 3 minutes to the ranking member of the Health Subcommittee, certainly a member of the committee, the gentleman from Georgia. (Dr. Price).

Mr. PRICE of Georgia. Madam Speaker, health care at its very core is a compassionate and a moral human endeavor. As a physician, I can tell you that I never saw a Democrat or a Republican disease. The medical decisions that each American makes for themselves and for their families are some of the most important and personal decisions ever made, and there are principles of health care that we should follow. Think about those principles of accessibility, and affordability and quality and responsiveness and innovation and choices. Think about those principles. None of those principles are improved by the further intervention of the Federal Government, which is why we should adopt and concentrate on positive, patient-centered health care reform.

It is so very important that principles be in place that will ensure that patients and their families and their doctors are able to make those personal medical decisions unencumbered by a stifling and oppressive Federal Government. But sadly, this bill will not allow those independent decisions and is wrong in so many ways.

This bill, on page 94, will make it illegal for any American to obtain health care not approved by Washington. This bill, on page 301, will force Americans to purchase health coverage that Washington picks, not that you and I pick, not that you, my constituents, have demanded. This bill, on pages 297 and 313, places job-killing taxes on virtually every single business. This bill, on page 211, will force millions of Americans to lose their current personal private health coverage.

This bill comes with a price tag of $1.3 trillion, which will be borne by our children and our grandchildren. This bill, on page 520, slashes billions of dollars from Medicare that will necessitate health care rationing for seniors. And this bill, on page 733, empowers the Washington bureaucracy to deny lifesaving patient care if it costs too much.

This bill is not a health care bill. This bill is an affront on the morality of the provision of American health care.

As a physician, when patients and their families and their doctors are not allowed to independently decide what care should be provided, we lose more than mere systems; we lose our morality and we lose our freedom.

This bill, whether known or not, is an oppressive affront to every single American. The positive vote, the bipartisan vote on this bill is "no."

Mr. ANDREWS. Madam Speaker, I am pleased to yield to a Member who understands the immorality of 47 million uninsured. The gentleman from Michigan (Mr. KILDEE) is recognized for 1 minute.

Mr. KILDEE. I thank the gentleman. Madam Speaker, I rise today in strong support of H.R. 3962, the Affordable Health Care for America Act.

Choices regarding health care are some of the most personal decisions we make. The ability to choose one's doctor and decide on a course of treatment with one's physician is an undeniable American right, and so is access to quality affordable health care.

Most of us can agree that our current health insurance system is broken. The cost of health insurance has skyrocketed in recent years, leaving many families struggling to afford coverage or forcing them to go without. Others are denied insurance due to pre-existing conditions, saddling them with terrible medical debt when they need treatment.

These treatments, along with other factors, Madam Speaker, have led to nearly millions of Americans without any health insurance; 71,000 live in my district.

I urge the passage of this bill.

Lack of adequate health coverage leads many people to wait until an emergency to seek medical care and what could have been a simple doctor's visit into a costly trip to the E.R. What many people do not realize is that when patients cannot pay their bills, the American taxpayer is charged for a portion of that cost. Medical providers also absorb some of the costs, forcing them to raise the prices of services and thereby increasing costs for everyone and driving up health insurance premiums. This problem will only get worse over time, and health care will continue to become more and more expensive.

The House Freedom Caucus legislation addresses this issue by increasing competition between insurers, thereby lowering costs. It also prevents insurers from denying or dropping coverage due to pre-existing conditions. By treating conditions earlier at a doctor's office, instead of at the emergency room, it will save money for the patient, the taxpayer and the medical providers, ultimately bringing down health care costs for everyone.

This is an issue that Congress has been tackling since the days of Harry Truman and even before. As one of my colleagues in this gentleman from North Carolina, a former member of this committee and now a member of the Rules Committee, Dr. FOXX.

Ms. FOXX. I thank my colleague from Minnesota.

The people of America are struggling with 70 percent effective unemployment brought on by actions of this Democratically controlled government. And what do the Democrats want to do? Give us more government. They expect us to believe that more government control of our lives is good. More government control is not good.

We've been successful as a Nation because of our freedom. Taking away freedom will weaken us as a people and a country. The American people know that and have told us that. They're opposed to this bill.

Medicare, the kind of treatment they want us to have, denies treatment more than twice as often as most private insurance. That will be our future: rationed health care and destruction of freedom.

My colleagues should say no to the Pelosi-Obama freedom-killing, job-kill- ing H.R. 3962.

Mr. ANDREWS. Madam Speaker, when people were about to be deprived the freedom to choose a public option, the Progressive Caucus stood up. The leader of the Progressive Caucus that led that effort will now be our next speaker.

The gentlewoman from California (Ms. WOOLSEY) is recognized for 2 minutes.

Ms. WOOLSEY. Thank you to Congressman ROB ANDREWS, who kept this clear and made it understandable for every single person in this country. Thank you, Congressman.

Well, let's put aside all the numbers and fuzzy terminology and let's talk about what this bill really means to average Americans.

Madam Speaker, I will never forget 40 years ago waking up in the middle of the night with a start night after night after night because I did not have health insurance for my three small children, and it was not anything that had to do with anything that we had caused. I would wonder what would happen, what if my children got ill or one of them was injured because of no health insurance? Well, this bill that we're talking about today, with it, our family would have been secure. We wouldn't have been much healthier because we would have known that we had health insurance.

So, Madam Speaker, let's take a family of two, two working parents, two children. With this bill, if one of the children gets sick, the parents won't have to worry about arguing with the health insurance company for treatment. If the mother gets breast cancer, the family won't have to worry that their health insurance company will cover the cancer, because it doesn't want to pay for her treatment. If one of the parents loses his or her job, and along with it the family's health insurance, they will be able to go into the health exchange and choose between private and public plans. If the family can't afford to pay the premiums, there will be affordability credits to help them.

That security would have meant a better life for me. It would have meant a better life for my children that year. We want to make sure that every child has that security.

Mr. KLINE of Minnesota. At this time, I am very pleased to yield 1
minute to a very important member of the committee, the gentleman from Wisconsin (Mr. PETRI).

(Mr. PETRI asked and was given permission to revise and extend his remarks.)

Mr. PETRI. I thank my colleague from Minnesota.

Madam Speaker, unemployment is 10.2 percent, the highest in 26 years, yet here we are being asked to vote on a bill which will radically alter and disrupt six of our economy. It is businesses with costly new regulations, ratchet up monstrous Medicaid mandates on the 50 States, raise taxes on job creators, impose skyrocketing insurance premiums on individuals and families, and destroy popular Medicare Advantage plans, all this while failing to bend the cost curve down and providing no real liability reform.

At a time of record deficits, this bill spends over $1 trillion to provide health insurance to less than 15 percent of our population. To pay for this budgetary train wreck, it imposes $730 billion in new taxes and relies on a series of budget gimmicks in a slippery attempt to claim it won’t contribute to our deficit tsunami.

The legislation will bring about a radical intrusion of government into every sector of health care. It puts bureaucrats between patients and their doctors. It doesn’t make sense, isn’t very smart.

Let’s not pass this monstrosity. I certainly agree that it is time to fix the health care system in the United States so that all Americans have access to quality, affordable health care. In order to achieve this goal, I strongly believe that any bill that is approved by Congress must institute reforms that will address the rising cost of health care.

The majority of Americans have some kind of health insurance they are generally satisfied with. What they really care about is rising costs. Spending on health care services already accounts for about 17 percent of our gross domestic product (GDP)—an expected total of about $2.6 trillion in 2009. Health care inflation has outpaced general inflation by approximately 2.5 percent a year. Government spending on health care continues to grow exponentially and without action, spending on Medicare and Medicaid will rise from 4 percent to 19 percent of GDP in 2082.

However, the bill we are considering today takes us in the entirely wrong direction by instituting reforms that will increase health care spending. To pay for this budgetary train wreck, H.R. 3962 imposes $729.5 billion in new taxes on small businesses, individuals who cannot afford health insurance, and employers who cannot afford to provide coverage that meets new insurance standards. In Wisconsin, the “surtax” that provides the largest source of funding for the bill will hit 11,900 small businesses with only one employee, and is hovering around nine percent. Individuals who are dependent on medical equipment such as wheelchairs and hearing aids will also face increased costs because of additional taxes in this bill—at a time when many families are struggling to pay their mortgages.

Furthermore, H.R. 3962 relies on a series of budget gimmicks to make it appear that the bill would not increase the federal deficit. First, the legislation fails to account for this year’s projected 21 percent cut to Medicare physician reimbursements, which if allowed to go through would severely threaten seniors’ access to physicians. However, preventing this and future cuts will cost over $200 billion. Instead of making this fix in H.R. 3962 and accounting for its cost, the Democratic House leadership introduced it as a stand-alone bill to be paid for through the Senate already rejected this approach. H.R. 3962 also proposes over $400 billion in cuts to Medicare. However, as many acknowledge, Congress has a history of reversing itself on unpopular cuts to Medicare, so it is very questionable that these savings will be realized. The legislation also authorizes a new long-term care program which is funded through a voluntary payroll tax. H.R. 3962 uses these pay roll contributions for other spending priorities in the bill, instead of the coverage that was eventually have to be paid for under the new program. Even the Democratic Chairman of the Senate Budget Committee, KENT CONRAD, called the inclusion of this program a “Ponzi scheme.” Finally, only 7/10th of a percent of new spending occurs in the first three years, while most of the tax increases begin at enactment, representing a debt and “tax” time bomb.

Besides increasing taxes and adding to the exploding deficit, this legislation represents a radical intrusion of government into every sector of our economy. The bill authorizes new mandates that will eventually have to be paid for, and nearly all of them will be paid for out of both the states and multi-collaborative programs which will surely eliminate or reduce benefits to the 216,000 beneficiaries in Wisconsin.

Furthermore, the legislation places an 8 percent tax on businesses that don’t offer acceptable coverage, as defined by federal bureaucrats. According to the Galen Institute, a non-profit think tank, “data from a 2009 Kaiser Family Foundation survey shows that at least 30 percent of firms with fewer than 200 employees that now offer insurance would fail the test for family coverage, and about 20 percent would fail individual coverage.” However, instead of complying with the new mandates, employers will likely drop health insurance to their employees because the 8 percent payroll tax penalty is less than the cost to provide coverage. Furthermore, the extensive new federal record keeping and audit requirements provide future incentives to stop offering coverage. In fact, a study by Blue Cross and Blue Shield demonstrated that “complying with the new actuarial standards in the bill would increase average costs by 17 percent for individuals and almost 10 percent for small employers.

The bill of the money spent on health care in the United States today is spent on the delivery of health care. Yet, what we see in today’s bill is just “more of the same” in the delivery of care instead of making fundamental changes to reward high quality, low cost care. The bill authorizes hundreds of Medicare pilot programs to test different ways to pay doctors and hospitals for quality of care. But once again, these pilots are governed from the top-down and typically take years to initiate and rarely result in reforms applied throughout the system. Instead, we should be supporting efforts that are coming out of both the states and multi-collaborative projects between networks of hospitals, businesses and physicians. Wisconsin hospitals such as ThedaCare, Marshfield Clinic, Gunderson Lutheran, and Aurora Health Care all have been engaged in transforming the delivery of care to get rid of the inefficiencies and provide low cost, high quality care. We should be supporting these reforms from the bottom-up, instead of repeating the work that has already been done.

Today, I will vote in support of Congress­man BOEHNER’s substitute amendment which is a good step forward in lowering health care premiums for families and small businesses,
increasing access to affordable high quality care, and promoting healthier life styles—without adding to the deficit.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Members are reminded to heed the gavel.

Mr. ANDREWS. Madam Speaker, I yield myself 30 seconds before the next introduction.

There is a credibility issue here. The minority says the bill doesn't have enough prevention, but the American Cancer Society supports the bill. The minority destroys the doctor-patient relationship, but the American Medical Association supports the bill. The minority says it's bad for America's seniors and for Medicare, but the AARP supports the bill. I think there is a credibility issue, and it doesn't work for the minority.

At this time, I would be happy to yield 1 1/4 minutes to the gentleman from Pennsylvania (Mr. SESTAK).

Mr. SESTAK. Madam Speaker, a little over 30 years ago, I came to this Congress to pay back a debt. After three decades in the U.S. military, my young 4-year-old was struck with the same brain tumor Senator Ed Kennedy had. Because of the wonderful health care system and the Congress that provided our families in the military, she was given a chance.

I was taken in the U.S. military by how and why we do that. It's not because we're generous. It's because we reap great dividends for this Nation. This Congress sent me off for 11 1/2 months to a war, and while I was gone, my daughter and my wife were taken care of and my mind was on the mission. In the military, we reap the benefit of healthy, focused warriors.

I am taken with this bill. It gives us healthy, productive workers. It actually combines, in my mind, the best of America's character—rugged individualism allied with the common enterprise. It gives us the quality of life that in the military reaps such great dividends. This bill, to me, is no different, and it's time.

Mr. KLINE of Minnesota. Madam Speaker, at this time, I yield 2 minutes to the ranking member of the Armed Services Committee and the former ranking member of the Education and Labor Committee, the gentleman from California (Mr. McKEON).

Mr. McKEON. Madam Speaker, I thank the ranking member for yielding.

It's been said that Abraham Lincoln said, "You cannot bring about prosperity by discouraging thrift. You cannot strengthen the weak by weakening the strong. You cannot help the poor by destroying the rich. You cannot keep out of trouble by spending more than you earn. You cannot help man permanently by doing for them what they could and should do for themselves."

Madam Speaker, what we're doing here violates all of these principles that Abraham Lincoln spoke so eloquently about.

I rise today in strong opposition to this Pelosi bill of over 2,000 pages. At a time when we're suffering the highest unemployment in this country since 1983, the American people can't afford these massive new spending increases, and I refuse to pass this great burden on to my children and grandchildren.

I would like to try to improve this bill: one to require Members of Congress to enroll in the public option like we're going to require all of you to do, and one that said that illegal immigrants would not receive new benefits under this new bill; commonsense provisions that were voted down by the Democrats in the Rules Committee. In fact, Democrats voted down every single Republican amendment but one. How is that for bipartisanship?

The bill raises taxes, kills jobs, and costs over $1 trillion in money we don't have. The Republican plan will cut costs through tort reform, negotiating across State lines, and through purchasing power.

The minority says it's bad for America and for Medicare, but the American Cancer Society supports the bill. The American Lung Association supports the bill. The American Heart Association supports the bill. The American Diabetes Association supports the bill. The American Diabetes Association supports the bill.

Supporting the minority is strong support for the Republican alternative and oppose the Pelosi plan. This is an absolute disaster.

Mr. ANDREWS. Madam Speaker, before I yield to my next speaker, I yield myself 30 seconds.

With all due respect, what is an absolute disaster are the repeated misrepresentations of certain things that are in this bill, and we just heard one. No one is forced to join the public option. No one. It is not in the bill; and I would, frankly, invite the minority to show us where it is.

Secondly, Members of Congress are positioned exactly the same as everyone else is with the public option. When and if the time comes that the Federal Government is a participating employer in the exchange, we can either choose the public option or not. The House deserves an accurate record.

I yield 1 1/4 minutes to a woman who stood for fiscal soundness not only here in Washington but in New Hampshire, the gentlewoman from New Hampshire, CAROL SHEA-PORTER.

Ms. SHEA-PORTER. Madam Speaker, I rise today to support the Affordable Health Care for America Act. This is a historic moment for our Nation.

In my district, this bill will provide coverage for 37,000 uninsured residents; 128,000 households will qualify for credits to help them afford the coverage of their choice. We will invest more in community health centers. We make Medicare stronger, which is why AARP has endorsed this bill. We start to close the Medicare Part D doughnut hole in 2010, and it will be completely closed by 2019. We will provide a 50 percent discount for name-brand drugs for those in the doughnut hole, and we eliminate copayments for preventative care.

Today, we make history for our seniors, for our children, for the middle class—for all Americans. Today, we vote for an America where discrimination based on preexisting conditions is a thing of the past. Today, we vote for an America where getting sick doesn't mean losing your home. Today, after decades of debate, we finally vote for a healthier America.

Ms. SHEA-PORTER. Madam Speaker, before I yield to the gentlewoman from Washington, I yield for a unanimous consent request to the gentleman from Kentucky (Mr. ROGERS).

Mr. ROGERS. Madam Speaker, and was given permission to revise and extend his remarks.

Mr. ROGERS of Kentucky. Madam Speaker, I rise in opposition to this federal taking of health care.

We can all agree that health care costs are too high and that we need to open up access for more Americans. That being said, we need to pass a bill that actually cuts costs and increases access rather than a government-run takeover of health care. I cannot support Speaker Pelosi's monster bill because it puts a Washington bureaucrat between individuals and their doctor, it adds to our immense debt in Washington, and, even more frightening, it will limit health care availability in rural regions like southern and eastern Kentucky.

In these challenging economic times, with double digit unemployment, out of control government spending sprees, and bailout after bailout, we should not pass a bill that will kill jobs, raise taxes, and raise insurance—our government-run health care bill not only imposes new penalties and taxes on small businesses, it raises taxes on already struggling individuals and families. Whether someone wants health insurance or not, they'll be forced to purchase it, and the federal government will garnish wages or send them to jail if they don't comply. Even more troubling, the more vulnerable and ailing one is, the more they'll pay, as this bill imposes new taxes on critical medical supplies like wheelchairs, hospital beds, and prosthetic limbs. As if that wasn't enough, the bill opens the floodgates of taxpayer money for illegal immigrants to abuse the system and obtain free government health insurance—on the backs of law-abiding Americans. Lastly, I am scared for our seniors as this bill makes devastating cuts to the Medicare program to the tune of $500 billion, and puts the popular Medicare Advantage program on life support, virtually eliminating its existence.

I support the Republican alternative health care bill that focuses on lowering health care premiums for families and small businesses, increases access to affordable high-quality health care, and promotes healthier lifestyles without adding to Washington's crushing debt. The plan I support offers access to affordable care for those with pre-existing conditions, ends junk lawsuits against our doctors, allows small businesses to band together to purchase insurance for their employees and allows individuals to shop for insurance across state lines, which would increase competition such as these will lower insurance premiums by at least 10 percent, and provide health insurance to millions more Americans.
This bill reflects a fundamental and drastic change in our way of life, and is the largest government intrusion into the private lives of our citizens ever. I, for one, am truly frightened by the potential consequences.

Mr. KLINE of Minnesota, I am now pleased to yield 2 minutes to the gentleman from the committee, the ranking member on a subcommittee, the gentlewoman from Washington, CATHY MCMORRIS RODGERS. 

Mr. McMORRIS RODGERS. I thank the gentlewoman for yielding.

Madam Speaker, we just need to slow down the American public has made it clear that they want the right health care reform bill enacted, not just any bill.

Look at the stimulus bill that was rushed through Congress. Look at what has happened. They said, Oh, unemployment won't go over 8 percent. We are now at 10.2 percent. We have lost 3 million jobs, and we have a $1.4 trillion deficit.

Like my mom used to say, You rush, you make mistakes.

This health care reform bill will be no different. It spends $1.3 trillion. It taxes employers $750 billion, many of whom have been business owners at the very time that we need these small business owners to be creating jobs. We need jobs. Isn't it interesting that even the administration's own economic adviser has estimated that this bill will cost America an additional 5.5 million jobs.

Other reforms in the bill all but eliminate Medicare Advantage, hurting 20,000 seniors in eastern Washington and millions across the country. For rural communities, the bill calls on the Institute of Medicine to study payment disparities in rural regions. So we are spending $1.5 trillion, and the only relief we get is another study? My list of concerns goes on and on.

The Republicans have a better way, one that lowers premiums for families by as much as 10 percent; one that saves billions in medical liability reform, allowing people to purchase health insurance across State lines; one that continues the continuity and coverage; and it's a solution that doesn't indebted our children and our grandchildren.

Madam Speaker, just this week, thousands of people stood on the Capitol steps. They called on Congress to oppose this legislation. I urge us to heed their warning. Vote "no." Let's slow down the process, and let's get the right kind of reform, not just any kind of reform.

Mr. ANDREWS. Madam Speaker, I yield myself 15 seconds.

The gentleman just quoted an unnamed phantom Obama administration adviser, Christina Romer, the CEA chairperson for the Obama administration, says this bill will increase the GDP between 1-2 percent and will add several million jobs.

I am pleased to yield 1½ minutes to a strong voice for working families in this country, the gentleman from Illinois (Mr. HARE).

Mr. HARE. Thank you, Congressman ANDREWS.

Madam Speaker, when I was growing up as a young boy, my parents lost their home. My father was ill. He shouldn’t make the payments. I remember coming home the day of my older sister’s wedding to see a process server with a notice to evict and 30 days to leave.

Two days before my father died, I sat by his bed, and he told me, There are two promises I want you to make to me: take care of the girls and your mother, and no matter what you do, please see that this will not happen to another family.

Tonight, in a few hours, I will have the opportunity to keep that promise to my dad and to the tens of thousands of other people who have lost their homes and everything they had simply because they were sick. All the fearmongering. All the misstatements of facts and figures. Health care in this country, my friends and fellow citizens, is a right. It is not a privilege.

So, tonight, for my father and for the people who came after him, I will stand proud for this bill no matter the amount of shouting, of tearing this down and of calling the bill whatever you want to call it. I call it getting people exactly what this country promises them: life, liberty, and the pursuit of happiness.

Mr. KLINE of Minnesota. Madam Speaker, I am pleased to yield 1 minute to a member of the committee, the gentleman from Michigan (Mr. HOEKSTRA).

Mr. HOEKSTRA. I thank my colleague for yielding.

Madam Speaker, today, I met Theresa. Theresa had a sign that read: I love my country. On the other side, it read: My future. Her brother, Xavier, had a sign that read: Give me liberty, not debt.

If we pass Pelosi health care tonight, tomorrow morning, we will still all love our country; but we will have jeopardized Theresa’s future. A bailout, a stimulus, cap-and-trade, and Pelosi health care have jeopardized her future. For Xavier, we will have given him debt: another $1.2 trillion on top of the $1.4 trillion we gave him last year.

I will vote “no” because I believe that the vote that says: I love my country. I will vote “no” because I believe that is the vote that preserves our future. I will vote “no” because I know that that will preserve Xavier’s liberty and not give him more debt.

With that, I urge my colleagues to vote “no” on this bill.

Mr. ANDREWS. Madam Speaker, I am pleased to yield 1½ minutes to a member who fought tirelessly for equality in Medicare reimbursement for the State of Iowa, the gentleman from Iowa (Mr. LOEBSACK).

Mr. LOEBSACK. Thank you, Mr. ANDREWS.

Madam Speaker, I am proud to be a part of this effort to improve health care in America, and I will support the bill before us because I have heard from countless Iowans about the desperate need to change the current system, and I believe this legislation before us today will provide true and comprehensive reform.

However, since coming to Congress, I have told just about everyone I could and everyone who would listen to me that comprehensive reform cannot be achieved without addressing geographic disparities in the Medicare payment system. Many other Members agreed, and we formed the Quality Care Coalition, and we brought about that change.

There is much needed language in this bill to fix a broken Medicare payment system. By focusing now on the quality of services provided to patients instead of the quantity of services, this provision will provide a significant cost savings to Medicare, and it will benefit patients in Iowa and all across America.

In particular, I want to thank my leadership: my chairman on the committee, GEORGE MILLER; my friend ROB ANDREWS; Chairman WAXMAN; and Chairman RANGEL for their work on this issue.

I urge everyone to vote for this bill before us.

Mr. KLINE of Minnesota. Madam Speaker, I yield 1 minute to a member of the committee, the gentleman from South Carolina (Mr. WILSON).

Mr. WILSON of South Carolina. Madam Speaker, America’s leading voice for small business, the National Federation of Independent Business, the NFIB, opposes H.R. 3962, the Pelosi takeover bill. The NFIB has sounded the alarm about the employer mandate, payroll tax penalty and unnecessary paperwork mandate crippling small businesses.

The opposition letter from the NFIB warns that the Pelosi takeover includes multiple mandates. Economic research shows mandates are ultimately borne by the worker through job loss and lower wages. The NFIB also warns how the payroll tax penalty is a tax on jobs and job creation. Additionally, the unnecessary paperwork mandate will place a new paperwork burden on all small businesses at a time when they are struggling to stay afloat. The NFIB has estimated the takeover effort will kill 1.6 million jobs at a time of record unemployment.

We should support health insurance reform, not a government takeover.
NFIB has been a constructive participant in the healthcare debate and has spent more than a decade voicing our need for reform. With healthcare costs ranking as the No. 1 issue facing small businesses, our employees and must carefully weigh the potential benefits of reform against the new costs imposed on business owners in the legislation. NFIB members have experienced increases in H.R. 3962 that will raise those costs:

Employer Mandate: H.R. 3962 includes an employer mandate that will require employers to cover healthcare for full-time and part-time employees. An employer mandate does not address the No. 1 issue facing small businesses: the ability to purchase over-the-counter medications, shrinking options employers have to provide affordable health insurance options. However, small employers are paying today. In some states, the cost of an “acceptable” plan has more than doubled for Nevada’s small businesses. Without comprehensive reform, health insurance premium has more and more employers until there is no one exempted at all.

Paperwork Mandate: H.R. 3962 places a new tax on payroll and job creation because they tax labor. The legislation requires that all employers with a payroll of $500,000 or more pay a surcharge of up to 8 percent if they do not provide “qualified” health insurance to their employees. No matter how profitable or unaffordable a business might be, they must pay this tax. In addition, because the exemption thresholds in H.R. 3962 are not indexed for inflation, the exemption will become a healthcare equivalent of a minimum tax on growing more and more employers until there is no one exempted at all.

Big Business and More Mandates: Small employers need a guarantee that plans offered in an exchange will be less costly, not more expensive, than what they are paying today. In addition, small businesses pay an average of 18 percent more for their healthcare, leaving them continuously searching for more affordable choices. H.R. 3962 gives a political board the power to define “coverage” and will determine whether an employer plan is “acceptable.” However, the bill does nothing to ensure that the plans will be any less costly than what small employers are paying today. In some cases, the legislation will also require some small employers to cover benefits that are not currently mandated under federal law.

Takes Away Small Business Solutions: Small employers need more, not fewer, affordable health insurance options. However, the prohibition of HSA, FSA and MSA funds to purchase over-the-counter medications, along with the $2,500 limit on FSA contributions, threatens to further limit the cost-shrinking options employers have to provide meaningful health care to their employees.

Public Option: A government-run plan cannot compete with the private market, and threatens to destroy the marketplace, further limiting choices. We believe that with proper reforms the private market can be held accountable to provide greater competition and lower-cost solutions where insurers compete based on their ability to manage, rather than risk. Instead, the excessively prescriptive insurance reforms in H.R. 3962 will drive up costs.

Surtax: Seventy-five (75) percent of small business owners believe that state mandates are passed through entities and pay their business taxes at the individual level. More than one-third of small businesses employing 20 to 50 employees pay a payroll tax. Finally, since the tax is not indexed for inflation, the effect of the tax will creep downward, making more and more businesses vulnerable to a tax increase. Poorly-Structured Tax Credit: There are two reasons the credit in H.R. 3962 is of limited value. First, the availability of the credit is too short. A credit that is only available for two years is too short a time for an employer to benefit from the tax credit to see a large spike in their out-of-pocket costs for health care in year three. Second, the wage limits are too restrictive. Phasing the credit out based on average wages of $20,000 or less severely reduces the amount of a tax credit available for most small businesses. NFIB will continue to advocate for reform because, as both democratic and republican lawmakers have said, the status quo is not acceptable. Our small business owners agree, but reform must make things better, not worse. Because H.R. 3962 will not lower healthcare costs and threatens our economic recovery, NFIB will consider a NO vote in support of small business. This will be an NFIB KEY VOTE FOR THE 111TH CONGRESS.

Sincerely,

SUZAN ECKERLY,
Senior Vice President, Federal Public Policy.

Mr. ANDREWS. Madam Speaker, I yield 2 minutes to a gentlewoman from Illinois (Ms. TITUS).

Ms. TITUS. Thank you, Mr. ANDREWS.

Ms. TITUS. Madam Speaker, for more than 6 months, I’ve discussed the need for health care reform with my constituents; and time and again I’ve heard from small business owners who are struggling to afford health care coverage.

Over the last decade, the average health insurance premium has more than doubled for Nevada’s small businesses. Without comprehensive reform, Nevada’s small business health premiums are projected to again double over the next decade. In this year alone, small businesses across the country are being hit with a 15 percent average increase in premiums. It is clear that the status quo is unacceptable and unsustainable.

I had concerns about earlier versions of this bill, but I am pleased that H.R. 3962 before us today is significantly improved and takes important steps to help make health insurance more affordable.

I worked to raise the income level at which people are assessed a health care surcharge. The new threshold is significantly higher, up from $350,000 for couples to $1 million. This means that 98.8 percent of all small businesses will be exempt from any surcharge.

The bill also now exempts small businesses with payrolls below $500,000 from the employer mandate. That means that 86 percent of all employers are exempt, and many small businesses which choose to offer insurance to their employees will be eligible for a tax credit to help offset those costs.

I am especially proud that the provision I championed, which was to exclude health insurance so that more businesses could participate, was included and strengthened in this bill. This will ensure that small businesses have additional options for purchasing health insurance at a lower cost.

All of these improvements combined will strengthen small businesses so they will be critical engines of growth in our communities. It is time small businesses knew who really stood up for them and cared about them and their employees.

I urge my colleagues to support this bill and to stand up for small business.

Mr. KLINE of Minnesota. Madam Speaker, I yield 1 minute to a gentleman for yielding from Illinois (Mrs. BIGGERT).

Mrs. BIGGERT. I thank the gentleman for yielding.

Madam Speaker, I rise in strong opposition to this $1.3 trillion government takeover of health care.

Time and again, the President promised the American people that, if they like the health insurance they have, they can keep it. So I introduced an amendment in the Education Committee that said what he said: if you like the health insurance you have, you can keep it.

The Democrats defeated this amendment with a unanimous vote.

This bill does not keep the President’s promise. Instead, it would allow a group of unelected government bureaucrats to determine if the health insurance you have is up to government standards. If they say it’s not and if you don’t buy what they say you should buy, you will be fined. If you don’t pay the fine, it’s jail time.

I urge my colleagues to defeat the bill and, to, instead, vote for the GOP alternative. Not only does it expand access to those who lack it and not only does it lower costs for everyone, but it cuts the deficit, preserves the doctor-patient relationship, and ensures that you can keep the coverage you have.

Mr. ANDREWS. Madam Speaker, a number of great and visionary men have stood at the podium where you stand now as Speaker of the House. Many of them tried to achieve significant health care reform; each of them failed, so we will succeed with a strong, visionary woman.

It is my privilege to yield 1 minute to the Speaker of the House of Representatives, Congresswoman NANCY PELOSI.

Ms. PELOSI. I thank the gentleman for yielding.

Mr. ANDREWS. Madam Speaker, a number of great and visionary women have stood at the podium where you stand now as Speaker of the House. Many of them tried to achieve significant health care reform; each of them failed, so we will succeed with a strong, visionary woman.
Madam Speaker, today as we all know is an historic moment for our Nation and for America's families. For nearly a century, leaders of every party and political philosophy have, as far back as Teddy Roosevelt, called for health care reform. For generations, the American people have called for affordable, quality health care for their families. Today, the call will be answered. Today, we will pass the Affordable Health Care for America Act.

This legislation is founded on key principles for a healthier America: innovation, competition and prevention. It improves quality, lowers cost, expands coverage to 36 million more people, and retains choices.

Our innovation began in the recovery package in January with $19 billion for health IT, the first step in lowering cost and improving quality, and $8 billion in investments for biomedical research. This legislation will mean affordable care for the middle class; no dropped coverage if you are sick; no copays for preventive care. There is a cap on what you pay in, but there is no cap on the benefit that you receive.

It works for the seniors, closing the doughnut hole, offering better primary care and strengthening Medicare for years to come. It works for women, preventing insurance companies from charging women more than men for the same coverage. No longer will being a woman be a preexisting medical condition.

It works for young people, offers affordable choices and copays for preventive care to stop problems before they start, and allows young people to stay with their parents until their 27th birthday. It works for small business owners, providing access to affordable group rates and creating a tax credit to help them insure their employees. It works for consumers, keeping insurance companies honest and encouraging competition with a public option.

This legislation puts you and your doctor in charge. No longer will insurance companies come between you and your health care. President Obama has said that health care reform is entitlement reform, and this legislation proves that point. It is fiscally sound, it is paid for, and it reduces the deficit by tens of billions of dollars over the next 10 years.

This legislation is the result of extensive deliberation here in the Congress, where we have held more than 100 hearings and is the product of extensive input from the American people. Members of Congress have held over 3,000 town meetings. It has resulted in a better bill than H.R. 3200. However good or excellent that was, this bill is a better one with significant differences, and my colleagues have pointed them out, as did Congresswoman DINA Titus, who just spoke before me at the podium.

We are brought to this historic moment in our Nation for our families because of the leadership of Chairwoman HENRY WAXMAN of the Energy and Commerce Committee, Chairman CHARLIE RANGEL of the Ways and Means Committee, Chairman GEORGE MILLER of the Education and Labor Committee, and Chairwoman LOUISE Slaughter of the Rules Committee.

I thank all of those committees, including the Rules Committee, for being in so late so that we could have this legislation on the floor today and for their ongoing service to the Congress.

More than 300 groups representing tens of millions of Americans have expressed their support for the bill: the AARP, American Medical Association, the American Nurses Association; the list of medical groups goes on and on. The American Cancer Society Cancer Action Network, American Heart Association, American Diabetes Association. And I am particularly proud the Consumers Union supported this legislation. My colleagues, this morning we were part of history, and we are this evening as well.

But a particularly poignant moment occurred when Chairman DINGELL took the Chair to preside over the debate, the beginning of the debate for health care. When he was a young man as a Member of Congress, he gavelled Medicare into law. It had been, as one of our colleagues said, in his DNA, this pursuit of the goal of health care for all Americans. His father had introduced the bill over and over again when he was in Congress and, as his successor, he continued that great legacy.

Today he will see a lifelong dream of generations in his family come true as we begin the process of making this a reality.

It's impossible to talk about health care reform in America without talking about Senator Edward Kennedy. His leadership and his contribution to this debate is boundless. Health insurance reform was the cause of his life. He called it the great unfinished business of our society. On this issue he said what is at stake is the character of our country. When the President came to address the joint session, he quoted those comments by Senator Kennedy from a letter that the Senator had sent to him. What the Senator also said in the letter that was sent to President Obama before he died was this:

"I entered public life with a young President who inspired a generation and the world. It gives me great hope that as I leave, another young President inspires another generation and once more on America's behalf, inspires the entire world."

He acknowledged President Obama's "unwavering commitment and understanding that health care is a decisive issue for our future prosperity."

President Obama's leadership gives our Nation hope. Today, with this legislation, we will give them health. President Obama has said, "We will measure our success in the progress that is made by America's working families."

Today, with the passage of the Affordable Health Care for America Act, we will make history. We will also make progress for America's working families.

I urge my colleagues to support this important legislation.

Mr. COURTNEY, Mr. SOUDER, Minnesota. Madam Speaker, at this time I am pleased to yield 1 minute to someone who tells me that he is, in fact, very proud he doesn't have a section in this bill, a member of the committee, the gentleman from Indiana (Mr. SOUDER).

Mr. SOUDER. This is indeed a historic day. It’s a crossroads in America. What you just heard from our distinguished Speaker was we, the government, will do this. We, the government, will do that. We, the government, will do that. Instead of having the private sector do this, instead of having competition, instead of having capitalism do this, we, the government, will fix everything. We, the government, will provide everything.

We are in an economic crisis in this country. Just yesterday, for the first time, an over 10 percent unemployment. In my eight counties, over half are over 15 percent unemployment.

What are we doing today? Taxing small business, the number one producer of jobs, adding regulations to those businesses, adding expenses to those businesses, taxing medical technology, which will reduce R&D, reduce jobs, reduce quality of health care.

What are we doing today? We are not going to require identification for illegal immigrants. We are going to hope that they self-report. With 1,990 pages of ignoring the voices of American people, higher taxes, fewer jobs, an unconstitutional takeover of 17 percent of our economy, a trillion dollars of debt, and free health care for the illegals who took your jobs.

Mr. ANDREWS. Madam Speaker, I am pleased to yield 2 minutes to the gentleman who made sure that the ban on discrimination based on preexisting conditions will take effect as soon as this bill does, the gentleman from Connecticut (Mr. COURTNEY).

Mr. COURTNEY, Mr. SOUDER, Mr. CULBERTSON, Mr. MILLER. 45 percent of Americans suffer from some form of chronic disease, leaving them exposed to preexisting condition discrimination. The Commonwealth Fund found that 12.6 million non-elderly adults were, in fact, discriminated against. What are we doing today? Taxing and charging more for insurance to Americans based on medical underwriting. Like Jim Crow laws, like separate but equal laws, like laws denying women
Mr. KLINE of Minnesota. Mr. Speaker, I yield 1 minute to a distinguished member of the committee, the gentleman from Delaware (Mr. CASTLE).

Mr. CASTLE. Mr. Speaker, I rise in opposition to the legislation but in strong belief that the vast majority of us in Congress are committed to reducing the skyrocketing costs of health care today and expanding access to insurance coverage for those in need.

Additionally, I am certain that if we focused on the on the many shared bipartisan goals, we could pass a health reform package that took common-sense approach without making financial commitments that this country is unable to afford. Such items include insurance market reforms such as preventing denial of care for preexisting conditions, purchasing insurance across State lines, encouraging regional exchanges between States and portability, small business pooling and tax credits, negotiating drug prices, eliminating the $60 billion in Medicare fraud each year, rewarding efforts to prevent common disease and illness, enrolling those who qualify into existing programs like Medicaid and SCHIP, tax benefits for needy individuals for help purchasing insurance, and limiting abusive lawsuits.

Instead, we are confronted with a bill that overreaches by creating new government programs costing over $1 trillion paid for from tax increases and cuts to Medicare which are more gimmicks than real entitlement reform. Independent analysis of H.R. 3962 continues the trend of government reforms which will result in higher costs for too many patients in addition to increasing the Federal debt which continues to rise dramatically under this Democratic administration and Congress.

Universal health care will not happen overnight. An incremental approach that expands access to health care coverage, contains costs and limits government involvement should be at the forefront of building a meaningful program. The process to date has been driven by politics. It is not too late to enact policies that enjoy broad bipartisan support.

Mr. ANDREWS. Mr. Speaker, our next speaker fought hard to make sure the vast majority of entrepreneurs in small businesses were exempt from any taxes under this bill. I am pleased to yield 1 minute to the gentleman from Colorado (Mr. POLIS).

Mr. POLIS. Mr. Speaker, I would like to thank Mr. ANDREWS, the committee staff, and Chairman MILLER for their hard work on this bill.

Where are we today? Our country spends more and gets less from health care. We spend more and get less. Many small businesses and individuals are unable to afford insurance. Americans receive fewer personal increases in costs every year, and that is for those of us lucky enough to have insurance. People with preexisting conditions often can’t get coverage, or the very condition they need coverage for is excluded.

Where does this bill take us? It encourages competition among insurance companies, giving us more choices and more stability so we can choose from hundreds of different policies, including shopping across State lines. It covers most of the uninsured by empowering them to choose the provider of their choice. It prevents pricing discrimination based on preexisting conditions. It allows small businesses to have the same purchasing power as large corporations, and saves them money. It reforms our legal system to reduce the cost of frivolous lawsuits. It supports doctor and nurse training, reduces the deficit by over $10 billion, and applies free market principles to establish a playing field for health care that is good for practitioners and consumers.

I encourage my colleagues to support health care.

Mr. KLINE of Minnesota. Mr. Speaker, I yield 1 minute to a member of the committee and the ranking member of the subcommittee, the gentleman from Kentucky (Mr. GUTHRIE).

Mr. GUTHRIE. Mr. Speaker, I have heard from many of my constituents who are worried and anxious about Speaker PELOSI’s health care bill. Speaker PELOSI’s bill spends $1.2 trillion, cuts Medicare benefits, includes a $34 billion unfunded Medicaid mandate and increases premiums for those already struggling to pay for health insurance. Because of that, the bill raises taxes for just about everyone. The bill taxes individuals who choose not to purchase health insurance, taxes small businesses, taxes medical devices, and taxes health savings plans. The bill is the exact opposite of what the American people said they wanted. The Republican alternative addresses Americans’ number one priority for health care reform: lowering the cost for premiums they pay now. The Congressional Budget Office has confirmed that our plan will lower health care premiums and reduce the deficit without taxing families and small businesses.

I am voting “no” on Speaker PELOSI’s bill because of the devastating consequences it will have on Kentucky’s families, seniors, and small businesses.

Mr. ANDREWS. Mr. Speaker, I am pleased to yield 1 minute to a gentleman who has led the fight to help small businesses in this bill, the gentleman from New York (Mr. BISHOP).

Mr. BISHOP of New York. Mr. Speaker, I would like to thank Mr. ANDREWS, whose lead the fight to help small businesses.

Let’s be honest with our constituents. Reducing corporate welfare and promoting efficiencies in Medicare spending is not equivalent to cutting benefits or covering fewer services. Rather, the Affordable Health Care for America Act is a thoughtful approach to ensuring Medicare works better for seniors and for those who provide care. Most importantly, the Affordable Health Care for America Act promotes stability and peace of mind for the family who just learned their child has diabetes or the husband whose wife has just been diagnosed with breast cancer. No longer will such devastating news be followed by the fear of impending bankruptcy.

Vote “yes” on H.R. 3962.

Mr. KLINE of Minnesota. Mr. Speaker, I yield 1 minute to the gentlewoman from Kansas (Ms. JENKINS).

Ms. JENKINS. Mr. Speaker, the health care system in America needs reform, but the Pelosi plan is the wrong prescription. Unlike the Republican plan, this bill does nothing to reduce health care costs.

While there are many reasons I am opposed to this bill, the most glaring is we can’t afford it. Unemployment has hit 10.2 percent, the highest level since 1983; yet Democrats are forcing through yet another job-killing bill that, according to modeling created by the President’s economic advisers, will kill an additional 5.5 million jobs.

Kansas just announced it is facing a $460 million budget shortfall; yet this
body is set to send my State another unfunded mandate estimated to cost $230 million. And the deficit just exceeded $1.4 trillion; yet the majority wants to pass this $1.3 trillion government takeover of health care.

Let’s reject this fiscally irresponsible legislation.

Mr. ANDREWS. Mr. Speaker, may I inquire as to how much time each side has left?

The SPEAKER pro tempore (Mr. PASSEY of Arizona). The gentleman from New Jersey has 18 minutes remaining, and the gentleman from Minnesota has 21 minutes remaining.

Mr. ANDREWS. Mr. Speaker, I am very pleased to yield 1 minute to the newest member of our committee, who has made a tremendous contribution to this bill already, the gentlelady from California (Ms. CHU).

This bill already, the gentlelady from California has made a tremendous contribution to our committee.

Mr. HOLT. Mr. Speaker, the question many are asking is, Can we afford this health care reform? I would say not only can we afford it, we can’t afford not to pass it.

Consider where we are today: Businesses, large and small, feel a heavy weight on their shoulders trying to afford health care for their employees. It hurts our economy. It costs jobs. Businesses and families are paying a hidden tax of over $1,000 each per year for the care of the uninsured. Costs continue to go up because our procedure-based system rewards the ordering of unnecessary and expensive tests that not only don’t help the patient, they can be detrimental. Any family, even well-off families who think they have good health coverage, can find themselves in bankruptcy from a bad accident or arbitrary actions of the insurers.

All of this would change under this bill. This bill would reduce costs in a number of ways: By reducing the ranks of the uninsured, whose more expensive care we all pay for; by increasing the insurance competition through the new marketplace with a large interstate risk pool; by removing the antitrust exemption; and by moving toward more efficient record-keeping and by moving toward outcome-based, health outcome-based, patient-centered care.

In addition to all this, the revenues raised by this bill exceed the expenditures, so passing this will reduce the deficit by billions of dollars below what it would be if we do not pass this tonight.

We can’t afford not to pass this health care reform. The bill will reduce the costs individuals, families and businesses face and reduce the government deficit defined by CBO.

Mr. HOLT. Mr. Speaker, I am pleased to yield 1 1/2 minutes to the gentlelady from New Jersey, my neighbor and friend, Mr. HOLT.

The Affordable Health Care for America Act would improve the American health care system for all Americans, regardless of how they currently receive their health coverage. First, the legislation would lead to stable health care costs that do not threaten family finances by establishing consumer protections for those purchasing private insurance. The bill would eliminate insurance benefit caps to ensure families do not have to worry about leaving the hospital with bills too big to pay because their benefits have run out. The bill would set an annual cap on out-of-pocket health expenses to eliminate cases where one disease forces a family into bankruptcy.

Second, the bill would provide stable coverage for those who have lost coverage or the self-employed by creating an insurance marketplace, where they could get insurance at group rates. Most of the policies in this insurance marketplace would be private insurance, while one of the plans would be a non-profit public plan. This public plan would be subject to the same requirements and regulations as the for-profit plans in the marketplace. The public option would be just that—an option in which no one would be forced to enroll. The bill also would eliminate the practice where patients with a pre-existing condition, like diabetes or cancer, or pregnancy cannot purchase insurance. According to a Congressional committee report, the bill would help 10,000 uninsured individuals in Central New Jersey gain access to affordable health insurance.

Third, the bill would strengthen Medicare by setting an annual cap on out-of-pocket health expenses to eliminate cases where one disease forces a family into bankruptcy.

Now, it was said this morning by a Democratic colleague that we need to redefine freedom. We are going to need all kinds of new definitions. We are going to redefine freedom as the ability to do what the government tells you to do. We are going to redefine helping the patients to get bonuses and destroying jobs. We are going to redefine bending the cost curve as more than doubling costs in 10 years.

Consider not the rhetoric, but the facts. Please reject this bill.

Mr. ANDREWS. Mr. Speaker, I am pleased to yield 1 1/2 minutes to the gentleman from New Jersey, my neighbor and friend, Mr. HOLT.

This is a historic debate we are having. For the past century, since Teddy Roosevelt ran for President in 1912, our nation has been debating how to ensure that American workers can access the care they need. As a U.S. Representative and the husband of a primary care physician, I have heard many stories from hard-working New Yorkers about the need for reform. Some Americans have access to excellent care, often thanks to the advanced biotechnology and pharmaceutical products created in New Jersey, while others lack even basic care. One of the goals of the health care reform is to help all Americans gain stable access to quality medical care and life-saving medicines.

At a July roundtable in Trenton, a spouse of a cancer patient told me that when she and her husband came home from the hospital after an extensive treatment, she received a foot-high stack of insurance paperwork and $150,000 of out-of-pocket charges for her husband’s needed care. A self-employed woman from East Brunswick wrote to me recently to let me know she pays $2,000 a month for her family’s coverage and still has to pay out-of-pocket to see many of her physicians. These stories are a reminder that health care reform is about real people who are disserved by the broken health insurance system.

These are not isolated stories. While in the U.S., we will spend over $8,000 per person through the health care system, New Jerseyans lacked insurance in 2007 and family insurance premiums are projected to rise from $14,000 in 2009 to $24,000 in 2019. In a country where we are projected to spend 18 percent of our Gross Domestic Product ($2.6 trillion) this year on health care, we can do better.

The Affordable Health Care for America Act would improve the American health care system for all Americans, regardless of how they currently receive their health coverage. First, the legislation would lead to stable health care costs that do not threaten family finances by establishing consumer protections for those purchasing private insurance. The bill would eliminate insurance benefit caps to ensure families do not have to worry about leaving the hospital with bills too big to pay because their benefits have run out. The bill would set an annual cap on out-of-pocket health expenses to eliminate cases where one disease forces a family into bankruptcy.

Second, the bill would provide stable coverage for those who have lost coverage or the self-employed by creating an insurance marketplace, where they could get insurance at group rates. Most of the policies in this insurance marketplace would be private insurance, while one of the plans would be a non-profit public plan. This public plan would be subject to the same requirements and regulations as the for-profit plans in the marketplace. The public option would be just that—an option in which no one would be forced to enroll. The bill also would eliminate the practice where patients with a pre-existing condition, like diabetes or cancer, or pregnancy cannot purchase insurance. According to a Congressional committee report, the bill would help 10,000 uninsured individuals in Central New Jersey gain access to affordable health insurance.

Third, the bill would strengthen Medicare by setting an annual cap on out-of-pocket health expenses to eliminate cases where one disease forces a family into bankruptcy.
It is worth repeating: not only would Medicare remain intact under this legislation, it would become better. The legislation would strengthen the Medicare trust fund by increasing the efficiency of the program, expanding its ability to flight waste, fraud, and abuse, and eliminating subsidies to private insurance companies. No standard Medicare benefits would be cut. In fact, Medicare would be improved by eliminating the "doughnut hole" in the prescription drug benefit. Each year in Central New Jersey, 8,300 seniors face the "doughnut hole" and are forced to pay their full drug costs, despite paying for Part D drug coverage every month. H.R. 3962 would provide these seniors with immediate relief by cutting brand name drug costs in the "doughnut hole" by 50 percent and ultimately eliminating the "doughnut hole" altogether. Further, the legislation would help seniors by eliminating co-payments and deductibles in Medicare for preventative services to ensure that diseases would be treated at their earliest stages and to keep seniors well. The legislation creates new Medicare incentives to encourage hospitals and hospices to coordinate medical care and seek to reduce duplicate tests, x-rays, and labs. These and other provisions are why AARP, among several others, has endorsed this health care reform legislation.

This bill was created from one of the most open and deliberative processes in recent memory. During the past few years, Congressional committees held more than 53 committee hearings, debated and voted on almost 240 amendments, and considered health reform bill in smaller groups. A majority of the amendments reflected concerns raised by constituents and have improved this bill further.

While there are strong humane and moral reasons to pass this health reform bill, the economic reasons are equally strong. Businesses, large and small, feel a heavy weight in trying to afford health care for their employees—hurting the economy and costing jobs. Any family, regardless of their income, can find themselves in bankruptcy from one accident or expensive illness. All of this would change under this reform bill. The bills would lower health costs for families by increasing competition across all states through a new marketplace and eliminating the antitrust exemption. It would reduce costs by promoting coordinated medical care to eliminate duplicative tests, by simplifying insurance paperwork and electronic records. The bill would decrease costs by expanding research on which treatments work best for different patients, helping physicians and nurses provide effective medical care. Long term, the legislation would limit costs by shifting to a focus on health outcomes and awarding physicians for treating the whole patient.

It would do all this without adding one penny to the debt. Instead, it will lower the debt and, according to the Congressional Budget Office (CBO), produce a $109 billion surplus over a decade. We cannot afford not to pass health care reform and reduce the crippling health costs facing our nation, our businesses, and our families.

Sadly, there is a great deal of misinformation about the proposed health reform bill. I have heard from some of the myth that Members of Congress would be exempt from health care reform. It is worth noting that Members of Congress receive their health insurance like any other of the eight million federal employees and we pay premiums just like any other worker. The health insurance reform bill includes several improvements to the overall insurance marketplace, all of which would apply to the federal employee health insurance plans. I welcome the fact that the reform legislation would apply to Members of Congress, just like employees of other large companies.

Opponents of reform also claim that the House health reform bill would encourage euthanasia or insert the government into end-of-life care. Nothing could be further from the truth. This claim is false. The truth is that the legislation would provide doctors with better payment for talking with their patients. This bi-partisan provision would provide payment for a doctor's time if a patient chooses to have a conversation about the care that the patient prefers if he or she becomes very ill, but it does not require anyone to use this benefit. These conversations would not involve any government employee, but would be solely between the patient and his or her physician. As noted by the AARP, "[this measure would not] only help patients make the best decisions for themselves but also better ensure that their wishes are followed."

There is no reasonable basis for concern that seniors' conversations with their doctors on personal requests for end-of-life care would take anything but an informed role, which is illegal in New Jersey and 47 other states, or euthanasia, which is illegal in all states. Discussions between the sick or the elderly and their doctors about end-of-life care have long been an accepted part of modern patient care. Physicians who carry out these wishes are carried out. In 2003, under the Bush administration, the Agency for Healthcare Research and Quality issued a report outlining a five-part process for physicians to discuss end-of-life care with their patients. Unfortunately, doctors are not paid for such discussions and thus are not encouraged to have them. According to the National Hospice and Palliative Care Organization, which supports this provision, the bill simply would allow for counseling on decisions that require time and considerable discussion.

Another myth is that health reform would provide federal benefits for undocumented aliens. Undocumented immigrants currently may not receive any federal benefits except in specific emergency medical situations. There are no provisions in the House health reform bill that would change this policy. In fact, the legislation explicitly states that federal funds for insurance would not be available to any individual who is not lawfully present in the United States.

I have heard from many constituents concerned about the inclusion or exclusion of family planning services in health insurance reform. The legislation would exclude federal funding of abortion, and maintain existing federal laws protecting conscience rights in health care. In fact, the amendment adopted tonight, which I benefited in error, would go further than existing law and even prevent women from using their personal funds from purchasing coverage for family planning services. I hope the conferees will revisit this issue to ensure women have the freedom to purchase coverage to the extent that best serves their needs and conscience.

I am pleased that health reform will help small businesses. According to a report issued from the Council of Economic Advisors in July 2009, the current health care system places a heavy burden on small businesses through high premiums, fixed administrative costs, adverse selection, and comparative disadvantage with larger businesses in America and with businesses in other countries. This is why small businesses pay up to 18 percent more per worker for the same health insurance plan than a large firm. The House legislation would help small business employees purchase insurance at group rates through an insurance marketplace, and by providing a tax credit to help small businesses that purchase insurance. Almost 18,000 small businesses in Central New Jersey would receive this tax credit.

The bill further recognizes the constraints facing small businesses and exempts many small employers from the shared responsibility requirement to provide insurance for their employees. The Congressional Budget Office and respected Massachusetts Institute of Technology health care economist Jonathan Gruber have pointed out that for the large majority of small businesses, the reform legislation would be a great improvement and would provide real savings.

For years, small businesses have asked me and other Members of Congress to allow them to get better rates by pooling their employees in large numbers, which is currently available only in larger companies. The new marketplace would allow insurance plans to pool the health risks of millions of people and thus get lower rates. In addition to the marketplace for small businesses created by the House health reform bill, I worked with my colleagues, including Rep. ANDREWS (D–NJ) to include language in this legislation that would allow affiliated small businesses to join together to purchase insurance. This proposal for helping small businesses was brought to me by a small businessman in my district.

I also was pleased to write a section of the bill that would create an online job training programs for health care workers, modeled after a successful program originating at Rutgers University. This program is needed to help meet the increasing need for health care workers, which was indicated by a July report by the Council on Economic Advisors. The demand for health workers soon will exceed the supply with 48 percent growth in health support occupations such as medical record, clinical laboratory, and health information technicians. My amendment, included in H.R. 3962, would provide new training opportunities to meet this additional demand for health professionals.

While I support the Affordable Health Care for America Act, I look forward to working with my colleagues to improve this bill as the legislative process moves forward. I have heard from home care and hospice providers in my district and across New Jersey who are concerned about the reductions in Medicare home health payments. I have spent time with home care organizations and with individual patients at home and have gained a deep understanding of the challenges and successes that occur each day. I fear that additional cuts to home health would make it harder to do the essential job that home care and hospice workers do so well. I am concerned that several provisions of the bill may impede biomedical research and innovation, as this research has supported patient care
Mr. ANDREWS. I am honored to yield 1 minute to a gentleman who has done an extraordinarily effective job of representing his constituents, the gentleman from the Commonwealth of the Northern Mariana Islands (Mr. SABLAN).

Mr. SABLAN. Speaker, I rise today in support of H.R. 3962, the Affordable Health Care for America Act. The need for health care reform has never been greater nor more urgent. This is true for my district, as it is for another on the other side of the country. We must seize the moment and pass a law that will go a long way toward providing quality, accessible, and affordable health care for all Americans.

I urge my colleagues to support the bill.

Mr. KLINE of Minnesota. Mr. Speaker, before I recognize the gentleman from California, I yield myself such time as I may consume.

There has been quite a bit of discussion here about how this bill is going to help small businesses and reduce their taxes. I think it is no accident that business group after business group, after small business after large business across this country is opposing this legislation. It is the businesses who are going to bear the brunt of the legislation. It is the businesses who are going to bear the first brunt of the taxes, bear the costs, and that is going to be a burden on them.

For example, I have a whole list of organizations: the Associated Builders and Contractors; the Associated General Contractors; the International Franchise Association; the National Association of Manufacturers; the National Federation of Independent Businesses; the U.S. Chamber of Commerce; and on and on, oppose this bill because it does not help business. It puts a burden on them.

Now I am pleased to yield 1 minute to the gentleman from California (Mr. MCCLINTOCK).

Mr. MCCLINTOCK. Mr. Speaker, the question before us comes to this: Will Congress force American families to surrender their health care to the Federal bureaucracy? There is nothing optional about this law. The word “shall” appears 3,400 times in it, each time backed with the full force of the government.

You shall only get your health care through the government exchange.

You shall only select among the health care plans that the government czar has approved for you, whether they fit your family’s needs or not.

You are forced to lose jobs.

You are forced to lose jobs.

You pay a government-approved plan and pay for every government-imposed mandate in it through higher premiums, lower wages or higher taxes, and you will face steep fines and even Federal prison if you decline to do so.

You “shall” 3,400 times.

Whenever such a system is imposed, the result is always the same: massive cost overruns, followed by a brutal rationing of care.

Instead of destroying everything that is good about American health, shouldn’t we first repair what is wrong? Primum non nocere—first, do no harm.
somehow. Democrats could not come up with a real solution for medical malpractice reform except to try to protect trial lawyers’ share of jury awards. Malpractice is proven to cost the health care system billions of dollars every year, but the reforms being proposed make the current system worse.

This bill taxes everyone and everything. It taxes medical devices. It taxes individuals who choose not to purchase insurance, and drives up premiums for individuals who do purchase insurance. It taxes employers who fail to offer health insurance, then taxes them further if they try to increase their employees’ wages. It taxes small business owners, who could be creating jobs and getting us out of the recession, and instead forces them to cut jobs or wages. It taxes health savings accounts, which reduces the use of catastrophic health insurance coverage.

It cuts Medicare. Home health care, skilled nursing facilities and Medicare Advantage would all be cut, and seniors with prescription drug coverage will have their premiums increased. Seniors oppose this bill because they get it—their care is going to be decreased and costs are going up.

After the bill finishes up taxing everything and everyone, it spends all that money even faster. The bill dramatically expands Medicaid, despite the fact that I’ve never heard of anyone saying they want access to the program. It creates a huge new federal bureaucracy to navigate through. And it funds a government competitor to private insurance companies that will siphon people off of private insurance onto a Medicaid-like program, just like Tennessee did with TennCare.

After the Democrats finish spending $1.5 trillion, they say the bill is quote unquote deficit neutral. But they ignore that every major government health care expansion before it—Medicare, Medicaid, SCHIP to name a few—have come up with a bill that actually addressed the deficiency in our broken health care system, would all be cut, and seniors with prescription drug coverage, nursing facilities and Medicare Advantage are satisfied with the status quo of rising premiums, denied coverage because of preexisting conditions, satisfied with ignoring the pain and suffering of the 47 million Americans who are uninsured.

Mr. Speaker, I urge all of my colleagues to vote for this measure.

Mr. Speaker, today, I rise in support of H.R. 3962, Affordable Healthcare for America Act. This evening, as we approach the dawning of the second decade of the new millennium, we will usher in a new assurance of the health and well-being of all Americans. Our children will have the health and peace of mind to exceed the productivity of our generation. Our willingness to do what it takes to transition to a 21st century healthcare delivery system will guarantee future generations the advancement of a productive civil society.

In the United States, one of the richest countries in the world, nearly 47 million Americans lack health insurance. 15 percent of whom are New Yorkers. Last year alone, New York City’s hospitals spent $1.2 billion in charity costs. Tragically, people who are either uninsured or underinsured often have to go without vital healthcare simply because they cannot afford it.

Every American has a human right to adequate physical and mental healthcare, and I believe that we as a national government have a responsibility to assist our citizens in securing quality healthcare.

Unfortunately, Republican colleagues don’t seem to fully grasp the dire situation our healthcare system is in. Maybe they would have come up with a bill that actually addressed the deficiency in our broken healthcare.

It is unfortunate that there are those amongst us who just couldn’t care less; those who were satisfied with the status quo of rising premiums, satisfied with individuals being denied coverage because of pre-existing conditions, satisfied with ignoring the pain and suffering of the 47 million Americans who are uninsured.

Instead of working with us to fix the problem, they capitalize on people’s fears and doubts. It is meant to distract, delay, confuse, and engender fear among our citizens. Today we will not allow the voices of fear to dominate the healthcare discourse. This bill provides healthcare coverage to 96 percent of Americans and includes a strong public option that will provide the needed competition to lower premium costs. That is why I support H.R. 3962, Affordable Healthcare for America Act.

Mr. KLINE of Minnesota. Mr. Speaker, may I inquire as to the time remaining on each side?

The SPEAKER pro tempore. The gentleman from Minnesota has 16 minutes. The gentleman from New Jersey has 14 minutes.

Mr. KLINE of Minnesota. Thank you, Mr. Speaker.

At this time I am pleased to yield 1 minute to the gentleman from Pennsylvania (Mr. Thompson), a member of the committee.

Mr. THOMPSON of Pennsylvania. Mr. Speaker. I rise today in opposition to H.R. 3962. I came to Congress this past January following 28 years in nonprofit health care. In January, the Democratic majority quickly moved the SCHIP reauthorization. I supported the final passage of the bill. SCHIP was modeled after Pennsylvania’s CHIP program, a bipartisan public-private partnership to offer private insurance to my State’s most vulnerable population. CHIP works in Pennsylvania.

Mr. Speaker, I am dismayed to learn that this bill will scrap the SCHIP program. This will jeopardize access to health care to our seniors, small businesses, family farms, and agriculture. Now you are hearing about the cost to our children.
As a health professional, I urge my colleagues to vote "no" on this measure, and I would like to submit a letter from five of my Republican colleagues from Pennsylvania on this issue.

CONGRESSIONAL RECORD — HOUSE

November 7, 2009

Mr. ANDREWS. Mr. Speaker, I yield myself 3 minutes.

Mr. ANDREWS asked and was given permission to revise and extend his remarks.

Mr. ANDREWS. I would like to thank my friends on both sides of the aisle. This has been a stressful time for Americans, and today may have been a very stressful day for Americans.

This might have been the day that someone thought they were going to get a job but found out that they won't get the job because they had breast cancer 5 years ago and can't get health insurance because of their preexisting condition. It has not been their day.

Or it might be the day that a senior citizen decides that they don't have the money this week to renew their prescription bill, and they're going to pay their rent instead of their prescription bill, and they're going to get very sick. It's just not their day.

Or it might be the day that someone is lying awake in bed, churning about the fact that their child seems a little sicker than usual. But if they take them to the doctor, they might get sent to the hospital, and they can't pay the hospital bill because they have no health insurance, and it might mean means testing or foreclosure or losing their home. It's just not their day.

If we pass this bill and it gets to the President's desk, a new day will come to this country, because no person with a preexisting condition will ever suffer discrimination again; because effective next year, eventually no senior will run out of drug coverage at any time during the year because they work for it and they deserve it. The new day will come to that uninsured person because they're in the doughnut hole under Medicare. So they're going to pay their rent instead of their prescription bill, and they're going to get very sick. It's just not their day.

Time is a great health care killer.

There was no objection.

Mr. GEORGE MILLER of California. I yield 1 minute to the gentleman from Ohio (Mr. WILSON).

Mr. WILSON of Ohio. Mr. Speaker, as we wind down the clock on the health care debate, I have thought long and hard about what's best for my district back in Ohio, and I have concluded that the Affordable Health Care for America Act is an important step forward in fixing our broken health care system.

While this legislation is not perfect, there are benefits that are simply too hard to ignore. For example, in my district, 13,000 small businesses will have the opportunity to provide their employees better health care.

Mr. Speaker, I always promised the people that I work for back home that I will vote in their best interest and that I will stand up for what is right. I am
Mr. KLINE of Minnesota. Mr. Speaker, I am pleased to yield 1 minute to my colleague, the gentlewoman from my home State of Minnesota (Mrs. BACHMANN).

Mrs. BACHMANN. Mr. Speaker, the American people overwhelmingly reject the government takeover of our health care. Last Friday, a couple from Hawaii decided the time is so short they needed to get on a plane, come to Washington to beg their Representative to vote "no" from Hawaii. What sacrifices freedom-loving Americans are making to get their government's attention and how big our government has gotten.

They brought me this beautiful, precious lei, and I am reminded that the one who created this lei also created our forebears so insensible to the high cost our forebears paid to purchase our freedom? Tonight, would we foolishly bargain those freedoms away? The American people, our forebears, generations yet unborn, are crying out to us for aight for us to preserve their freedoms.

Vote "no" on the government takeover of health care.

Mr. GEORGE MILLER of California. I yield 1 minute to the gentlewoman from Pennsylvania (Mrs. DAHLKEMPER), Mrs. DAHLKEMPER. Mr. Speaker, the American people overwhelmingly have called on us, their Representatives, to enact real change in our country and in their lives. The Affordable Health Care for America Act embodies the positive change the American people have demanded.

This bill creates effective, affordable, and quality reform for all Americans. Seniors will benefit from a stronger Medicare system, no longer subject to the prescription drug doughnut hole or have to pay out of pocket for their primary care needs. Small businesses will no longer be burdened by skyrocketing health care costs. Tax credits and greater competition in the health care market will make coverage affordable for these small businesses, and no individual will ever again be denied health insurance because of preexisting or chronic conditions.

My colleagues, the need for reform is clear, and the time for reform is now. I urge Members on both sides of the aisle to vote for the Affordable Health Care for America Act for our seniors, for all women, for small businesses, and mostly for our precious children and grandchildren of tomorrow.

Mr. KLINE of Minnesota. Mr. Speaker, at this time, I yield 1 minute to the gentleman from Texas (Mr. SMITH), the ranking member of the Judiciary Committee.

Mr. SMITH of Texas. Mr. Speaker, I thank the gentleman from Minnesota, the ranking member of the committee, for yielding me time.

According to CBO estimates, this bill will cost $1.3 trillion and includes $750 billion in new taxes and $500 billion in Medicare cuts. It increases premiums, increases taxes, cuts benefits, and leads to health care rationing. The government, rather than patients and doctors, will make health care decisions. The bill represents a loss of freedom and more government control for the American people.

I support health care reform to help the long-term, low-income uninsured, but it is not a government takeover of health care. The House Republicans have a better health care bill that lowers premiums for families and small business owners, cuts the deficit by $80 billion, and includes tort reform...

Mr. GEORGE MILLER of California. If I could inquire of the Chair as to how much time is remaining on both sides... The SPEAKER pro tempore. The gentleman from California has 10 minutes.

Mr. CARNAHAN. Mr. Speaker, "millions do not now have protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection." President Truman delivered these words in a special message to Congress in 1945, calling for comprehensive health care in America.

Health care in America has been broken far too long, unavailable and unfair for too many, becoming more unaffordable every year. Health care premiums have doubled in 10 years. Health care bills are the number one reason for personal bankruptcies in our country. Health care costs are the number one contributor to our deficit. We spend more on health care than any other country, yet we rank near the bottom in terms of health care results.

This bill builds upon the best parts of our private employer-based system and fixes what’s broken to lower costs, increase competition, promote preventative medicine, and protect seniors. Many ideas and concerns from Missourians I represent have been included in this bill to make it even better. History and the American people are calling us to action. The time is now to fix health care in America.

Mr. KLINE of Minnesota. Mr. Speaker, now I yield 1 minute to the gentleman from Alabama (Mr. ADERHOLT).

Mr. ADERHOLT. Mr. Speaker, there is no question we need to address health care problems in this Nation. That is something both Democrats and Republicans both agree on. However, the government takeover of health care that we are debating tonight adds up to way too much spending, too much government bureaucracy, too many unfair mandates, too much government control in an area with where government just doesn’t belong.

The Republican substitute is about to be debated tonight, and it will attempt to fix the broken aspects of health care. There will be many of us tonight in this Chamber who will vote “yes” on that Republican substitute because there needs to be changes. However, we will vote “no” on final passage because we do not want to throw the baby out with the bath water in order to fix the problems.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 1 minute to the gentleman from Michigan (Mr. SCHAUER).

Mr. SCHAUER. Mr. Speaker, because of rising medical costs, families in America are literally going broke. Yes, broke. The American Journal of Medicine reported that 62 percent of American bankruptcies are linked to medical bills. These medical bankruptcies have increased by 50 percent in just 6 years. The shocking fact is that 78 percent of these people actually had health insurance, but gaps and inadequacies in the current system left them unprotected when they were hit by devastating bills.

Important insurance reforms in this bill will fix this, and as a result of this debt, 30,000 of my constituents will finally be able to afford quality health care coverage and peace of mind for their families.

Perhaps more than in any other State, people in Michigan know that the current system is broken. It’s time for us to fix it. It’s time for us to pass H.R. 3962.

Mr. KLINE of Minnesota. Mr. Speaker, at this time I yield 1 minute to the gentleman from Indiana (Mr. BURT). Mr. BURTON of Indiana. I thank the gentleman for yielding.

Government can’t give until it takes. There is no such thing as a free lunch. In this case, it can be achieved without any sacrifice of the freedoms we so dearly cherish.

Mr. GEORGE MILLER of California. Mr. Speaker, my district needs one thing: jobs. Jobs. Jobs. And then deal with some of these things in a more responsible way.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 1 minute to our New Member from New York (Mr. OWENS). Mr. OWENS. Mr. Speaker, my district needs one thing: jobs.

In Upstate New York, small businesses are the jobs engine. Over the past 15 years, they have been responsible for nearly two-thirds of all jobs.
created in America. But the cost of health care is grinding the engine down. Over the last decade, small business insurance premiums are up 129 percent. That means much higher expenses, more businesses dropping coverage, more financially strapped workforce, and enormous pressure on small business owners from competitors overseas and big businesses at home.

The bill can change that. It creates a complex marketplace where individuals and small businesses can shop for policies at fair rates. It guarantees free preventative care for a healthier, more productive workforce. And it encourages Americans to start businesses of their own because the cost of health care will no longer tie them to the same job.

The people of my district need jobs. They need me to vote “yes.” I came to Congress to move America forward. This bill does that.

Mr. KLINE of Minnesota. Mr. Speaker, at this time I yield 3 minutes to the distinguished Republican leader, the gentleman from Ohio (Mr. BOEHNER).

Mr. BOEHNER. I thank my colleague for yielding.

For many of us on both sides of the aisle who believe in the sanctity of human life, the underlying bill allows for taxpayer funding of abortion. The Speaker has allowed Mr. STEMPAK and others to offer an amendment tonight.

And, Mr. MILLER, if that amendment were to pass and this bill were to get to conference and there were a vote in the conference on this, would you guarantee me that you would support the House-passed version?

Mr. GEORGE MILLER of California. Will the gentleman yield?

Mr. BOEHNER. I’m happy to yield.

Mr. GEORGE MILLER of California. As he has already acknowledged, when he was Chair and he went to conference many times, he could not guarantee anything. You will take into this House if that amendment should fail that will be his position of this House on that subject, on that amendment. We will take that with the full dignity of that vote into that conference committee.

Mr. BOEHNER. If you can speak for the Senate—nobody else has been able to.

Mr. BOEHNER. Reclaiming my time, the question was this: If the House is to pass the Stupak amendment and this bill is to pass tonight and there is a vote on insurance on this issue, would you guarantee me that you will support the House-passed version?

Mr. GEORGE MILLER of California. I will not guarantee that. You know the nature of the conference committee.

Mr. BOEHNER. Reclaiming my time, this is the third chairman tonight who will provide no guarantees that if the House were to pass the Stupak amendment that they would vote in conference to support the House-passed version.

This is the point of why I’ve been down here making this an issue: just because we pass an amendment to help facilitate the passage of what I think is a bad bill does not mean that the language that this House votes on is committed to by the Democrat leaders in this House.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 1 minute to our new Member to the Congress from California, Congressman GARAMENDI.

Mr. GARAMENDI. Mr. Speaker, 3 days ago I had the great honor of joining this august body, which for more than a century has debated health care.

Two hours ago a dear friend Chic Dambach and his adult son came to my office. At the age of 2, Kai’s kidneys failed. Chic and his family had health insurance. Their insurance company refused to cover transplants. Chic and his wife, Kay, were faced with a choice: enormous personal debt or their son’s life. They chose life.

A decade of battles with their insurance company together with crushing debt, Kai, when he becomes 23, will be uninsurable. He has a preexisting condition.

H.R. 3962 is America’s opportunity to end this despicable situation. The bill will create a comprehensive insurance reform and creates the penultimate enforcement mechanism: the public option. Americans should not be at risk any longer. The bill deserves our support.

Mr. Speaker, three days ago I had the great honor of joining this August body that for 220 years has debated the momentous issues of the day, wars, industrial and labor policy, civil rights, environmental protection, and social security, and for more than a century—a health care policy.

Today we are faced with a choice. Do we vote no health insurance reform and continue the current situation that has placed in jeopardy every person in America who is not yet 65 years of age? Or do we vote today to provide every American with a comprehensive, affordable, and available health care policy?

One example of why we must vote yes on H.R. 3962 and end the health care crisis that millions of Americans face each year is Chic Dambach and his son Kai.

Some of you may know Chic as the former President of the Returned Peace Corps Association. Chic and his family had a comprehensive family health insurance policy. At the age of two, Kai’s kidneys failed.

Their insurance company refused coverage for kidney transplants. With his insurance company he went to Congress. And when he came to my office, when he came to Congress, we made sure that he got what he needed. He got it.

Their insurance company refused coverage for kidney transplants. With his insurance company he went to Congress. And when he came to my office, when he came to Congress, we made sure that he got what he needed. He got it.

H.R. 3962 is America’s opportunity to end this despicable situation. The bill will create a comprehensive insurance reform and creates the penultimate enforcement mechanism—The public option—that in its fullness would allow all of us to walk away from the clutches of the profit before people private insurance companies whose first operating commandment is “Pay as little as late as possible.”

This must end. Americans should not be at risk any longer. H.R. 3962 is the solution. It deserves our support.

Mr. DENT of Minnesota. Mr. Speaker, I yield for the purpose of making a unanimous consent request to the gentleman from Pennsylvania (Mr. DENT).

Mr. DENT asked and was given permission to revise and extend his remarks.

Mr. DENT. Mr. Speaker, I rise in opposition to this government takeover bill.

Mr. Speaker, I rise today to ask unanimous consent to revise and extend my remarks and have them submitted to the CONGRESSIONAL RECORD.

I have spent the past week reviewing the 1,990 page health care bill—H.R. 3962—that was introduced last Thursday and the manager’s amendment that was filed late Tuesday night. I oppose this legislation which will exacerbate rather than solve the problems in our health care system and take our Nation in the wrong direction.

Although I believe health care reform is needed, diminishing Americans’ control over their health care decisions, cutting Medicare benefits for seniors, eliminating SCHIP coverage for low-income children, imposing punitive taxes on small businesses and increasing health care costs for all Americans in order to create an unsustainable entitlement program that will bury our Nation in debt is not the way to do it. I believe this legislation moves the United States in the direction of a European style welfare state which is accompanied by much higher European style tax rates, slower economic growth and structurally higher unemployment rates. The bottom line is that this legislation will lead to fewer opportunities for our children and grandchildren.

H.R. 3962 is bad for Americans because it won’t reduce health care costs—in fact many will see increased costs—and it will cause millions of working Americans to lose their current coverage.

It’s bad for seniors. The bill includes nearly a half-trillion dollars in cuts to Medicare benefits. It will mean less choices, as well as increased premiums and prescription drugs costs for thousands of seniors in the 15th District.

It’s bad for Pennsylvania’s children, who will be forced out of the State’s successful CHIP program into plans offered through the health insurance exchange where families will face higher costs.

It’s bad for Pennsylvania’s already struggling budget, forcing an unfunded Medicaid mandate of at least $2.2 billion on our cash-strapped Commonwealth.

It’s bad for small businesses. It will stifle innovation and job creation by imposing punitive surtaxes. It’s bad for the Pennsylvania economy, an economy that is particularly hard hit by $20 billion in taxes on the makers of medical devices, an industry that employs thousands in my district and the surrounding region.

And above all it’s bad for America, spending more than $1 trillion in taxpayer dollars to create a program that will add to our debt and saddling our children and grandchildren with debt. Only in Washington can someone say with a straight face that by creating a new
trillion dollar program that we will not add a dime to the deficit now or in the future.

If we are serious about enacting meaningful health care reform that will ensure that all Americans have access to quality care, we must address the issue of cost. American families and businesses are struggling with health care costs and health care spending is taking up a larger and larger portion of Federal, State, and local governments’ budgets.

Regrettably, H.R. 3962 fails to address one of the key reforms that will save billions of dollars and reduce health care costs—meaningful medical liability reform. In fact, the provisions in H.R. 3962 will actually heighten the medical liability crisis facing our Nation.

The medical justice system is one of the major drivers of cost in our health care system. Doctors practice defensive medicine—ordering tests and treatments that are not truly needed but prescribed to ward off frivolous lawsuits. We have all been in our doctor’s office and thought, “Do I really need this?” This defensive medicine doesn’t mean better care; it just means more expensive care. The litigious environment has caused medical liability insurance premiums to skyrocket. In turn, patients pay more for health care because the costs are passed down.

The practice of defensive medicine costs the United States more than $100 billion per year—five times the estimated cost. The cost may be as high as $151 billion to $210 billion annually. In Pennsylvania, not only are medical liability insurance rates increasing costs for patients, they are driving qualified doctors out of the Commonwealth.

Recently, the Congressional Budget Office, CBO, released an analysis indicating that medical liability reforms would save the government $54 billion over 10 years and cut national healthcare spending by 0.5 percent a year. These savings would be the result of direct savings from lower premiums for medical liability insurance and also indirect savings from reduced utilization of health care services.

The original House health care bill, H.R. 3200, was silent on medical liability reform. Just 3 of the 1,990 pages of H.R. 3962 addressed the issue. Tragically, the language in H.R. 3962 actually discourages States from adopting the medical liability reforms that CBO has said will save $54 billion. This politics at its worst—protecting trial lawyers at the expense of patients.

Yesterday, I offered an amendment to the Rules Committee that would have inserted significant medical liability reform provisions into H.R. 3962. My amendment would enact nationwide reforms aimed at ending the costly practice of defensive medicine and encourage States to adopt effective alternative medical liability laws that will reduce the number of health care lawsuits initiated, reduce the average amount of time taken to resolve lawsuits and reduce the cost of malpractice insurance. Specifically, I believe we must stabilize compensation for injured patients, hold parties responsible for their degree of fault, ensure that meritorious claims are swiftly resolved, encourage compliance with accepted clinical practice guidelines, and guarantee that medical care is available to those who need it the most by providing protections to safety-net providers.

Unfortunately the leadership in the U.S. House of Representatives made the choice to prohibit meaningful reform from being debated on the House floor today. I sincerely regret that the majority decided to bulldoze ahead without considering practical policy that will reduce costs and produce significant savings in our health care system.

With courage and bipartisan discussion, we can make straightforward reforms to our health care system that will address the most pressing problems. We can enact strong insurance market reforms that provide consumer protections and promote transparency. We can ensure that those with chronic conditions and preexisting conditions have coverage through high-risk pools and reinsurance models. We can actually lower the cost of health care and increase access to affordable coverage by removing restrictive barriers on competition across state lines, allowing businesses to pool together and get the same buying power as their larger competitors, equalizing tax treatment for individuals buying health insurance, and enacting meaningful medical liability reform. We can put our Nation on the path to a healthier future by focusing on preventive health care.

Today, the House majority has failed the American people. Now the Senate has an opportunity to prevent this ill-conceived measure from moving forward, and embrace the calls of the American people to unite behind meaningful reforms that will reduce cost and increase access without fundamentally altering the American economy.

Mr. KLINE of Minnesota. Mr. Speaker, at this time I yield 1 minute to the gentleman from Florida (Mr. BILIRAKIS).

Mr. BILIRAKIS. Mr. Speaker, I rise today to oppose the Democrats’ government takeover of health care.

This bill will raise taxes on individuals and small businesses, cut Medicare for seniors, and raise health care premiums. The bill raises taxes by $730 billion and costs nearly $1.3 trillion. We literally cannot afford this plan.

There is a better way, however. The Republican health care plan is a response to the economic reality. It doesn’t raise taxes during a recession or cut Medicare. It will lower premiums, making coverage more affordable for families and employers while reducing the deficit by $58 billion. Commonsense ideas like medical liability reform, strengthening association health plans, and allowing people to purchase health insurance across State lines will make health care more affordable without breaking the bank.

The choice is simple. Mr. Speaker, I urge my colleagues to oppose Speaker PELOSI’s health care bill and support the Republican alternative.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 1 minute to the gentlewoman from Maryland (Ms. EDWARDS).

Ms. EDWARDS of Maryland. I thank the gentleman for yielding.

Mr. Speaker, I rise today in support of this historic legislation. It is the most historic in a generation. H.R. 3962 will indeed change the face of health care in this country. This bill really is not about partisanship and it’s not about politics, but it is about the American people; and it’s time for us to deliver on our promise to them.

As I’ve listened to my colleagues today talk about why this bill is good for their districts for the uninsured, for men, for women, for our seniors, I’m reminded that I was one of those uninsured. As a young mother, I became so sick that I collapsed in a grocery store, and I was taken to an emergency room. Without health care insurance, I was treated. I was one of those responsible for their degree of fault, ensure that medical care is available to those who need it the most by providing protections to safety-net providers.

Unfortunately the leadership in the U.S. House of Representatives made the choice to prohibit meaningful reform from being debated on the House floor today. I sincerely regret that the majority decided to bulldoze ahead without considering practical policy that will reduce costs and produce significant savings in our health care system.

With courage and bipartisan discussion, we can make straightforward reforms to our health care system that will address the most pressing problems. We can enact strong insurance market reforms that provide consumer protections and promote transparency. We can ensure that those with chronic conditions and preexisting conditions have coverage through high-risk pools and reinsurance models. We can actually lower the cost of health care and increase access to affordable coverage by removing restrictive barriers on competition across state lines, allowing businesses to pool together and get the same buying power as their larger competitors, equalizing tax treatment for individuals buying health insurance, and enacting meaningful medical liability reform. We can put our Nation on the path to a healthier future by focusing on preventive health care.

Today, the House majority has failed the American people. Now the Senate has an opportunity to prevent this ill-conceived measure from moving forward, and embrace the calls of the American people to unite behind meaningful reforms that will reduce cost and increase access without fundamentally altering the American economy.

Mr. KLINE of Minnesota. Mr. Speaker, at this time I’m very pleased to yield 1 minute to my friend and colleague, the gentleman from Ohio (Mr. JORDAN).

Mr. JORDAN of Ohio. I thank the gentleman for yielding.

Mr. Speaker, how bad does it have to get? How bad does it have to get before we stop the out-of-control spending? A $1.4 trillion deficit, a $12 trillion national debt, a trillion dollars in bailouts and stimulus, and now here we come again with $1.3 trillion takeover of our health care system. One of the things that makes this country so special, one of the things that makes this country the greatest Nation in history is this simple concept, that parents make sacrifices for their children so that when they grow up, they can have life a little better than we did, and then they in turn do it for the next generation, and each generation in this country has done it for one that succeeds them.

And now, unfortunately, what we are doing is borrowing and spending and living for the moment and passing the bill on to our kids. It’s wrong and it should stop here.

Vote this bill down. Support the Republican alternative.

Mr. KLINE of Minnesota. Mr. Speaker, can I inquire as to exactly the time remaining for each side?

The SPEAKER pro tempore. The gentleman from Minnesota has 5 minutes remaining, and the gentleman from California has 5 minutes remaining.

Mr. KLINE of Minnesota. Mr. Speaker, I am pleased at this time to yield 1 minute to the gentleman from Kansas (Mr. MORAN).

Mr. MORAN of Kansas. Mr. Speaker, the Pelosi health care bill creates 111 new bureaucracies and it only cuts one program: Medicare.

I chair the Rural Health Care Coalition. I care about health care especially as it affects rural States, rural
Americans like Kansans. And I have concluded that this bill will not make health care more affordable or more accessible for rural America. The standard by which I judge this is not a Republican plan or a Democrat plan, but what is good and right for America.

I have concluded that coupled with all the other bad ideas of this Congress—stimulus packages, bailouts, Cash for Clunkers, cap-and-trade—we will be leaving our children with more debt, less freedom, diminished personal responsibility, and fewer economic opportunities. Worse, we will have failed to honor the dreams for a better life for another generation of Americans. This I will not, cannot support.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 1 minute to the gentlewoman from Texas (Ms. EDDIE BERNICE JOHNSON).

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I rise in strong support of this bill, H.R. 3962, the Affordable Health Care for America Act. It is a time that we should have been here. We have been trying this for so very long.

You know, if this bill said anything as bad as what I have heard from the Republicans, I wouldn’t support it. But it does not. It says very clearly that we don’t know what bill they are reading.

I want to share, though, that I know this will bring relief to my constituents. In my district, there are 15.7 percent of the residents uninsured, and the average district, District 32 of Texas, has about the same number, but we are on different sides for bringing that relief.

The American people have heard so many untruths, they must be confused. Having access, though, to better coverage will show them what the truth is. This bill is a win for all Americans. I stand in strong support of this legislation and urge my colleagues to vote in favor of this bill.

Mr. KLINE of Minnesota. Mr. Speaker, I am very pleased to yield 1 minute to the distinguished gentleman from Oklahoma (Mr. COLE).

Mr. FARR. Mr. Speaker, I respect, like all Members do, everybody in this House, from the Speaker and the minority leader right down to the most junior Member. But the reality is, this isn’t our House; this is the people’s House. And I have listened to my friends on the other side, I have wondered, frankly, did you listen to what the people had to say in August in meeting after meeting after meeting? Have you taken the time to look at what they say, “Put it up or pull it up”? This is not an issue that has come on us suddenly. It is not a crisis. The American people have had a chance to study the issue, read the bill, and listen to the debate, and quite frankly, register an opinion. If we listen to them today, Mr. Speaker, we will follow their loud and insistent voice and vote “no.”

Mr. GEORGE MILLER of California. Mr. Speaker, I am ashamed on this great day of hope to hear so much fear, fear outside and fear inside. And I don’t think they know fear. I know the fear of a woman carrying a baby dying because she has no access to health care. I saw that over and over again as a Peace Corps volunteer in Latin America.

Without health care, you can’t start the day. You can’t get up. You can’t cope. You can’t go to work. You need health care.


Mr. FARR. Mr. Speaker, I rise in support of this historic bill and ask unanimous consent to revise and extend my remarks.

My first exposure to real poverty was as a Peace Corps volunteer in Medellin, Colombia. People there lived hard-scrabble existences, barely eking out subsistence-level lives.

My role as a Peace Corps volunteer was to help the community organize and petition its government for basic resources to improve the lives of the people. What I learned in that barrio is that unless people have shelter, unless they have food, and unless they have health care,—yes—health care, there can be no stability in the community and no confidence in the future. People need to have their health in order to cope and to be productive.

The lesson I learned in Colombia 45 years ago is still true today in the U.S.A., people in health care limbo can’t focus on the future. They are too busy worrying about today.

History teaches us that America was built on neighbor helping neighbor. Colonists clung together in the New World and protected each other. Settlers out West never turned away a traveler. I am ashamed and amazed at the tone of debate today that would deny our fellow Americans access to health care coverage. That is not the American way. When did we become so selfish? At a time of historical hope why are we hearing so much about fear?

There is nothing to fear—tomorrow or a year from tomorrow you will still have you insurance policy, hospitals and doctors will be doing their jobs of caring and healing and for the first time the hope for health care for all will come true.

Tonight we are asked to make history—leadership is about getting results. To make just law we have to vote yes. I am proud to say “yes” to health care for all in America. “Yes” to compassion and care. “Yes” to healing and health. “Yes” to my grandchildren’s future.

Mr. KLINE of Minnesota. Mr. Speaker, at this time I yield 1 minute to the gentleman from South Carolina (Mr. INGLIS).

Mr. INGLIS. Mr. Speaker, I identify with the sentiments of the gentleman who just spoke. The only problem is if you look at Martin Feldstein’s article yesterday in The Post, what you see is that we are going to have another problem with the cost of this, that as folks have a problem with the cost shift continuing, we are actually going to make insurance more expensive, and actually people are going to lose coverage because they are going to decide to go bare until they get sick, then access the guaranteed issue, then cause premiums to rise, which will actually cause more people to be uninsured.

So the mandate here doesn’t work because the penalties aren’t high enough in the mandate to keep people from deciding to go bare until they are diagnosed with a problem.

The result will be that we actually end up with more people uninsured and higher premiums. The bill needs to be rethought. That is the kind of thing that we could develop in a collaborative process. That’s not the process here. That’s why we have this problem.
Mr. GEORGE MILLER of California. I yield to the gentleman from Massachusetts (Mr. OLVER) for the purpose of making a unanimous consent request.

(Mr. OLVER asked and was given permission to revise and extend his remarks.)

Mr. OLVER. Mr. Speaker, I rise in favor of H.R. 3962.

Mr. Speaker, we often hear that America has the best health care system in the world. But, our health care system largely takes care of those who are lucky enough to be able to afford it.

In the past decade, the premiums charged by private health insurance companies have risen more than 75 percent while workers' wages have risen less than 25 percent. To add insult to injury, the profits of the 10 largest health insurers have risen by 400 percent, and the salaries of their CEO's have tripled.

America now has 50 percent higher health care costs than the highest of the next 20 most industrialized nations.

Yet Americans suffer the highest infant mortality rate among the G-7 countries. Our infant mortality rate is 50 percent above the average for the other 6 countries.

American life expectancies are more than 2 years lower than the average for the other 6 countries.

Clearly, we have the most expensive health care system in the world, but, equally clearly we don't have the best.

We can and must do better. We must reverse past trends.

This is our chance to fix a broken system. I am proud to vote in favor of H.R. 3962, the Affordable Care for America Act.

For the 50 million Americans who still do not have health insurance, this historic legislation guarantees you will have good insurance—insurance that you can afford—which provides a sliding scale of credits available to families that earn up to 400 percent of the federal poverty standard, or $88,200 for a family of 4.

For those of us that are lucky enough to have health insurance, this legislation will provide stability by immediately banning lifetime caps and by 2013 eliminating pre-existing condition exclusions and annual caps on insurance coverage. You cannot be denied coverage.

For those who are concerned about losing or having to switch jobs—especially important in our current economy—this bill brings you added stability. You will always have access to affordable, quality health insurance.

For senior citizens on Medicare, H.R. 3962 protects your benefits. We know that seniors live on largely fixed incomes. As such, this bill puts money back into your pockets by reducing the donut hole immediately by $500 and providing the critical investments in training primary care providers, helping them with overwhelming student loan debt and paying them well for their service.

This is a historic time in our country's history. This bill makes the critical investments that are needed to turn our health care system around and provide the health care that our citizens deserve.

I am proud to cast my vote in favor of this monumental legislation.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 1 minute to the gentleman from Tennessee (Mr. COHEN).

Mr. COHEN. Mr. Speaker, this debate in the House is part of a 97-year-old debate in America. It started with a Republican, Richard Nixon, who, while short on veracity, was great on policy and government. It continued through Bill Clinton, and now we are in a day when we have a chance to accomplish something worthwhile, something Daniel Webster tells us we should do while we are here in our generation and our time, to do something worthy of being remembered.

Theodore Roosevelt said, In this world the only thing supremely worth having is the opportunity, coupled with the capacity, to do well and worthy a piece of work, the doing of which is of vital consequence to the welfare of mankind.

I plan to take my voting card, along with hopefully at least 218 others, and do something that Teddy Roosevelt would see as proper, and provide health care for Americans.

The SPEAKER pro tempore. The gentleman from Minnesota and the gentleman from California each have 1 minute remaining.

Mr. KLINE of Minnesota. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, let me just say that what we have before us here is a true loss for American families seeking quality health care and American workers seeking quality jobs. It is remarkable that our colleagues believe 2,000-plus pages of more red tape, more government control and more bureaucracy, more taxes will do anything other than make health care more costly and more complicated and kill more jobs in this country.

Why, when we have a 10.2 percent unemployment rate, the highest in a quarter century, would we ever want to pass legislation that will destroy millions of jobs? It defies logic. Why would we want to strip Medicare from the seniors who depend upon it? Why would we want to pile debt on our children and the young? Why would we want to raise health care costs? Why would we want to raise taxes? I have yet to hear an answer to these questions.

This bill is not health care reform. The American people deserve better than this. We can do better than this. Let's make the right decision. Stop this Big Government takeover of health care and return to the table for real reform.

I yield back the balance of my time.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield to the gentleman from Pennsylvania for the purpose of a unanimous consent request.

(Mr. FATTAH asked and was given permission to revise and extend his remarks.)

Mr. FATTAH. Mr. Speaker, I support this bill, and I thank the chairman for yielding me the time.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 1 minute to the gentleman from Minnesota (Mr. OBERTAR).

Mr. OBERTAR. Mr. Speaker, I have advocated a national health care system for as long as I have served in Congress. Today I take a decisive step toward that goal.

This is not a perfect bill but a good bill. The three committees have worked hard to address the needs of the people in my district and across the country. Regional disparities in Medicare reimbursement that penalize Minnesota health care providers, and ensuring taxpayer dollars are not used to fund abortion services.

This summer I met with the Skare family in Cloquet. Their son, born with a congenital liver disease, required a liver transplant as a child. Today he is 20 years old. The family is buried under mountains of medical bills, despite having health insurance. They constantly have to fight the insurance providers to make them live up to their commitments. This bill will ensure that families like the Skares will not be held hostage to insurance companies. It will protect all Americans from being denied coverage due to pre-existing conditions.

Today, we keep faith with the American people. Today we ensure that quality, affordable health care is available to everyone. Support this bill.

Mr. OBERTAR. Mr. Speaker, throughout my service in the House of Representatives, I have been a strong proponent for a national health care system to ensure that all Americans have access to affordable health care. Our current health care system is paradoxical. A nation that leads the world in the best trained health care professionals and the most advanced medical devices, far too many Americans do not have access to essential health care. Our current health care system has failed this fundamental fairness principle, and as a result, health care has represented an important opportunity to make health care more affordable and more accessible to more Americans.

Finally, H.R. 3962 makes major investments in primary care so that we will have the critical infrastructure in place to efficiently combat the steady, preventable illnesses in this country. Between 1997 and 2002, when researchers compared preventable deaths—from diabetes, cancer, and heart disease amongst others—in 19 industrialized countries, the United States placed last. During those years alone, at least 75,000 men, women and children died because they lacked access to quality preventive care. Furthermore, H.R. 3962 makes new critical investments in training primary care providers, helping them with overwhelming student loan debt and paying them well for their service.

I am proud to cast my vote in favor of this monumental legislation.

Mr. OBERTAR. Mr. Speaker, today we are in a day when we have a chance to accomplish something worthwhile, something worthy of being remembered.

I plan to take my voting card, along with hopefully at least 218 others, and do something that Teddy Roosevelt would see as proper, and provide health care for Americans. Today we ensure that all Americans do not have access to essential health care. Our current health care system has failed this fundamental fairness principle, and as a result, health care has represented an important opportunity to make health care more affordable and more accessible to more Americans.
Comprehensive health care reform involves more than just extending access to the uninsured. The explosion of health care costs has created tremendous challenges for the private sector that has hindered our ability to compete in the global marketplace. Additionally, it is imperative to constrain health care spending that consumes an unacceptable percentage of our federal budget. Health care reform is vital to the nation’s economic recovery and fiscal responsibility.

I commend the leadership of the three committee chairmen who have worked tirelessly to craft legislation to repair what is not working well and preserve what is working in our health care system. Thank you, Charlie Rangel, Henry Waxman, and George Miller for your dedicated efforts to seize this historic opportunity and produce a sensible health care bill that builds upon and improves the employer-provided and private health insurance market.

I am very pleased that the House health care bill (H.R. 3962) includes many essential reforms that will improve health care. The health provisions to ensure that Americans will not be denied coverage due to a pre-existing condition, the requirement for guaranteed issue and renewal, and the limit on out-of-pocket spending are much needed reforms that will make health insurance more affordable. For seniors, I strongly support the funding to close the donut hole in the Medicare Part D prescription drug program.

I am also delighted that H.R. 3962 contains provisions to address the historic disparities in Medicare reimbursement that have long penalized Minnesota and other high-quality, low-cost states. I greatly appreciate the dedicated work of my colleagues in the Quality Care Coalition (BETTY MCCOLLUM, RON KIND, BRUCE BREALY, JAY INSLEE) to include language that will promote Medicare geographic equity. I believe that the requirement for the Secretary of Health and Human Services to implement the recommendations of an Institute of Medicine study will lead to Medicare payment reform that will reward value, not volume. This payment reform is one of the biggest priorities because in 2007, Medicare paid Minnesota hospitals $1 billion below the actual cost of care.

While I am very pleased that the House will have the opportunity to vote on amendments to ensure that taxpayer dollars are not spent for abortion, I am disappointed that several important amendments were not made in order. It was expected that the House would consider an amendment that would create a single-payer system for health care. While I continue to have great concerns about a single-payer system, I believe that lowering Medicare rates, I would have supported the single-payer amendment. I am disappointed that the Kucinich amendment which was supported in the committee markup to enable states to develop their own innovative state programs was stricken from the bill, and we do not have the opportunity to re-store this language.

I am also disappointed, however, that the House health care bill does not contain a number of important policy reforms recommended by the National Rural Health Association (NRHA). The NRHA made more than ten specific recommendations regarding health care financing, including elimination of standing payment inequities that were unfortunately not addressed in this bill. I am especially troubled that several rural health improvementsthat were accepted in committee mark-up were not included in the updated House bill. It is essential that provisions to ensure rural representation on MedPac, and improvements in the 340B Drug Pricing program and the super rural ambulance reimbursement are restored in conference. I urge my colleagues to support this bill today.

I strongly believe that Minnesota’s leadership in health care reform should serve as a model for national reform. Minnesota is unique in requiring all health maintenance organizations (HMOs) to be nonprofit as a condition of coverage. Minnesota extends health care coverage to lower-income children long before the enactment of the federal SCHIP program, and Minnesota has done a better job in expanding access to care through its MedisotaCare program than the rest of the nation. Minnesota is a leader on integrated health systems to coordinate care, and a new partnership between Fairview Health and the Medica health insurance company that provides payment incentives to invest in health care rather than paying for “sick care” should be emulated across the nation. Minnesota’s continued leadership that is far ahead of national policymakers.

Even with the expected improvement in Medicare reimbursement that will benefit Minnesota, I am concerned in many respects that Minnesota is picking up the tab to pay for national health reform. While I understand and support the need to reduce the excessive payments in the Medicare Advantage program, it is far easier for high-cost states to absorb a 14 percent cut than for Minnesota which receives significantly less in Medicare Advantage payments. I am also concerned with the addition of a tax on medical devices that will negatively impact Minnesota’s important medical device industry, as well as changes in the second generation biofuel producer credit that will preclude “poly ethanol” from eligibility for this biofuel credit that will impact the wood product industry in Minnesota. I will strongly encourage modifications in the financing in the final version to ensure fairness for Minnesota.

During the thorough discussion and debate regarding health care, I have greatly appreciated the opportunity to visit with constituents in Minnesota and in Washington. From seniors and health care providers to organized labor, the small business community and the faith community, I have gained valuable insights and recommendations to improve this legislation.

While I recognize and understand there are still many issues that need to be addressed, I am prepared to support this legislation today to move this necessary process forward.

Mrs. LOWEY. Mr. Speaker, I rise in support of the Affordable Healthcare for America Act. Over the last eight months, I have communicated with tens of thousands of my constituents in Essex County and Rockland Counties in meetings, conference calls, round-tables, telephone town halls, and neighborhood office hours.

Among people from all walks of life—small business owners, doctors, patient advocates, and seniors—one constant is the passion which most agree on the need for health care reform despite different opinions on how best to achieve reform.

Since 2000, personal premiums have more than doubled.

Since 1987, the cost of the average family health insurance policy has risen from 7 percent of the median family income to 17 percent.

In 2007, 60 percent of all U.S. bankruptcies were due to medical costs. The U.S. is on track to spend nearly $33 trillion on health care over the next decade. The financial security of our families, businesses, and our overall economy depends on meaningful health care reform.

That’s why I will support this bill today to:

Provide health coverage to approximately 36 million Americans, including 39,000 residents in my congressional district.

Help small businesses who are struggling to provide coverage to their employees while exempting 86 percent of the smallest businesses from the requirement to do so.

Ensure that reform is fully paid for while exempting 99.7 percent of all American households from paying a health care surcharge.

Guarantee additional protections to those who have insurance, including ending discrimination for pre-existing conditions; limiting annual out-of-pocket costs; and preventing health insurance companies from dropping your coverage if you become sick.

Improve and strengthen Medicare.

Now, this bill is not perfect. I am deeply disappointed that the House approved language which puts new restrictions on women’s access to abortion coverage in the private health insurance market even when they would pay primarily with their own money.

If we want to reduce abortions we should give millions of women health coverage so they can get regular reproductive care, contraceptives to prevent unintended pregnancies, and prenatal care to ensure healthy pregnancies.

Despite this damaging provision, we must move forward in improving health care coverage for those who have it, providing coverage for those who don’t, and controlling costs throughout the system.

I urge my colleagues to support this legislation today.

Mr. LOEBSACK Mr. Speaker, this August and September I held 16 town halls across the 2nd District of Iowa. I heard from countless constituents about the need to change the current health care system. Though some disagreed with provisions in the original House proposal, almost everyone agreed that the fact that a family in Iowa pays an extra $1,100 per year in premiums to support a broken system was unacceptable. So I am proud to be a part of a Congress that decided the status quo is no longer acceptable. Iowa, like the rest of the country, wants stable health care coverage that can’t be taken away, they want greater choices, and they want to know that if they get sick they won’t be forced into bankruptcy. The Affordable Health Care for America Act answers these calls to action and I’m proud to support a bill that is good for Iowans.

This legislation keeps what works in the current system and fixes what doesn’t. If you like your current health insurance and you like your doctors you can keep them. If you don’t have health insurance, you will be able to access many of the greatest changes from the original House proposal to the bill we are considering today are the immediate reforms. We aren’t saying wait for coverage, we...
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are saying the status quo is not fair and we will no longer tolerate it starting right now.

There will be help for hardworking families now. The revised bill immediately creates an insurance program with financial assistance for those who have been uninsured or denied coverage through existing programs and fills the gap until the Health Insurance Exchange is up and running. The bill immediately prohibits health insurance companies from rescinding coverage. If you find out you are sick one day, you don’t have to worry that your health insurance will be taken away the next. The bill also immediately eliminates prohibitive health insurers from utilizing lifetime limits on benefits, and extends COBRA eligibility to permit individuals to remain in their COBRA policy until the Health Insurance Exchange is up and running. America’s Affordable Health Care for America Act also makes immediate changes to improve the health and well being of our seniors. The legislation begins closing the Medicare Part D Donut Hole in January. There will also be an immediate 50 percent discount for brand name drugs in the donut hole.

In addition to the immediate benefits, this legislation takes a comprehensive approach to long-term reform. I am a native, I am proud to say. Since I came to Congress I have been committed to fixing the broken Medicare payment system. With some of the lowest reimbursement rates in the system have caused problems not only for providers in my District, but also for the patients. I have always been proud of how hospitals in my District have achieved so much under the constraints of the current Medicare payment system. With some of the lowest reimbursement rates in the country, they provide some of the highest quality care. However, the current system is broken and now I’m proud to say that the Affordable Health Care for America Act reforms Medicare payments so that they are based on the quality of services rather than the quantity of services. This fix benefits not just Iowa, but all of America.

I also want to mention another provision with direct benefit to Iowa in this legislation. According to a 2008 Institute of Medicine report, the number of Americans in an Aging America: Building the Health Care Workforce, in the near future, the nation will be aging dramatically, leading to an increase of older adults from 12 percent of the U.S. population in 2005 to almost 20 percent by 2030.

As the population ages, their health care needs will increase, and they will need additional supports. In the same report, it’s stated that meeting the demand that is expected in coming years will require expansion of the roles of many members of the health care workforce, including technicians, direct-care workers, and informal caregivers, all of whom already play significant roles in the care of older adults.

I was very pleased to have language included in this bill that takes much needed steps towards meeting these workforce demands as well as other projected long-term health needs. The provision encourages the identification, promotion, and implementation of investments in the long-term care workforce and assists States in developing comprehensive state workforce development plans.

It also establishes a Workforce Advisory Panel which will identify core competencies for long-term care workers and recommends training curricula and resources for these workers. The bill also creates a demonstration project to evaluate the Panel’s recommendations. In addition, this legislation improves assistance to family and informal caregivers, and improves the dissemination of information to seniors regarding their long-term care health insurance options.

In a recent guest column in the Des Moines Register, John Hale from the Iowa Caregivers Association, highlighted the efforts that Iowa has already undertaken on long-term care workforce shortages and spoke about the national need to address these issues. Mr. Hale made some very strong points. “We need to respond with leadership that does not equal access to care.” I could not agree more.

Federal support is essential in helping all states continue to look at both workforce shortages and the core competencies that should be required of those in the field. I have said many times in the past weeks and months that quality health care is the key to patient outcomes. I am glad this legislation takes much needed steps to support our long-term care workforce.

There are many more important provisions in this legislation and in the coming days, weeks, and months I look forward to discussing this bill, and what it does for Iowans, with my constituents. I look forward to voting for the Affordable Health Care for America Act, and abolishing the status quo.

Mr. Speaker, on this bill the Congress is scheduled to vote on today will cost more than $1.3 trillion over the life of the bill.

It’ll expand entitlement spending, it’ll raise taxes on small business payrolls, it’ll cost jobs by mandating coverage that some businesses can’t afford, it’ll put government in between the doctor and the patient, and it’ll cut Medicare funding. By expanding Medicaid eligibility, the legislation puts new burdens on states that already are struggling to pay their bills. The states share the cost of the Medicaid program, and this could cost my home state $2 billion to $4 billion over the next 10 years. That’s a huge share of Georgia’s state budget, and it’s a cost we simply can’t bear.

But, luckily, there is a better way. Republic- cans like me believe in giving states the freedom to innovate, although the Democrats continue to insist we’re not offering ideas. We are. They just don’t want Americans to know it.

Ms. SPEIER. Mr. Speaker, today, I look forward to keeping my promise to the voters and taxpayers who sent me to Congress by cast- ing a vote for a historic health care reform bill that has been sixty years in the making.

Still, with any effort as far-reaching as reforming health care, Americans are right to ask: “What’s in it for me?”

Well, I’ll tell you.

If you are a woman, this bill has plenty for you. You know, far too well, that our fight for equality is not limited to the boardroom. We must fight for our rights in every line of fine print in every insurance contract. The fact is that women’s health care premiums cost, on average, more than 145 percent of the price of a similar man’s policy. Even then, women are more likely to be denied coverage for a pre-existing condition, including for things as common as getting pregnant (or the inability to get pregnant) having a c-section, even in a state with survivors’ violence. With the passage of this health care reform bill, these practi ces will be tossed on the ash-heap of history atop corsets, chastity belts and other limitation on women’s rights and equality. In fact, with this bill, America’s mothers, wives and sisters will finally enjoy the same health care coverage that their fathers, sons and brothers have.

If you are an American of retirement age, this health care reform legislation contains provisions that ensure high quality, effective health care throughout your retirement years. We have heard your frustrated calls to end the ill-conceived Medicare Part D donut hole and I am proud to immediately reduce it by $500 and, by 2019, getting rid of it once and for all. The bill also cuts in half the cost of name-brand drugs. No older American should ever have to decide between purchasing food or the life-saving medicine prescribed by their doctor.

When Congress voted for Medicare nearly 45 years ago, this House promised seniors quality, affordable health care in their retirement. They did this despite a future president, Ronald Reagan, decrying Medicare as socialism.

Well, by cutting waste, fraud and abuse, eliminating the out-of-pocket payments for preventive care and banning overpayments, this Congress is making good on that promise and extending the Medicare trust for future generations.

If you are one of the 14,000 Americans who lose their health insurance coverage every day, this bill offers comfort and hope when you are most in need. Just last night during a telephone town hall a constituent told me how, at 55 years old, she lost her job and her health coverage. She wonders if, even after the economy recovers, she will be able to get a job—at her age—that provides health care. Today, when workers like her lose their job and their coverage, they are forced into the snake pit that is the individual insurance market where insurance company practices like denying coverage because of a preexisting condition are common. Fortunately this practice, along with dropping customers once they fall ill, has been outlawed in this bill. Also, while the health care exchange—which will provide access to affordable, quality health care—is being set up, a high-risk insurance pool will be available so that you have coverage in the meantime.

For the majority of Americans who have health insurance through their employer, you get the best news of all. I don’t have to tell you that, since 2000, employer-sponsored health insurance premiums have more than doubled. Your employer’s real health care costs have risen at a rate that is three times faster than wage increases and business profits. This is, quite simply, unsustainable. If we took a page from the opposition party and did nothing, the cost of employer-sponsored family insurance plans will reach $10,000 in less than ten years. This same price spike would result in families spending 45% of their income on health insurance. Also, the insurance exchange will allow you or your employer to purchase coverage from health plans that meet guaranteed benefit levels, cap annual out-of-pocket spending and end annual and lifetime benefit limits. There will also be a public option that is completely self-supported by premiums.

This is not a decision that has been made in haste. No issue has been studied, scrutinized and debated more than health care reform. And, like every time in our nation’s history when sweeping changes are proposed—
Mr. Speaker, we have all heard these stories. They are unremarkable. And today we have the opportunity to bring such hardship and heartache to an end. The American people deserve a health care system that works for them—one that provides access to stable coverage, quality care, and affordable premiums and copayments. The legislation before us today will correct the failures of the American health care system without compromising its many strengths or adding to the budget deficit.

If you have coverage at work, you’ll be able to keep it—but the loss of a job will no longer mean the loss of affordable coverage. And your insurance company will no longer be able to impose lifetime benefit limits; discriminate on the basis of age, gender, or pre-existing conditions; or cancel your policy if you get sick.

If you have coverage through Medicare, you’ll have more benefits and lower out-of-pocket costs, including no more copayments for preventive and many diagnostic services, and a 50 percent discount on your brand-name prescriptions, and a progressive closing of the gap in coverage known as the “doughnut hole.”

If you don’t have coverage at all, you’ll be able to buy it on the National Health Exchange at the same affordable group rates that big companies have always been able to negotiate for their employees. And you’ll have more than one choice, so that companies will have to compete for your business instead of the other way around.

Landmark reforms—Social Security, Medicare, Medicaid—these things do not come easily. We were sent to Congress this year to do what is difficult. Despite the efforts of some shrill voices, we are on the verge of overcoming the special interests that halted reform more than a decade ago, to deliver on landmark legislation that will make a positive difference in the life of every American. It is an historical moment, an essential investment in our nation’s long-term fiscal and economic well-being, and it’s long overdue. I urge my colleagues to vote yes on the Affordable Health Care for America Act.

Mr. BACA. Mr. Speaker, today is a historic day for all of us. As Members of Congress, it is our duty to pass real healthcare reform this year. The American people need it. 47 million people lack even the most basic care, and for those lucky to have insurance—their premiums have more than doubled over the last 10 years.

Perhaps no state is in greater need of this reform than my home state of California. 217 thousand people in my Congressional District go everyday without insurance.
And for California as a whole—we have 13 million uninsured residents.

The people of California, and people across the United States need health care reform that: ends discrimination based on pre-existing conditions; ends dropped healthcare coverage because they get sick; ends co-pays for preventative care; and ends skyrocketing costs for individuals and families.

The Republican alternative does none of these things.

It simply keeps the status quo! It does nothing to provide quality, affordable health care to the American people.

The 217,000 people living in my District without insurance cannot afford inaction any longer.

The 13 million people in California without insurance cannot live with the status quo.

The 15 hundred families in my District who went bankrupt because of health costs cannot afford the status quo.

Now is our opportunity to make history—and to move America forward.

We must not be short-sighted and focus only on politics and polls.

As a Christian—my faith teaches me we must love and care for our fellow man, as if they were our brother or sister.

I know that fixing our broken health care system is not just an economic issue—it is also a humanitarian and a moral issue.

I am especially pleased that today’s bill includes the Indian Health Care Improvement Act.

As a Member of the House Native American Caucus and the Natural Resources Committee—I have been a strong supporter of ending the health disparities that exist on our reservations.

I will close my statement by again stressing the importance of this historic moment.

We passed Social Security in 1935. We passed Medicare in 1965.

I urge my colleagues to stand with the American people and pass legislation in 2009 that will make quality, affordable health care a right for all Americans.

Mr. LANCE. Mr. Speaker, this evening members of the U.S. House of Representatives are being asked to vote on legislation that dramatically revamps our Nation’s health care system.

This 2,000-plus page, $1.3 trillion Democratic health care proposal is a measure that raises individual and business taxes and reduces funding for Medicare.

H.R. 3962 increases spending by more than $1 trillion at a time when our levels of debt and deficits are at all-time highs.

The bill imposes a 5.4 percent “surtax” on thousands of individuals and families in my congressional district during an economic recession when New Jerseyans are paying some of the highest federal, state and local property taxes in the country.

The health care bill levies at 2.5 percent tax on the Garden State’s medical device industry that employs more than 300,000 in New Jersey alone.

New Jersey’s unemployment rate is nearly 10 percent.

The measure ignores common-sense malpractice reforms while cutting Medicare by nearly $500 billion leading the Medical Society of New Jersey and its doctors and medical professionals to come out in opposition to H.R. 3962.

In short, this bill, if signed into law, will be harmful to New Jersey’s taxpayers, seniors and businesses. As such, I rise in strong opposition to this measure.

But make no mistake—I support health care reform.

Like the majority of my colleagues I strongly support health care reform. But not the reform we are being asked to vote on.

I stand in support of common sense steps to broaden health care access and responsible solutions that address the rising cost of health care.

I believe reform ought to include portability—allowing people to keep their health insurance whether they change jobs or move to a different state. And no one should be denied coverage for preexisting conditions.

Yet the call for common sense health care reform should be one that our Nation can afford.

The Republican substitute offered by House Republican Leader JOHN BOEHNER is a fiscally responsible alternative health care reform measure that reduces costs and expands insurance coverage without raising taxes, rationing care or putting the government between patient and doctor.

The Republican reform bill includes medical liability reform that will seek to end junk lawsuits that force doctors to practice defensive medicine driving up health care costs.

The Coalition of families and businesses buy health insurance across state lines while also allowing individuals, small businesses and trade associations to pool together and purchase health insurance at lower prices.

It levies no taxes on New Jersey’s medical device industry and includes important safety provisions concerning innovative biologic drugs by requiring research and clinical trials before the Food and Drug Administration can approve generic biologics.

To maximize safety, I believe that research and those clinical trials should be conducted within the United States.

We by creating this process for approval of innovative biologic drugs protect the health and safety of patients, lower health care costs and provide adequate incentives for innovation to ensure that New Jersey continues to be the ‘Medicine Chest of the World.’

These are ideas that have strong, bipartisan support but most are absent from the Democrats’ new reform legislation.

Instead of focusing on fiscally responsible reforms that have bipartisan support, the Democratic Leadership has chosen a path that ignores good ideas from the Republican side of the aisle.

The Republican substitute is the only health care reform measure that improves what is working in our health care system and fixes what is broken in a fiscally responsible manner without raising taxes or increasing our ever-growing debt and deficit.

Mr. WILSON of South Carolina. Mr. Speaker, I have criticized many of the provisions of this bill (H.R. 3962) and rightfully so. But in fairness, I do believe the sections relating to the creation of a market for biosimilar products is one area of the bill that strikes the appropriate balance in providing lower cost options to consumers without destroying a healthy and functioning industry in this country. These provisions were included in the bill adopted on an overwhelming bi-partisan vote for the Eshoo-Inslee-Barton (EIB) amendment in the Energy and Commerce Committee.

Creating a pathway for new products that doesn’t destroy the ability or the incentives for innovator companies to develop breakthrough technologies and at the same time providing a safe and effective way to bring competition to benefit patients is a laudable achievement. I would remove from this fatally flawed piece of legislation and consider it separately because it would pass with the kind of overwhelming bi-partisan support that Americans across the country wish to see.

However, these provisions are only the first step in a long path to bring these new products.

New research and clinical testing will have to occur and the FDA will write rules that will ensure this research is done safely and effectively. One of the reasons I have long supported the U.S. biotechnology industry is that it is a long-standing success story that has been an engine of job creation in this country. Unfortunately, many of the largest companies that would seek to enter the biosimilar market have made their money by outsourcing their research to foreign countries like India. With this week’s devastating news that unemployment has reached 10.2 percent it is critical that we preserve jobs in the United States.

While the innovator’s have created jobs here, these generic companies have shipped them overseas, so they can turn around and sell cheap knockoffs of innovative American products.

As this new market launches in the U.S., we need to ensure that we foster innovative products in this country for the creation of jobs and research that will go into proving whether these products are interchangeable with the innovators products. I have my doubts that these companies can create such interchangeable products, but I am certain that the research and testing of whether or not they can be shown to be safely and effectively identical is critical to preserving the jobs and quality of health care.

Mr. SMITH of Texas. Mr. Speaker, although the Democratic Leadership has had several months to address the concerns voiced by countless Americans, the latest health care reform bill is no better than the last.

I support health care reform. I wish we could remove this provision from this bill.

Mr. WILSON of South Carolina. Mr. Speaker, I have criticized many of the provisions of this bill (H.R. 3962) and rightfully so. But in fairness, I do believe the sections relating to the creation of a market for biosimilar products is one area of the bill that strikes the appropriate balance in providing lower cost options to consumers without destroying a healthy and functioning industry in this country. These provisions were included in the bill adopted on an overwhelming bi-partisan vote for the Eshoo-Inslee-Barton (EIB) amendment in the Energy and Commerce Committee.
individuals and $135 billion in penalties for employers under the government mandate or "pay or play" requirements.

Raising income taxes on hard-working Americans and threatening small businesses with penalties to fund a government takeover of health care is a terrible prescription for a troubled economy.

In order to pay for this government takeover of health care, Democrats also have proposed cutting more than $500 billion in Medicare spending. The plan also includes an expansion of the current health insurance tax by 25 percent, to raise $34 billion over the next 10 years. I believe Congress should pursue reform in terms of costs and access, but the legislation advanced by Democratic leaders is equal parts faulty premise and flawed logic. Their legislation will increase health care spending, limit choice, and cut Medicare benefits.

The current health care proposal being considered by Congress will lead to higher costs, rationing of care, higher taxes on families and small businesses, elimination of jobs through punitive taxes on small businesses, granting of unchecked power to a new "health care choices commissioner," elimination of choices for patients, tax-payer funded abortions and a government panel placed between doctors and patients.

Americans deserve the freedom to choose the type of health care that is best for them and their families.

During his campaign, then-Senator Obama promised that he would "have all the negotiations around a big table" and "televised on C-SPAN" to "allow people to stay involved in this process and find out what the negotiations and decisionmaking process have taken place behind closed doors with the media and American people shut out.

That is why the bill lacks bipartisan support. In fact, there is bipartisan opposition to the House Democrats' government take-over.

Rather than increasing taxes and rationing care, the President needs to address medical liability reform, which is one of the biggest sources of waste and added cost.

Frivolous lawsuits force physicians to practice defensive medicine and carry expensive medical malpractice insurance, the cost of which is passed on to patients. Uncapped lawsuit awards paid by insurance companies also get passed on to patients as higher premiums.

It is a disservice to the American people that this legislation fails to include the legal reforms that are necessary to make any expansion of health care coverage financially sound.

Unlimited lawsuits enrich trial lawyers while increasing the cost of health care for everyone. Unfortunately, we now know that opposition by the reason tort reform has been excluded from all the Democrats' health care proposals, including the one we will be voting on today. Former Democratic National Committee Chairman Howard Dean said the following publicly at a recent town hall meeting: "[T]he reason why tort reform is not in the bill is because the people who wrote it did not want to take on the trial lawyers . . . and that is the plain and simple truth."

That political opposition, which Governor Dean admitted is not based on the merits but on raw self-interest, flies in the face of the facts.

The CBO estimates that enacting tort reforms nationwide would result in a reduction of medical malpractice insurance rates by 25 percent to 30 percent. And according to the Government Accountability Office, rising litigation awards are responsible for skyrocketing medical professional liability premiums.

Lower premiums mean Americans will pay less to have better health care. The President's own Medical Association said "If the [health care] bill doesn't have medical liability reform in it, then we don't see how it is going to be successful in controlling costs."

And the President's own doctor of over two decades supported tort reform. He said recently fully that "I once briefly talked to [the President] about malpractice, and he took the lawyers' position."

In the handful of States that have enacted tort reform, health care costs have fallen, and the availability of medical care has expanded. In my home State of Texas, premiums fell by 30 percent, and more than 14,000 doctors returned or set up new practices in the state.

To give just one example, a charitable hospital in Texas that serves the poor and troubled socioeconomic sections that enacted tort reform, its legal costs have gone from $153 million per year to just $2.3 million last year.

Doctors are so concerned about frivolous lawsuits that they order unnecessary—and expensive—tests and procedures that are of no benefit to patients.

HHSS estimates the national cost of defensive medicine is more than $60 billion. The Congressional Budget Office just issued a report that concludes it costs $54 billion. The costs of litigation and defensive medicine are then passed off to the patient in the price of health care.

If tort reform were enacted, trial lawyers would stand to lose one of their primary sources of income: medical malpractice suits, which are often just a form of legalized extortion. But all Americans would gain, and tens of billions of dollars would suddenly be freed up and could be used to help provide health insurance to the uninsured.

Regrettably, the Democrats' health care bill not only fails to contain any of the tort reforms the CBO concluded would save at least $54 billion in health care costs, but also contains a provision that bribes States with Federal taxpayer dollars not to enact such reforms in the future. It explicitly prohibits tort reform "demonstration project" funds from going to States that put limits on damages or attorneys' fees.

Section 2531 of the Democrats' bill states that "the Secretary [of HHS] shall make an incentive payment . . . to each State that has an alternative medical liability law in compliance with this section," but then goes on to say that such funds apply only if "the law does not limit attorneys' fees or impose caps on damages," which are exactly the tort reforms the CBO concluded yield real health care costs savings.

That is not only a blow to State reform efforts. It is a federally funded bribe discouraging states from enacting real reform and giving a giant bailout for trial lawyers.

H.R. 3962 also contains two antitrust provisions that are within the House Judiciary Committee's jurisdiction: Sec. 262, which repeals the McCarran-Ferguson Act for health and medical malpractice insurers. Further, the protection for information gathering by a State insurance commission or other State regulatory entity that were included in the similar bill (H.R. 3596) reported by the Judiciary Committee over my opposition have been completely eliminated from the legislation.

Uncertainty created by this provision threatens small and large insurers alike, but the smaller ones that depend on sharing information, under oversight by State regulators, are most at risk. Thus the bill threatens to reduce competition among health and medical malpractice insurers. Further, the lack of demonstrable benefits and many potential adverse effects, Sec. 262 should not have been included in the bill.

Section 2573 raises different concerns. When a generic drug manufacturer files an Abbreviated New Drug Application under the Hatch-Waxman Act with the Food and Drug Administration, it indicates its intention to infringe on a brand manufacturer's patent. This is nothing new. Most cases in the United States, whether civil or criminal, anti-trust or patent, settle. The reasons for this simple: litigation is expensive and its outcomes are uncertain.

The supposed problem is when a settlement in the Hatch-Waxman context involves a payment in lieu of or in addition to an agreement on the date of entry into the market by the generic manufacturer. Such payments are said to frustrate the intent of Hatch-Waxman by allowing the brand company to "pay to delay" entry by generic manufacturers.

The proposed solution to this problem, incorporated in Sec. 2573, goes too far. The bill calls for a ban on all Hatch-Waxman settlements that feature any consideration, such as cash or an exchange of patents, in addition to the date of entry. Such a ban dramatically reduces the ability of companies to settle these cases. After all, if the parties could not agree on date of entry, then they would effectively be forced to litigate the case to the bitter end. This means that, in some cases, a settlement would have resulted in generic entry into that particular drug market much earlier than if the brand company wins its patent suit.

I fear this ban will itself frustrate the intent of Hatch-Waxman by limiting the incentives for
generics to challenge these patents and for brand companies to innovate.

The best way to reach the appropriate balance is through a case-by-case analysis by a neutral third party of the competitive effects of these settlements using the rule of reason. This, I believe, is the conclusion that the majority of the Courts of Appeals, including the Second, Eleventh, and DC Circuits, have reached in these cases, and we should uphold the judgment of these courts.

The only saving grace of Sec. 2573 is that it creates these action separate and apart from the antitrust laws and will not affect how those laws are interpreted in the future. This also means that the provision, as written, did not come before the Judiciary Committee, even though it remains, at heart, a competition issue. By keeping the Judiciary Committee from considering this legislation, we are eliminating the incentives for drug invention and generic competition that have served American consumers so well. Innovative new drugs, after all, are created in the laboratory, not the courtroom.

Sec. 1640 of the bill also contains a provision that allows the Department of Health and Human Services to issue administrative subpoenas to insurance companies during investigations of decisions to exclude benefits. The standard for issuing an administrative subpoena is extremely low. The information sought must simply “relate to” the matter under investigation.

It is highly ironic that we are considering this bill with this administrative subpoena language during the same week the Judiciary Committee approved the Democratic revision of the FBI's authority to issue National Security Letters, which are the functional equivalent of administrative subpoenas used in foreign intelligence and terrorism investigations.

The Democrats' bill reported this week by the Judiciary Committee replaces the current “relevance” standard for issuing a National Security Letter with a heightened standard, requiring the FBI to show “specific and articulable facts” in order to seek particular information using a National Security Letter. House Democrats want to make it easier for the government to investigate insurance companies than to investigate terrorists plotting to kill Americans.

In the end, this 1,990-page bill will raise premiums and health care costs on all Americans. It imposes mandates and new taxes on the middle class and small businesses. It fails to address tort reform and it dumps a huge unfunded expansion of Medicaid on the states. Combined with budget gimmicks to hide $245 billion in costs and massive cuts to senior benefits, this is not the kind of legislation that should be the engine of job creation in this country. Testing and research on these interchangeable biosimilar products should occur in this country to ensure that it is done properly and safety to benefit our patients and our economy.

Ms. GRANGER. Mr. Speaker, I have criticized the majority of the provisions in H.R. 3962, the Affordable Health Care for America Act, and I will vote against it. However, I am pleased that H.R. 3962, as well as the Republican Substitute Amendment that I support, both include language relating to biosimilar products.

The provisions related to the creation of a market for biosimilar products is one area of the bill that is a win-win for Americans. As the new biosimilar market develops in the United States, we need to ensure that we foster innovative products in this country for the creation of jobs and research that will go into determining whether these products are interchangeable with the innovator's products. Testing and research on these interchangeable biosimilar products should occur in this country to ensure that it is done properly and safety to benefit our patients and our economy.

Mr. MORAÑ. Mr. Speaker, after reviewing H.R. 3962, the Affordable Health Care for America Act, and interviewing the concerns of Kansans, and visiting Kansas hospitals to speak with doctors, nurses, patients, and administrators, I have concluded that this bill will be harmful to Kansas and I strongly oppose it.

However, I do believe the sections relating to the creation of a market for biosimilars products is one area of the bill that is a win-win for Americans. As the new biosimilar market develops in the United States, we need to ensure that we foster innovative products in this country for the creation of jobs and research that will go into determining whether these products are interchangeable with the innovator's products. Testing and research on these interchangeable biosimilar products should occur in this country to ensure that it is done properly and safety to benefit our patients and our economy.

The biosimilar provisions in this bill are only the first step in a long path to the marketing of these new products. New research and clinical testing will have to occur and the FDA will implement regulations that ensure this research is done safely and effectively.

One of the reasons I have long supported the U.S. biotechnology industry is that it is a homegrown success story that has been an engine of job creation in this country. With this week's news that unemployment has reached 10.2 percent, it is critical that we preserve jobs in the United States. Testing and research on these generic biosimilars should take place in the United States to ensure that it is done properly and safely while benefitting our economy.

Innovative biotechnology companies have created jobs here in the United States and we must continue to support them.

Mr. PAYNE. Mr. Speaker, I am others have spoken at length on the ways that this bill will improve health care for all of our constituents. Another significant benefit of this legislation which has not received as much attention will be the creation of new high-paying jobs in this country. Let me repeat that for some of my friends on the other side of the aisle, this bill will create high-paying, high-quality jobs in healthcare delivery, technology and research in this country.

First, this bill will create enormous demand for healthcare workers, specifically in the area of primary care. Insuring the millions of Americans in the country who currently have no insurance will allow them to see primary care providers and receive the wellness and preventive care they have been denied for too long. The influx of new patients will need doctors, nurses and technicians for their care, while reducing overall healthcare costs because they will not need much more expensive hospitalizations. I support channeling resources that for too long have been used to provide care once they become sick into jobs and services that will prevent people from getting sick in the first place.

Second, this bill will continue the efforts we began in the stimulus package to deploy new health information technologies that better manage both the quality of care people receive and the cost at which they receive it. New health-care exchanges and new demands on the health system to provide high-quality and cost-effective health care will create new opportunities and markets for our brightest technology minds. They will be incentivized to create and develop products that will be a win-win opportunity and a high-quality health care at an affordable price.

Third, this bill will create high-quality research opportunities in this country. The Energy and Commerce Committee enacted a framework for allowing biosimilar competition in this country. This new class of medicines will help lower costs and bring competition to drugs that is key to the future of our healthcare system. Biotechnology is on the cutting edge of efforts to reducing costly invasive procedures and allowing our constituents to live healthier and more productive lives. The creation of this new class of medicines comes with requirements for new clinical research and testing, especially in the area of whether a new biosimilar can be interchangeable with an innovator's product. This research will create high quality and high paying jobs and it is imperative that we keep this research and these jobs in this country.

We cannot allow these research opportunities to leave this country, and I intend to work with the Secretary of HHS and the Commissioner of the FDA to ensure they stay in the United States.
I do not look at this bill as one of cost or drain on the economy of our country like so many of its opponents on the other side of the aisle. I see this bill as an exciting opportunity to create the kind of jobs we so desperately need in this country while at the same time improving the lives of ALL Americans. This bill will improve health care, create jobs and grow our economy.

Mr. TERRY. Mr. Speaker, I have criticized many of the provisions of this bill and rightfully so. But in fairness, I do believe the sections relating to the creation of a market for biosimilar products is one area of the bill that strikes the appropriate balance in providing lower cost options to consumers without destroying a healthy and functioning industry in this country. These provisions were one of the few areas in the bill adopted on an overwhelming bi-partisan vote for the Eshoo-Inslee-Barton (EIB) amendment in the Energy and Commerce Committee.

Creating a pathway for new products that doesn’t destroy the ability or the incentives for innovators to develop breakthrough technologies and at the same time providing a safe and effective way to bring competition to benefit patients is a laudable achievement. I wish we could remove this provision from this fatally flawed piece of legislation and consider it separately because I would pass with the kind of overwhelming bi-partisan support that Americans across the country wish to see.

However, these provisions are only the first step in a long path to the marketing of these new products. New research and clinical testing will have to occur and the FDA will write rules that will ensure this research is done safely and effectively. One of the reasons I have long supported the U.S. biotechnology industry is that it is a homegrown success story that has been an engine of job creation in this country.

As this new market launches in the United States, we need to ensure that we foster innovation and ensure the safety of any new product brought to the market.

Ms. CLARKE. Mr. Speaker, I ask unanimous consent to revise and extend my remarks in support of this legislation because it eliminates gender rating that allows young women to be charged 45% more than men for identical coverage.

Mr. POE of Texas. Mr. Speaker, H.R. 3962 forces businesses and individuals to purchase health insurance. It raises at least two constitutional issues. Congress should never pass an unconstitutional bill, and I will vote against H.R. 3962.

The Constitution doesn’t give the Federal Government direct authority to compel the purchase of health insurance. The Supreme Court would once again have to come in and by judicial edict give the government the intrusive powers to make this happen. The Court would once again have to come in and by judicial edict give the government the intrusive powers to make this happen.

Mr. Speaker, I am strongly against H.R. 3962, and I will vote against it should it come to a vote on the House floor. However, I do believe the sections relating to the creation of a market for biosimilar products is one area of the bill that strikes the appropriate balance in providing lower cost options to consumers without destroying a healthy and functioning industry in this country. These provisions were one of the few areas in the bill adopted on an overwhelming bipartisan vote for the Eshoo-Inslee-Barton (EIB) amendment in the Energy and Commerce Committee.

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Unfortunately, many of the largest companies that would seek to enter the biosimilar market have made their money by outsourcing their research to foreign countries like India. With this week’s devastating news that unemployment has reached 10.2% it is critical that we preserve jobs in the United States. While the innovators, have created jobs here, these generic companies have shipped them overseas, so they can turn around and sell cheap knockoffs of innovative American products.

As this new market launches in the U.S., we need to ensure that we foster innovative products in this country for the creation of jobs and research that will go into proving whether these products are interchangeable with the innovators products. I have doubts that these companies can create such interchangeable products, but I am certain that the research and testing of whether or not they can be interchanged and not somewhere across the globe. Testing and research on these interchangeable biosimilars should occur in this country to ensure that it is done properly and safely and to benefit our economy.

Mr. KIRK. Mr. Speaker, our goal in health care reform should be to lower the cost of health care, making it more affordable for Americans to purchase coverage. Many young adults from Illinois and elsewhere will be hit very hard under this legislation if they do not have coverage provided by their employers. We should not force young Americans to purchase coverage that costs them more because of reform. This is a new expensive tax targeted to young workers—and I oppose it.

According to the Department of Health and Human Services, 29 percent of individuals between the ages of 18 and 24 are uninsured and 27 percent of individuals between the ages of 25 and 34 are uninsured. Prices in the individual insurance market are already so high that we must not ignore the mis-named "Affordable Health Care Act" that we are debating now will make this coverage even more expensive.

The reason is that this bill requires that insurers may not charge 64-year-olds more than twice what they charge healthy 19-year-olds. This mandate will raise premiums on young adults tremendously. Young, healthy people who lack coverage, mostly because they find it too expensive at a current cost of $1,700 to $2,000 for it, will be forced to buy policies that cost $3,000, even after federal subsidies. The House bill’s "age rating" of 2 to 1 is far below the 5 to 1 ratio currently prevalent in the insurance market. Why does this ratio exist? Simply because the medical bills of young healthy people are a fraction of what older Americans spend. Comparisons of the House bill with an estimate of what is available in the individual market now using data provided by the Kaiser Family Foundation demonstrate that a 25-year-old single individual making $30,000 will pay a premium of $3,169 under the House bill after subsidies, while an insured standard with a 4 to 1 age rating cost $2,256. It is almost a $1,000+ leap. This is a big deal for those earning only $30,000.

The Kaiser Family Foundation provides a way to estimate how insurance premiums will rise for young workers and their families:

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<th>Salary</th>
<th>House bill</th>
<th>Current market</th>
<th>Higher premium</th>
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I proposed an amendment to this bill that would ensure that anyone purchasing insurance coverage after January 1, 2013 is exempted from the individual mandate. This is an expensive insurance plan than those available under today’s bill Act was available six months prior to its enactment. Unfortunately, this amendment was not made in order by the Rules Committee.

In health care reform, we should do no harm. We must enact reforms that will actually lower the costs of insurance premiums so Americans can afford to purchase coverage. Enacting a bill that makes it more expensive for young workers to buy insurance coverage and then forcing them to buy such coverage is what this bill does.

In closing, I want to commend Shauna McCarthy of my staff for the many months she has committed to health reform, contributing to this amendment as well as the Medical Rights and Reform Act, which seeks to prevent government intervention in the important relationship between patients and their doctors.

Mrs. MALONEY. Mr. Speaker, Sunday, 42,000 people gathered in my hometown of New York City to run the NYC marathon while 2 million more people watched, cheered, and marveled at those who accepted the challenge of running 26.2 miles. It is likely that each participant had a different reason for running, but the ultimate goal was the same: to finish, to
succeed, and to accomplish a goal. As Greek legend explains, the concept of the marathon comes from the long distance a messenger ran to deliver the important news that the battle had been won. Mr. Speaker, as we stand here today to debate a historical bill that will substantially improve the delivery of health care in this country, now is the time to take care of all Americans, now is the time to make sure that families are not forced to see loved ones die because they did not get the care they need and deserve.

I’d like to thank and commend the leadership of Speaker PELOSI, Majority Leader HOYER, Chairmen WAXMAN, MILLER and RANGEL and of course, Chairman EMERITUS DINGELL who has been working on health care reform since he first came to Congress. H.R. 3962, the Affordable Health Care for America Act, is a significant and important step toward securing accessible, and quality health care for all Americans. Our current health care system is broken. Costs continue to increase at unsustainable rates and too many families and businesses are feeling the debilitating burdens brought on by these expenses. Too many Americans have inadequate coverage or lack coverage entirely and are suffering or dying as a result.

H.R. 3962 is critical to the health of our families, to the health of our economy and to the health of our nation; H.R. 3962 faces costs for every patient, reins in premiums, co-pays, and deductibles, limits out of pocket costs, and lifts the cap on the amount that insurance companies cover each year; H.R. 3962 strengthens Medicare, securing the financial stability and solvency of Medicare for years to come, and provides seniors with better benefits and guaranteed access to their doctors; H.R. 3962 reduces the deficit by over $100 billion in the first 10 years, and likely by even more in the following decades, according to the Congressional Budget Office; H.R. 3962 provides affordable coverage to those who cannot get health insurance because of pre-existing conditions, including domestic violence and pregnancy, and protects consumers from higher rates due to gender or other factors.

And, very importantly, I am proud that H.R. 3962 includes a public health insurance option that will increase competition and reform our current system. I am grateful to Speaker PELOSI for her steadfast support of this important provision and am confident that it will expand access to care to the many people in need. When 14,000 Americans are losing their health care coverage each day, it is clear that a public option is needed. It will bring down costs, increase access, and improve care for all Americans. The richest country in the world should not have people who go without the basic necessity of health care. The public option will hold health insurance companies accountable for the practices that price people out of the health care they need and deserve. Health care is the most important public policy issue of our generation that will affect generations to come. I am grateful for the opportunity to be a part of this momentous reform and would like to take the time to highlight some areas of the bill that specifically impact my Congressional district.

H.R. 3962 will improve employer-based coverage for 440,000 residents in my district and will provide credits to help pay for coverage for up to 120,000 households. It will also improve Medicare for 88,000 beneficiaries, including closing the prescription drug donut hole for 8,100 seniors. H.R. 3962 will allow 33,300 small businesses to obtain affordable health care coverage and provide tax credits to help reduce health insurance costs for up to 31,300 small businesses and will cover 26,000 uninsured residents. In short, H.R. 3962 will make health care affordable for the middle class, provide security for seniors, and will guarantee access to health insurance coverage for the uninsured while reducing the federal deficit over the next ten years and beyond.

In addition to representing the residents of the 14th Congressional District of New York, I am proud to represent 14 hospitals. Many of these are the American medicine, training our nation’s doctors, and facilitating cutting edge research that identifies cures and gives hope to millions of Americans and their families. I am pleased that H.R. 3962 recognizes the importance of teaching hospitals and preserves Graduate Medical Education. New York’s teaching hospitals, raising our future physicians, are treating the sickest of the sick and poorest of the poor. These payments, including Direct Medical Education and Indirect Medical Education are critical to the survival of these hospitals and to the greater good of medicine.

H.R. 3962 takes into account diverse patient populations, the cost of goods and services, and the higher costs incurred by teaching hospitals. Teaching hospitals tend to treat the most complex cases and are the first to adopt innovative technologies and techniques that advance patient outcomes, so their costs are often higher than average. A policy that reduces spending arbitrarily runs the risk of stifling innovation which is why I am pleased that the bill is sensible on how it addresses geographic differences and the pitfalls of a blanket overhaul. It requires the Secretary of HHS to contract with the Institute of Medicine to conduct two studies. The first is a study of wage levels which will look at the hospital wage index and the physician geographic practice index and will recommend changes to the methodologies, if necessary. The second study looks at the geographic variation associated with volume and intensity of services in Medicare, Medicaid, and private sector spending per capita. The current methodology must be updated and separate out higher-than-average spending due to unavoidable or desirable factors (e.g., patient demographic and clinical risk factors and wage levels) from higher-than-average spending due to avoidable or undesirable factors (e.g., excessive medical errors, and practice patterns different from best practices). The bill wisely includes specific prohibitions against recommendations to reduce graduate medical education, disproportionate share, and health information technology payments.

While I am pleased to see much of the bill, I am concerned that H.R. 3962 does not extend the 340B discounts to drugs purchased for inpatient use, a provision that was included in an earlier version of the bill. Currently, the 340B Drug Pricing Program requires pharmaceutical manufacturers that participate in Medicaid to sell outpatient drugs at discounted prices to disproportionate share hospitals (DSH) that serve a high threshold of low-income, uninsured and underinsured patients. H.R. 3962, the Affordable Health Care for America Act, is a significant and important step toward securing accessible, and quality health care for all Americans, now is the time to take care of all Americans, now is the time to make sure that families are not forced to see loved ones die because they did not get the care they need and deserve.
The idea behind medical debt counseling is simple: Create a network of non-profit organizations that provide counseling services specifically for medical debt. The nonprofit counselors will provide the participants with a number of options long before the idea of bankruptcy is even considered. This is a critical factor for everyone to avoid bankruptcy, and a health care provider such as a hospital or doctor, can receive payment for their services.

Nonprofit organizations with expertise in helping people with chronic diseases manage their burden, such as the Chronic Disease Fund which assists people in my state, should be put on the front lines of providing effective medical debt counseling. They are the experts which are best equipped to provide effective counseling so that individuals will not be forced into declaring bankruptcy because of their medical debt.

To my knowledge, there is nothing in the pending health care reform legislation that would help encourage medical debt counseling. This brings me to an important point. Because we have moved so fast on health care reform legislation, good ideas like medical debt counseling are not part of this bill. We need options like this for health care reform because it will work to save the American taxpayer money. Medical debt counseling will reduce the cost burden on the health care system, not increase it. And medical debt counseling is innovative. It is innovation like this that made America’s health care the best in the world.

Mr. Speaker, my constituents, like yours, provide for their families but they live on a tight budget. When faced with the reality of making a huge medical bill payment or putting food on the table, what do you think they are going to do? We can help them avoid this terrible scenario. Again, 60 percent of bankruptcies in this country are because of crushing medical debt. We can help lower the number of personal bankruptcies across this great nation, but to do so we need to encourage a system of medical debt counseling.

Ms. KILPATRICK of Michigan. Mr. Speaker, I rise today to support H.R. 3962, Affordable Health Care for America Act, offered by Rep. JOHNGELL of Michigan and ask all of my constituents to support this historic bill before we that will expand coverage to 36 million uninsured Americans, ensure that patients and physicians make their own health care choices, reduces administrative costs, invests in wellness and prevention, reforms the insurance industry by ending discriminatory practices, especially pre-existing conditions and health disparities, and allows young adults to remain on their parents’ insurance policy until the age of 27.

I have held numerous town hall meetings in my district to listen to the views of my constituents. My office has received numerous calls, emails, and letters on this subject, with an overwhelming majority asking me to vote YES on the bill because America cannot wait any longer for health care insurance reform. More than 300 groups, representing millions of Americans, have expressed their support for the bill, including the American Association of Retired Persons, the American Cancer Society, the AFL-CIO, the SEIU, Families USA and the National Committee to Preserve Social Security and Medicare. The groups expressing their support include a broad range, including groups representing doctors, seniors, small business, youth, women, persons with disabilities, consumers and patients.

Health care insurance reform is not a Republican or Democratic issue, it is an American issue under a Democratic President, we witnessed the beginnings of health care reform with Medicaid and Medicare in the 1960s. Under another Democratic President, we will witness the second coming of true health care reform.

Today’s vote can mark a change in our country where every American will know that health care is a top priority for this country. When I was a newly elected Member to the U.S. House of Representatives, Congress was in the throes of reforming health maintenance organizations or HMOs. While this was well intended, at the time, I asked, “what about those millions of people who go to work each and every day, who care for our senior citizens in nursing homes, who clean our bathrooms, cook our food, clean our streets, and send their children to college, but whose employment is at risk as they worry about their health care?” What has happened is that those individuals did not have health care coverage, period. Now is the time to help those janitors, street sweepers, short-order cooks, child care workers, home health care providers, and small businesses so that those workers, too, will be able to have health care.

The 111th Congress has taken bold steps to provide more access to health care for Americans. While we have expanded health coverage to more than five million uninsured children through the passage of the State Comprehensive Health Improvement Plan or SCHIP, we must complete what we started. Access to health care is vital to the health of not only individual Americans but to the American economy.

Even before our recent economic crisis, health care was getting more expensive, what few benefits were offered were eroding, and even more people were losing coverage. In 2007, according to various sources, 45 million Americans were uninsured; this number is an increase of uninsured Americans. And this is the uninsured; we are not even discussing the millions more senior citizens, working poor and families who are underinsured. I am talking about seniors who have to choose between eating or their prescriptions. I am talking about those families who have to choose between taking their child to the doctor or food for the week. The economic crisis has only made this situation worse.

The bankruptcy of the automobile industry, the closing of auto dealerships, and the crisis faced by auto workers have caused thousands more in our nation and in particular the state of Michigan to lose their employee health benefits.

Our version of health care reform, the Affordable Healthcare for All Americans Act, has four key highlights for Americans and American businesses: lower costs; greater choice; higher quality and peace of mind. As Health and Human Services Secretary Sebelius said earlier, if we do nothing to reform health care, we will continue to live sicker, die faster and pay twice.

Health care reform legislation should require coverage of the full range of women’s reproductive health services. H.R. 3962 protects these rights and ensures that all women have access to a health care plan that meets their needs while respecting current law. The Stupak amendment would limit access to reproductive care in the private and public options, and does not allow citizens to pay for the procedure out of their own pockets. I voted against the Stupak amendment.

HEALTH CARE REFORM WILL PROVIDE LOWER HEALTH CARE COSTS

Under the America’s Affordable Health Care Act, there will be no more co-pays or deductibles for preventive care. No more rate increases or exclusions for pre-existing conditions, gender or occupation. There will be an annual cap on the out of pocket expenses for individuals and businesses. Finally, for the first time, there will be guaranteed and affordable oral, hearing, and vision care for children.

By having a public health care plan, the bill will ensure competition for Americans to have the best health care at the most affordable cost. Also, since everyone will have health care, no one industry or business will be at an advantage over another one.

HEALTH CARE REFORM WILL PROVIDE GREATER CHOICE FOR ALL AMERICANS AND BUSINESSES

Americans will be able to keep their doctor, and their current plan, if you like what you have. With a high quality public health insurance option competing with private insurers, there will be more choice of providers and more benefits. The important aspect is this—every American will have a choice of providers, versus today’s choice, for the uninsured, of the emergency room or no care at all. No one will be forced into a public option. This will just be one of many choices.

HEALTH CARE REFORM WILL PROVIDE HIGHER QUALITY HEALTH CARE FOR ALL AMERICANS

You and your doctor—not insurance companies—will make health care decisions. As more primary care, family doctors, and nurses enter the workforce, even more access is guaranteed for all Americans. Also, the bill mandates coverage for mental health care, a legacy that will affect in particular, the families of our service members who are returning from the wars in Iraq and Afghanistan.

HEALTH CARE REFORM WILL PROVIDE PEACE OF MIND

The bill provides a cap on catastrophic coverage—coverage for traumatic injuries such as spinal cord injuries and long-term health care. There will be no more denial of coverage for preexisting conditions, and no reason to make a life or job decision based on whether or not you or your family will have health care coverage.

We need health insurance reform now. Access to quality, affordable health care is critical to the well-being of all Americans and all Americans, today and tomorrow. Central to all of this is addressing the needs of uninsured Americans, strengthening our Medicare system, providing health insurance to low-income children and families, funding research into diseases like diabetes and cancer, and giving patients the ability to make decisions with their doctors, not health insurance companies. An estimated 1,400 families lose health insurance every day that we do not pass health insurance reform.

One aspect of this legislation of which I am most proud is its fiscal responsibility. According to a letter dated November 5, 2009 from the non-partisan, objective Congressional Budget Office, this bill adds not one dime to...
The deficit. Furthermore, this bill reduces the deficit by an estimated $109 billion. This is not only fiscally responsible, it allows us to provide health care to the least of our sisters and brothers.

When this bill is signed into law, ten provisions of the bill will take effect immediately. It will begin to close the Medicare Part D “Donut” Hole. The bill reduces the donut hole by $500 per Medicare recipient and also institutes a 50-percent discount on brand-name drugs.

It gets health insurance to the uninsured. By creating a temporary insurance program, health care will be available for people who have been denied a policy due to preexisting conditions or who have not had health care for several months. It bans lifetime limits on health care coverage. The bill prohibits health insurance companies from placing lifetime caps on coverage—traditional coverage or catastrophic care coverage.

It provides health insurance for young people. It requires health insurance plans to allow young people age 26 to remain on their parents’ insurance policy at their parent’s choice. It eliminates cost-sharing for preventive services in Medicare. It eliminates copayments for preventive services and exempts preventive services from deductibles under the Medicare program.

It ends health care rescissions. It prohibits insurers from nullifying or “rescinding” a patient’s policy when they file a claim for benefits, except in cases of fraud. It eliminates copayments and deductibles. It eliminates copayments for preventive services and also exempts preventive services from deductibles under the Medicare program.

It increases funding for community health centers. It increases funding for Community Health Centers to allow twice the number of patients seen by Community Health Centers for the next 5 years. It increases the number of primary care doctors. It increases the investment by the Federal Government in training programs to increase the number of primary care doctors, nurses, and public health professionals.

Creates long-term health care for disabled adults. The bill creates a long-term care insurance program to be financed by voluntary pay-roll deductions to provide benefits to adults who become functionally disabled.

As with Medicare and Medicaid, the Federal Government has the Constitutional power to reform our health care system. The 10th amendment to the U.S. Constitution states that the powers not delegated to the federal government, nor prohibited by it to the states, are reserved to the states . . . or to the people. Article One, Section Three, also known as the Commerce Clause, says the same thing. The Constitution gives Congress broad power to regulate activities that have an effect on interstate commerce. Congress has used this authority to regulate many aspects, from labor relations to education to health care to agricultural production. Since virtually every aspect of the health care system has an effect on interstate commerce, the power of Congress to regulate health care is essentially unlimited.

The Affordable Health Care for America Act is good for small businesses. Under this legislation, many small businesses will be eligible for a new tax credit to help them provide coverage for their workers and their families—and they or their workers will get access to a new comparison shopping marketplace with low rates and good benefits like large groups get. Without health insurance reform, small businesses would pay nearly $2.4 trillion over the next 10 years for their workers. According to the nonpartisan Joint Committee on Taxation—only 1.2 percent of the wealthiest Americans will be subject to the surcharge and it would only apply to dollars earned over $1 million for a couple and over $500,000 for someone. 86 percent of all businesses are exempt from the requirement to provide health insurance coverage to their workers.

Nothing in the House bill will cut basic Medicare benefits. The Affordable Health Care for America Act strengthens and improves Medicare benefits for older Americans and helps eliminate waste, fraud and inefficiency from Medicare—including gross overpayments to insurance companies providing Medicare Advantage plans which do nothing to improve care for Medicare beneficiaries.

The Affordable Health Care for America Act is comprehensive health insurance reform that covers 96 percent of Americans, ensures affordability for the middle class, provides security for our seniors, ends discrimination by insurers, and ensures that the sick, caps what Americans pay out-of-pocket and protects our children’s future by not adding to our deficit.

Finally, health care reform will allow the United States to catch up to the rest of the industrialized world. Only 10 other countries, and Japan, do not provide universal health care coverage to its citizens. This puts the health of not only individual Americans at jeopardy, it puts the health of our economy in jeopardy. Businesses that have to compete with China, India, Europe and other countries are doing so on an uneven, unfair playing field, because while China, India and European businesses do not have to pay for health care, American businesses do. Health care reform will allow these businesses to truly compete on a global plane.

I applaud my colleagues in the House of Representatives for supporting this legislation in ensuring that health care reform is accessible, affordable, and affordable for all Americans and American businesses. Two generations is long enough for the American people to wait for comprehensive health care reform. Health care is the key moral and economic imperative for our Nation and this Congress. We must reform health care now.

Ms. CLARKE. Mr. Speaker, today, I rise in support of the Affordable Healthcare for America Act. In the United States, one of the richest countries in the world, nearly 47 million Americans lack health insurance, 13.5 percent of which are New Yorkers. Last year alone, New York City’s hospitals spent 1.2 billion dollars in charity costs. Tragically, people who are often uninsured or underserved often have to go without vital healthcare simply because they cannot afford it.

Every American has a human right to adequate physical and mental healthcare, and I believe that government has a responsibility to ensure quality healthcare. Unfortunately, my Republican colleagues don’t seem to fully grasp the dire situation our healthcare system is in. Maybe they would have come up with a bill that actually addressed the deficiency in our broken healthcare.

It is unfortunate that there are those who just don’t care. Those who are satisfied with the status quo of rising premiums, satisfied with individuals being denied coverage because they have preexisting conditions, satisfied with ignoring the pain and suffering of the 47 million Americans who are uninsured. Instead of working to fix the problem, they capitalize on people’s fears and doubts. It is meant to distract, delay, confuse, and engender fear among our citizens and other countries involved with the voices of fear to dominate the health care reform debate. This bill provides health care coverage to 96 percent of Americans and includes a strong public option that will provide the needed competition to lower premium costs. That is why I support H.R. 3962, Affordable Health Care for America Act.

In my district, the 11th Congressional District of Brooklyn, the Affordable Health Care for America Act will:

First, improve employer-based coverage for 367,000 residents. As a result of the insurance reforms in the bill, the best ways to provide insurance to small business will be purchased by either the small business or by the health insurance company. Small businesses will be able to provide insurance at a lower cost to their employees. There will be a new tax credit to help them purchase affordable coverage.

Second, it will provide credits to help pay for coverage for up to 160,000 households, if they need to purchase their own coverage.

Third, under the bill’s insurance reforms, 11,900 individuals in the district who have pre-existing medical conditions will now be able to purchase affordable coverage.

Finally, this bill will allow 11,500 small businesses to obtain affordable health care coverage and provide tax credits to help reduce health insurance costs for up to 11,400 small businesses.

Healthcare is a fundamental human right, rather than a commodity. A year ago, Americans cast a historic vote to change the course of this Nation. Today, we cast this historic vote, to finally manifest the change they demanded. Access to Affordable Healthcare. I am proud to cast my vote in favor of this bill.

Mr. Speaker, I believe that H.R. 3962, the Affordable Health Care for America Act, will improve health care for all of our constituents. Another significant benefit of this legislation, which has not received as much attention, will be the creation of new high paying jobs, high quality jobs in healthcare delivery, technology and research in the United States.

First, this bill will create enormous demand for healthcare workers, especially in the area of primary care. Insuring that the millions of Americans, who currently have no insurance, will have access to primary care providers so that they can receive the preventive care they have been denied for too long. This influx of new patients will create a need for doctors, nurses and technicians, while reducing overall healthcare costs because of the new focus on preventative medicine. I support channelling resources, that for too long have been used to treat people once they become sick, into jobs and services that will prevent people from getting sick in the first place.

Second, this bill will continue the efforts we began in the stimulus package to deploy new health information technologies that better
manage both the quality of care and the cost of it. New health care exchanges and new demands on the health system to provide high quality and cost-effective health care will create new opportunities and markets for our brightest technological minds. They will be incentivized to form new high quality healthcare products at an affordable price.

Third, this bill will create new research opportunities in this country. The Energy and Commerce Committee enacted a framework for allowing biosimilar competition in this country. This new class of medicines will help lower costs and bring competition to one area that is key to the future of our healthcare system. Biotechnology is on the cutting edge of efforts to reduce costly invasive procedures, thereby allowing our constituents to live healthier and more productive lives. The creation of this new class of medicines comes with requirements for new clinical research and testing. This research will create high quality, high paying jobs. It is imperative that we keep this research, and these jobs in this country. We cannot allow these research opportunities in this country, and I look forward to working with the Secretary of HHS and the Commissioner of the FDA to ensure they stay in the United States.

I do not look at this bill as a drain on our economy, like so many of its opponents on the other side of this aisle see it. I see this bill as a calling opportunity to create the kind of jobs we so desperately need in this country, while at the same time improving the lives of all Americans.

This bill will improve health care, create jobs and grow our economy. Mr. FATTAH. Mr. Speaker, in my fourteen years representing the people of Philadelphia and Montgomery County, Pennsylvania, I have had few opportunities as significant as this one to stand up for my constituents, their families, the future of our city and the destiny of our nation. This healthcare bill is the result of months of legislative negotiation and collaboration and answers the calls made for decades by mothers who could not alleviate the suffering of their children, conscience-minded small business owners who could not provide the health care their employees deserved and doctors and nurses who fought creatively to provide treatments they knew their patients needed and could never afford. I am proud that today we will take the most significant step in a century towards joining the rest of the industrialized world in assuring every American has access to the healthcare they need.

It is the nature of democracy that this bill contains some provisions which I do not support. I believe women deserve access to the full range of legally assured health services on equal footing with men. I believe it is our responsibility to vigorously address the persistent health disparities which disadvantage Americans of color and linguistic minorities. I believe overzealous efforts to deny some people healthcare on the basis of their immigration status will inadvertently limit care for native-born and legal residents as well. I believe a stow public option is the only way to ensure competition, choice and affordability in the American private insurance market. At the end of the day, we, the Representatives of the people, have to speak for them. Rarely do we have the opportunity to so directly improve their standard of living. It is with the people of the Second District in mind, and the generation to come, that I enthusiastically vote yes for the Affordable Health Care for America Act.

Ms. WOOLSEY. Mr. Speaker, at least 46 million Americans are uninsured right now. More than 85% of the uninsured are in working families or individuals with insurance. Now, without reform, the cost of health care for the average family of four is projected to increase by almost $2,000 a year. The need for health reform is urgent and that’s why I rise in strong support of this historic bill.

Many Members believe, myself included, continue to believe that the best way to provide high quality, affordable healthcare to everyone is to create a single payer health insurance system. However, while we would prefer single payer, we united behind a health reform bill with a robust public option.

We believed, and still believe, that the robust public option, a public option based on medicare plus 5% rates is the best way to increase competition, bring down the costs of premiums, and provide everyone with a real choice between a private and public health insurance plan. In August, many thought the public option was dead. But the Progressive Caucus, Tri-Caucus, and many in our leadership, made sure that the robust public option was very much a part of the debate in September and October.

Because of the work of so many Members, we have a public option in the bill we are considering today. While it’s not the plan I would have preferred, this public option will increase competition with private plans and provide a real choice in health insurance plans.

In addition, there is language in the manager’s amendment that will ensure that any increase in health insurance premiums must be justified, which will help make premiums more affordable for our Nation’s working families. As we move into conference with the Senate, I look forward to continuing to work with my colleagues to ensure that we have the best possible bill. Therefore, Mr. Speaker, to increase competition and provide choice, any bill reported out of conference must retain a strong national public option that goes into effect when the health exchange begins, and, is not based on any triggers. I urge my colleagues to support this bill.

Mr. HARE. Mr. Speaker, I wish to strongly voice my support for the Affordable Health Care for America Act on behalf of all hard working men and women across this great country and certainly in the State of Illinois.

For decades, our government has debated the issue of extending healthcare to all, yet too many Americans still lack it and the security and peace of mind that comes with it. For those fortunate enough to be insured, rising costs are making it harder and harder to stay afloat. We, as members of this body, have the opportunity today to take a historic step toward passing the Affordable Health Care for America Act, so that quality health care can be more affordable and accessible to all Americans and their families. This bill will drastically reduce the number of uninsured, increase competition and lower costs through a public option, reform the insurance industry so Americans don’t see their coverage unfairly dropped, and put more money in our seniors’ pockets by closing the Medicare Part D doughnut hole, all while reducing the deficit by $104 billion over 10 years.

With unemployment at its highest level since 1983, another significant benefit of this legislation that should be highlighted is the creation of new high-paying jobs in this country. Let me repeat that for some of my friends on the other side of the aisle, this bill will create high-paying, high-quality jobs both in the delivery, testing, and research in the United States. This bill creates a framework for allowing biosimilar competition in this country, which has the potential to lead to a new class of generic biologic medicines that will help lower costs and bring competition to an area that will be key to the future of our healthcare system. The development of generic biologics or biosimilars has the potential to create much needed jobs here at home in clinical research and testing. I intend to work with the Secretary of HHS and the Commissioner of the Food and Drug Administration to ensure that this new work is conducted here at home, in places like my home state of Illinois.

This bill will additionally create enormous demand for healthcare workers, especially in the area of primary care. Insuring the millions of uninsured in this country currently do not have coverage will allow them to see primary care providers and receive the wellness and preventive care they have been denied for too long. This influx of new patients will need doctors, nurses and technicians for their care, placing a new kind of pressure on the workforce because they will receive care based around prevention as opposed to hospitalization. I support channeling resources, that for too long have been used to treat people once they become sick, into jobs and services that will prevent the influx of patients in the first place.

The Affordable Health Care for America Act will continue the efforts this Congress first undertook in the Recovery Act that deployed new health information technologies throughout our healthcare system. These technologies help to better manage both the quality of care people receive and the cost at which they receive it. New health care exchanges and new demands on the health system to provide high-quality and cost-effective health care will create new opportunities and markets for our brightest technological minds. They will be incentivized to create and develop products that will be a win/win for Americans: high quality health care at an affordable price.

I was proud to work with my colleagues on the Education and Labor Committee to help shape this bill. I was pleased to have had the opportunity to add two critical pieces to this bill that are of great importance to my constituents: allowing for Small Employer Benefit Arrangements (SEBA), which facilitate the participation of small businesses and the self-employed in the Health Insurance Market; and protecting the ability of our nation’s veterans to be able to enter into the Health Insurance Exchange to attain additional insurance for their dependents while retaining their VA health coverage. These provisions were common-sense improvements that make this great bill even better.

I have cited many, but not all, of the reasons why I think this historic bill is worthy of my vote. I now ask that my colleagues join me in protecting American families from coast to coast in supporting this historic legislation. Mr. Speaker, thank you for your strong leadership on this issue and I look forward to proudly voting in favor of this bill in honor of the 39,000 uninsured residents of my District who would
finally have the ability to receive the quality health care they deserve.

Mr. PASCRELL. Mr. Speaker, I and others have spoken at length on the ways that the Affordable Health Care for America Act will improve health care for all of our constituents. Another outcome of this legislation which has not received as much attention will be the creation of new high-paying jobs in this country. Let me repeat that for some of my friends on the other side of the aisle: this bill will create high-paying, high-quality jobs in healthcare delivery, technology, and research in the United States.

First, H.R. 3962 will create enormous demand for healthcare workers, especially in the area of primary care. Expanding meaningful health insurance coverage to the millions of Americans in this country who are currently uninsured or underinsured will allow them to see the primary care providers and receive the wellness and preventive care they have been denied for too long. This influx of new patients will need the doctors, nurses, and technicians necessary to deliver the care they need—while the healthcare system can prevent more expensive emergency care and hospitalizations. I support channeling resources that for too long have been used to treat people once they become sick into jobs and services that will prevent people from getting sick in the first place.

Second, the Affordable Health Care for America Act will continue the efforts we began in the stimulus package to deploy new health information technologies that better manage both the quality of care people receive and the cost at which they receive it. New health care exchanges and new demands on the health system to provide high-quality and cost-effective care will create new opportunities and markets for our brightest minds in technology. They will be incentivized to create and develop products that will be a win-win for Americans—high quality health care at an affordable price.

Third, H.R. 3962 will create high-quality research opportunities for America. The legislation under consideration establishes a framework for allowing biosimilar competition in this country. This new class of medicines will help lower costs and bring competition to an area that is a key to the future of our health care system. Biotechnology is on the cutting edge of efforts to reduce costly invasive procedures and allow our constituents to live healthier and more productive lives. The creation of this new class of medicines comes with requirements for new clinical research and testing, especially in the area of new biosimilars’ interchangeability with innovator products. This research will enhance the safety and health of all jobs, and it is imperative that we keep this research and these jobs in this country. The Inspector General of Health and Humans Services is currently investigating the amount of data received from overseas clinical trials. We cannot allow these research opportunities to leave this country, and I intend to work with the Secretary of HHS and the Commissioner of the Food and Drug Administration to ensure that the clinical studies to support the safety and interchangeability for this new class of follow-on biologics is conducted in the United States.

Mr. Speaker, I do not view this legislation as a cost or drain on the economy of our country like so many of its opponents on the other side of the aisle. Instead, the Affordable Health Care for America Act is an exciting opportunity to create the kinds of jobs we so desperately need in this country while improving the lives of ALL Americans. H.R. 3962 will improve health care, create jobs, and grow our economy.

Mr. PASCRELL. Mr. Speaker, I am pleased to support the Affordable Health Care for America Act. I could not be prouder that H.R. 3962 expands coverage to 96 percent of Americans in a fiscally responsible manner. I strongly believe that all interested parties should indeed have a stake in this necessary effort, but I would like to recognize the contribution asked of the biopharmaceutical industry.

New Jersey has often been called the Medicine Chest for the World and for good reason. Last year, the biopharmaceutical and medical technology industries employed nearly 60,000 individuals in the state of New Jersey—with another 88,000 “spin-off” jobs through the purchase of goods and services, capital construction projects, and other industry activity. H.R. 3962 extends Medicaid rebates to Medicare dual-eligible and low-income subsidy beneficiaries while instituting a new 50 percent discount for Part D beneficiaries who find themselves in the prescription drug benefit coverage gap—the so-called “donut hole.” Pharmacy benefit managers (PBMs) will save about 10 percent of national medical expenditures, but the savings generated from these provisions represent a disproportionately larger share of the legislation’s savings and revenues.

There is little doubt that these industries are those that are both as millions of previously uninsured Americans and millions more who were underinsured are given access to meaningful health insurance that covers prescription medications and as seniors with expanded Part D coverage better adhere to the prescription regimens prescribed by their doctors. However, I have lingering concerns that a single industry may be paying more than their fair share and that this may have unfortunate consequences in New Jersey. The biopharmaceutical manufacturers in New Jersey state, by the way, as many as 12,300 jobs could be lost in New Jersey.

I believe that H.R. 3962 is an effort that will indeed create new jobs in the health care sector both as the demand for health care providers increases and as the result of a new pathway for the development of follow-on biologics, and I applaud the legislation for taking steps to close the Medicare Part D donut hole. However, we must recognize there will be consequences for New Jersey’s biopharmaceutical industry, and I express my hope that these consequences will be minimized as the House and Senate come together to formulate a compromise health reform package.

Mr. PASCRELL. Mr. Speaker, in my capacity as co-chair of the Congressional Brain Injury Task Force, I would like to share my understanding of the amount of provisions of H.R. 3962 for the Affordale Health Care for America Act—regarding the coverage of the treatment continuum for persons with brain injury.

News reports of returning veterans and recent high profile brain injury stories indicate that for many years: brain injury is a leading public health problem in U.S. military and civilian populations. I believe that any health care reform initiative must recognize that brain injury is not an event or an outcome but is the beginning of a lifelong disease process that impacts brain and body functions. These impacts of brain injury can result in difficulties in physical, communication, cognitive, emotional, and psychological performance, undermining health, functional community and productive living. Brain injury is also disease causative and disease accelerative because it predisposes individuals to re-injury and the onset of other conditions.

The Brain Injury Association of America (BIAA) has developed a series of guiding principles for assessing any health care reform bill from a brain injury perspective. I believe, consistent with policy statements by the BIAA, that health care reform must address the unique health care needs of individuals with brain injury by recognizing that brain injury is the start of a lifelong disease process. As such, individuals with brain injury require access to a full continuum of medically necessary treatment—including rehabilitation furnished by accredited programs in the most appropriate setting as determined in accordance with the choices and aspirations of the patient and family in concert with an interdisciplinary team of qualified and specialized clinicians.

I am pleased to conclude that the Affordable Health Care for America Act reflects and is consistent with these principles.

Principle 1: An individual with a brain injury should have an individualized medical treatment plan that documents specific diagnosis-related goals for individuals with a reasonable expectation of achieving measurable improvements through the provision of sufficient treatment.

Under the bill, payment for items and services included in the essential benefits package should be made in accordance with generally accepted standards of medical and other appropriate clinical or professional practice. In addition under the bill, a qualified health benefits plan may not impose any restriction (other than cost-sharing) unrelated to clinical appropriateness on the coverage of the health items and services included in the essential benefits package. Consistent with medical, clinical, and professional practice, appropriateness should be determined based on the unique needs of the individual with brain injury and treatment should be of sufficient scope, duration, and intensity.

Principle 2: An individual with brain injury should have access to the full treatment continuum to manage the disease. This continuum includes (1) early, acute treatment to stabilize the condition and (2) acute and specialty treatment of acute brain injury treatment and rehabilitation to minimize and/or prevent medical complication, recover function and cope with remaining physical or mental disabilities, and achieve long-term outcomes that maintain an optimal level of health, function, and independence following brain injury. These post-acute services include inpatient, outpatient, day treatment, and home health programs. I believe that for individuals with disabilities such as brain injury, rehabilitation and habilitation is equivalent to the provision of antibiotics to a person with an infection—both are essential medical interventions.

I am pleased to report that under the bill, the essential benefit package includes, among other things, hospitalization, outpatient hospital
and outpatient clinic services, professional services of physicians and other health professionals, prescription drugs, mental health and substance use disorder services (including behavioral health treatments), rehabilitative and habilitative services, and durable medical equipment, prosthetics, orthotics, and related supplies. "Rehabilitative and habilitative services" includes items and services used to restore functional capacity, minimize limitations on physical and cognitive functions, and maintain or prevent deterioration of functioning as a result of an illness, injury, or health condition. Such services also include training of individuals with mental and physical disabilities to enhance functional development.

Principle 3: Individuals with brain injury should receive treatment in the most appropriate treatment setting by accredited programs—including acute care hospitals, inpatient rehabilitation facilities, residential rehabilitation facilities, day treatment programs, outpatient clinics and home health agencies. The treatment and treatment setting should be determined in accordance with the demonstrated need of the patient, including the goals including the goals of recovery of the patient and family in concert with an interdisciplinary team of qualified and specialized clinicians.

I am pleased to report that under the bill payment for items and services included in the essential benefits package should be made in accordance with generally accepted standards of medical or other appropriate clinical or professional practice. The bill also requires adequacy of provider networks in order to ensure enrollee access to covered benefits, treatment, and services under a qualified health benefits plan. Rehabilitative and habilitative services should be available from a full continuum of accredited programs and treatment settings at a level of intensity that is consistent with the needs of the patient.

Principle 4: The bill should prevent private insurance systems from delaying or denying treatment as a means of transferring the burden of brain injury care to taxpayers at federal, state and local levels; ensure that both public and private health insurance systems meet the needs of people with brain injury; and avoid using Medicaid and Medicare as the first option for the coverage of people with brain injury.

I am pleased to report that the bill includes numerous requirements reforming the health insurance marketplace that should prevent private insurance systems from delaying or denying treatment for individuals with brain injury. These reforms include (1) prohibiting pre-existing condition exclusions, (2) requiring guaranteed issue and renewal, (3) requiring non-discriminatory benefit limitations, (4) requiring adequacy of provider networks, (5) limiting cost-sharing, and (6) prohibiting the imposition of annual or lifetime limits on coverage. I believe that these provisions will prevent private insurance systems from delaying or denying treatment to persons with brain injury.

Finally, the bill includes provisions regarding modernized payment initiatives and delivery system reform under which the Secretary may use innovative payment mechanisms and policies to determine payment for items and services under the public health insurance option, including bundling of services. Separate provisions are included in the bill regarding post-acute care bundling under Medicare. BIAA, in a recent submission to the chairs of the Education & Labor, Ways & Means, and Energy & Commerce Committees, commented that post-acute payment systems must facilitate, not impede, improvements in functional status of individuals with brain injury and their ability to return to their homes and communities. BIAA is pleased that the bill includes certain minimum requirements for any bundling proposal such as "any willing provider" in the bundled payment system; and test innovative payment methods that make payments directly to non-hospital-based treatment centers, including residential rehabilitation facilities specializing in the treatment of brain injury.

I believe that the deliberative process should address each of these issues. I also believe that the adoption of alternative innovative payment mechanisms and policies must be carried out in a way that accomplishes the goals of improving health outcomes, reducing health disparities, providing efficient and affordable care, addressing geographic variation in the provision of health services, preventing or managing chronic illness, and promoting care that is integrated, patient-centered, quality, and efficient.

I remain wary of mechanisms that bundle post-acute care to acute care hospitals for patients with complex and highly unpredictable diagnosis and health outcomes, like brain injury, under managed care. Such payment systems should not impede, rather than facilitate, improvements in functional status and should not result in premature return to homes and undue levels of preventable disability without adequate facilitation of progress through necessary step down levels of treatment.

Mr. LUETKEMEYER. Mr. Speaker, I have criticized many of the provisions of this bill and rightfully so.

However, one bi-partisan area that strikes me as sensible in providing lower-cost and lower-risk options to consumers without destroying a healthy and functioning industry in this country that is included in both the underlying bill, which I strongly oppose, and the Republican substitute, which I intend to support, are the sections relating to the creation of a market for biosimilar products. These provisions were one of the few areas in the bill adopted on an overwhelming bipartisan vote for the Eshoo-Inslee-Barton (EIB) amendment in the Energy and Commerce Committee.

Creating a market for new products that doesn’t destroy the ability or the incentives for innovator companies to develop breakthrough technologies and, at the same time, providing a safe and effective way to bring competition to benefit patients is a laudable achievement. I wish we could remove this provision from this fatally flawed piece of legislation and consider it separately because it would pass with the kind of overwhelming bi-partisan support that Americans across the country wish to see.

However, these provisions are only the first step in a long path to the marketing of these new products. New research and clinical testing will have to occur, and the FDA will write rules that will ensure this research is done safely and effectively. One of the reasons I have long supported the U.S. biotechnology industry is that it is a homegrown success story that has been an engine of job creation in this country. Unfortunately, many of the largest companies that would seek to enter the biosimilar market have made their money in innovative products sold in countries like India. With this week’s devastating news that unemployment has reached 10.2%, it is critical that we preserve jobs in the United States. While the innovators have created jobs here, these generic companies have shipped them away and sold cheap knockoffs of innovative American products.

As this new market launches in the U.S., we need to ensure that we foster innovative products in this country for the creation of jobs and research that will go into proving whether these products are interchangeable with the innovators products. I have my doubts that these companies can create such interchangeable products, but I am certain that the research and testing of whether or not they can achieve this can occur in this country, not someplace else, anywhere across the globe. Testing and research on these interchangeable biosimilars should be occurring in this country to ensure that it is done properly and safely and to benefit our economy.

Mr. EDWARDS of Texas. Mr. Speaker, after listening to thousands of my constituents and carefully reviewing the legislation, I have made a decision to vote "no" on the House health care reform bill.

Given the huge federal deficits facing our nation, I believe there is too much new spending in this bill.

I am especially disappointed that the bill does not have a fiscal trigger in it to cut spending if actual costs of new programs turn out to be higher than projected.

I also have concerns about a government-run "public option" insurance company and the question whether this bill goes far enough in actually reducing health care costs for working families and businesses.

Throughout this debate I have heard two extremes. Some on the far left would like to see the federal government run a socialized health care system. Some on the far right would get the government completely out of health care, which would mean the elimination of Medicare and Medicaid. I think both extremes are wrong.

What I have most people in our district recognize that health care reform is needed to hold down costs and to make health care more affordable and dependable, but they want any reform bill to be fiscally responsible. I agree.

Mr. SHUSTER. Mr. Speaker, after weeks of closed-door meetings, Speaker NANCY PELOSI has brought her healthcare reform to the floor for a vote today on Saturday while the attention of the majority of Americans is diverted. The Pelosi plan clocks in at over 1,900 pages, which is 648 pages longer than Hillary-care and it costs over a trillion dollars, or about $2 million a word.

The sheer size and scope of the Pelosi plan is enormous. As we enter a time of 10.2 percent unemployment, the American people will
not accept a government takeover of healthcare that will kill even more jobs, hurt small businesses, increase the deficit now and drown future generations in stifling debt.

While the sheer size and scope of the Democrats’ takeover of healthcare prevents me from pointing out every egregious part of the proposal, I would like to point out four areas that should give all Americans pause.

**Taxes:** The Pelosi plan would impose $730 billion in new taxes on businesses that can’t afford to pay for their employees’ health coverage. According to President Obama’s own economic advisor, Christina Romer, these new taxes would put 5.5 million workers at serious risk of losing their jobs. Close to 32,500 small businesses in Pennsylvania would be at risk from this new healthcare surcharge.

**Deficit Spending:** The Pelosi plan contains $1.055 trillion in new federal spending over the next ten years. All of this spending will be used to take healthcare decisions out of the doctor’s office and centralize them in Washington, DC, requiring the creation of over 100 new federal panels, commissions and unelected civil servants who will be charged with making decisions on your care.

**Senior’s Coverage:** Earlier this year, President Obama pledged that “the government is not going to make you change plans under health reform.” Today, he and NANCY PELOSI are going to make you change plans under the Affordable Care Act’s proposal, H.R. 3200, that was introduced this summer. Mr. Speaker, I doubt that there are many people in this great hall who can honestly tell you they are fully conversant with every provision in this bill. But after doing our best to read, study and understand the nearly two-thousand pages of H.R. 3962 we know certain things this bill will do. For example, we know it will cost taxpayers more than a trillion dollars. We know it will impose $730 billion in new taxes on small businesses and individuals. We know it will cost five-and-a-half million jobs. We know it will create over 100 new bureaus, commissions, and programs. And we know it will burden our states with tens of billions of dollars in new unfunded federal mandates. In Florida alone, the additional costs associated with the Medicare drug benefit will increase our costs by $1.5 billion dollars per year.

Mr. Speaker, we are told by the President and by the majority party in Congress that we need all this in order to make health care more affordable for the American people. How are we making health care more affordable if the government is driving businesses into bankruptcy by taking historic steps toward a federal takeover of the entire health care system? The Democract Majority seeks to pay for their health care reform bill in part through 8 percent payroll penalty taxes on employers who cannot afford to provide insurance coverage, and through a 5.4 percent surtax on individuals making $500,000 a year or more. These provisions are estimated to bring in more than $595 billion.

You don’t have to be an economist to know that these new taxes will have a direct and adverse affect on small businesses across America. An overwhelming majority of small businesses—approximately 75 percent of them—pay their business taxes through the owner at the individual level. Essentially, one in every three small businesses would be subject to the new surtax and just in the State of Florida as many as 57,000 small businesses would be affected. These provisions are effectively a tax on jobs that will stifle job creation and depress wages. In light of the latest unemployment numbers of 10.2 percent for the U.S. and 11 percent in Florida, the time to raise costs on small businesses and employ- ers.

If the taxes on America’s small businesses were not enough, this bill also imposes a 2.5 percent tax on medical devices. At a time when our country spends about 17 percent of its GDP on health care, and we are tasked with developing policies to bring down the overall cost of care, it is irrational that we should tax an industry that is such an integral part of health care. This tax, on everything from syringes to artificial hips, will undoubtedly be passed along to the consumer.

Mr. Speaker, America has the best health care system in the world. Why should we destroy the economic backbone of America to create a government-run health care plan that the majority of Americans oppose? It does not have to be this way.

We can take significant steps to address health care—steps guided by principles based on choice, competition, and encourage healthy behaviors in an effort to reduce our health deficit by $68 billion over the next ten years, without imposing tax increases on families and small businesses.

We can lower health care premiums for American families and small businesses, addressing Americans’ number-one priority for health care reform.

We can establish a universal access program to guarantee access to affordable health care for people with pre-existing conditions. The Republican alternative plan creates Universal Access Programs that expand and reform high-risk pools and reinsurance programs to guarantee that all Americans, regardless of pre-existing conditions or past illnesses, have access to affordable care.

We can curb the cost of defensive medicine in this country by putting an end to “junk lawsuits.” The fear of lawsuits drives doctors to order expensive tests and procedures for patients, and not necessarily because they think they are in the best interest of the patients. Some doctors have even had to close their doors because they cannot afford the malpractice insurance premiums. It is evident that meaningful medical malpractice reform should be a component of any health care reform proposal. The Republican plan would help save $54 billion in the health care sector by including measures that have been successfully demonstrated in California and Texas.

Just as we all want to reduce the cost of care, we should seek innovative ways to provide coverage without breaking the bank. We can do this by empowering small businesses with the opportunity to pool together and negotiate lower health care premiums—just as corporations and labor unions do—through association health plans. Another common sense reform would allow Americans to shop for coverage from coast to coast across state lines.

We can promote prevention and wellness by giving employers greater flexibility to finan- cially reward employees who adopt healthier lifestyles. Incidentally, about 75 percent of medical spending goes toward the treatment of chronic diseases. Research shows that the number of individuals suffering from chronic diseases like diabetes and heart disease could be reduced through proper wellness, prevent- ion, and disease management programs. The Republican alternative would allow employers to offer flexible coverage options to reward and encourage healthy behaviors in an effort to reduce overall spending on costly chronic diseases.

We can do all of these things and more. Mr. Speaker, and we can do these things with legis- lation that the Congressional Budget Office says will lower premiums by up to 10 percent and reduce the deficit by $68 billion over the next ten years, without imposing tax increases on families and small businesses.

Mr. Speaker, this alternative is what this Congress should be sending to the President’s desk—not the mammoth, unwise, and extraor- dinary expansion of government embodied in H.R. 3962.
I urge my colleagues to vote “no” on this bill.

Ms. JENKINS. Mr. Speaker, I have criticized many of the provisions of this bill and rightfully so. However, I do believe the sections relating to the creation of a market for biosimilar products in the brain that strikes the appropriate balance in providing lower cost options to consumers without destroying a healthy and functioning industry in this country. These provisions were one of the few areas in the bill adopted on an overwhelming bipartisan vote for the Eshoo-Inslee-Barton (EIB) amendment in the Energy and Commerce Committee.

Creating a pathway for new products that doesn’t destroy the ability or the incentives for innovator companies to develop breakthrough technologies and at the same time providing a safe and effective way to bring competition to benefit patients is a laudable achievement. I wish we could remove this provision from this fatally flawed piece of legislation and consider it separately because it would pass with the kind of overwhelming bipartisan support that Americans continue to wish to see.

However, these provisions are only the first step in a long path to the marketing of these new products. New research and clinical testing will have to occur, and the FDA will write rules that will ensure that research is done safely and effectively. I have long supported the U.S. biotechnology industry as it has been a strong engine of job creation in this country. Unfortunately, many of the largest companies that would seek to enter the biosimilar market have done so through acquisitions and by outsourcing their research to foreign countries like India. While the innovator’s have created jobs here, these generic companies have shipped them overseas, so they can turn around and sell cheap knockoffs of innovative American products.

As this new market launches in the United States, we must foster innovative products at home to create jobs, and conduct research that will prove whether products are interchangeable with innovators’ products. It is unlikely that these companies can create such interchangeable products; however research and testing of these products will have to be conducted within our borders without being outsourced.

Mr. EHLERS. Mr. Speaker, on November 14, 2009, Northrop Grumman will lay the keel of the first ship of the new Gerald R. Ford class of nuclear-powered aircraft carriers, the CVN–78, in Newport News, Virginia. Susan Ford Bales, the daughter of President Ford, is the ship’s sponsor and will serve as the keel authenticator for the ceremony.

President Ford was a good friend of mine, and I am honored to hold his former seat in the U.S. House of Representatives. In 2006, I supported an amendment to the 2007 national defense authorization bill, offered by then Senator John Warner, which expressed the sense of Congress that the CVN–78 should be named after President Gerald R. Ford. On January 16, 2007, the U.S. Navy followed Congress’s instruction and announced that CVN–78 would be so named. Consequently, CVN–78 and other carriers built to the same design all will be referred to as “Ford class carriers.”

The Gerald R. Ford class carrier design is the successor to the Nimitz class design, and it incorporates several improvements, such as allowing more sorties per day and requiring fewer sailors for its operations and maintenance. Expected to enter into service in 2015, the U.S.S. Gerald Ford, and its Ford class successors, will ensure that the U.S. Navy, and policymakers, will continue to have the assets they need to adequately defend our nation and protect our allies and interests around the globe.

President Ford served his country honorably and faithfully for more than 60 years, first as a Navy officer during World War II, then as a Congressman, Vice President and finally as President and former President. I believe it is fitting that we name this new class of aircraft carriers after President Ford, and I look forward to monitoring the future success of the U.S.S. Ford.

Mr. HONDA. Mr. Speaker, in our lives as public servants, Members of Congress are rarely presented with opportunities to support the passage of truly historic legislation. Today is such a day, and this health care vote such an opportunity. Over the past ten months that I have participated in the creation of this health reform bill, I have been thinking about the words of Hubert Humphrey: “It was once said that the moral test of government is how that government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; and those who are in the shadows of life, the sick, the needy and the handicapped.”

Today I rise in strong support of H.R. 3962, the Affordable Health Care for America Act. For 70 years Americans have been waiting for this moment. I would like to particularly thank Speaker Pelosi for her leadership and management of a complex policy debate, Majority Leader HOYER, Majority Whip CLYBURN, the Chairs of the Committees on Energy and Commerce, Education and Labor, and Ways and Means, along with my fellow progressive and colleagues in the Congressional Asian Pacific American Caucus, Congressional Black Caucus, and Congressional Hispanic Caucus (collectively known as the TriCaucus) for their public and private commitments to preserve the public option. Finally, I commend staff of all the committees for their hard work and commitment to this issue.

Against an organized, scorched earth campaign of misinformation and fear mongering, we are emerging with a strong bill, and an even stronger sense of unity and purpose in our fight to bring access, affordability, and health care to all Americans.

As Chairman of the Congressional Asian Pacific American Caucus, I am particularly encouraged by the inclusion of legislative language addressing racial and ethnic health disparities. As members of the TriCaucus, we have long been advocating on the issue of health disparities and I am proud of the impact we have had in making changes that will directly help the poorest and most disadvantaged communities. across this nation. As a long-time supporter of Native Americans in my home state of Wisconsin, I am particularly pleased by the inclusion of the Indian Comprehensive Health Insurance Act in...
health care reform. Native American communities worked for over a decade to come together and write policy that would help their communities begin to address the terrible and tragic health disparities they experience and the inclusion of ICHIA is a step in the right direction by the Federal Government to rectify some of the wrongs and abuses that they have caused in Native communities.

Despite the many extraordinary improvements to many aspects of our healthcare system, including an unprecedented expansion of access to Medicaid for many poor families, I am disappointed that we were not able to end the 5 year ban on legal immigrant participation in Medicaid. Legal immigrants are tax paying citizens in waiting who work hard and contribute. It is only fair that we afford them equal access to the benefits of Medicaid. I will continue to advocate on this issue in the future and I know that I am joined in my concern by many of my colleagues.

Americans live in the wealthiest, most powerful nation in the world and spend $2 trillion a year on health care every year—more than the rest of the world combined—but for the same or reduced level of service. We are not clear—not for an improvement in service, but for the same benefits as traditional Medicare, precluding or result in higher premiums and co-payments for fixed income seniors. But let me assure you, Speaker Pelosi wants even more of their tax dollars to be spent to provide federal health benefits to the 12 million illegal immigrants currently in the United States. As I understand the bill before us today, a person would only need to "declare" that they are a citizen, provide a name, Social Security number and they would be eligible to receive health insurance benefits. There is no requirement for the verification of identification documentation. It is absolutely unacceptable that this bill would not, at a minimum, require even one verified means of identification to receive taxpayer funded health care benefits. The bill should include clear processes and require documentation to confirm that an individual applying for health care benefits is a citizen or legal resident of the United States like the E-Verify 5 program I created in 1996 for employers to verify the legal status of new employees.

The drafting of the bill before us today spent American liberties to purchase House Democratic votes in order to secure a political victory. The resulting legislation has put freedom and American ingenuity under the knife. For the sake of American jobs, American families and future generations, we must kill this bill and restructure our work to create jobs, rein in government spending, increase healthcare freedom and choice and getting the U.S. government’s financial house back in order.

However, I look forward to voting in favor of the Stupak-Pitts Amendment, which maintains the current federal government policy of preventing federal funding for abortion and for benefits packages that include abortion. This amendment ensures that federal taxpayers will not be coerced into funding elective abortions and is supported by U.S. Conference of Catholic Bishops, Democrats for Life, National Right to Life, Americans United for Life, Family Research Council, Concerned Women for America and many other pro-life groups. I look forward to continuing to work to ensure taxpayer funds are not used to fund abortions and to provide the broadest possible conscientious protections for physicians, health professionals, hospitals, insurers, and all those in the business of caring for the health of Americans.

Mr. DICKS. Mr. Speaker, we have reached a pivotal moment in the House of Representatives today as we are about to approve the most significant expansion of access to health care in America in at least a generation. And the bill we are about to approve also represents the most substantial improvement of the quality of health care in our country that has been passed in the entire time I have been in Congress. I am proud to support this long-overdue and aptly-named legislation, the Affordable Health Care for America Act.

I am particularly pleased that we have come to an agreement within this bill on a provision that I believe will lead to a dramatic improvement in the way we pay for America’s seniors under Medicare. Under the current Medicare payment system, providers are reimbursed on a "fee-for-service" system that encourages more procedures and office visits. One of the most significant sections of H.R. 3962 is language that will help shift Medicare to a system that is more efficient and that encourages better coordination of health care for seniors.

Medicare’s complex reimbursement formula has long punished doctors for providing more cost effective, quality health care. It is truly unfair under our current system that Medicare spends $7,363 per enrollee in a city in my district—Tacoma, Washington—while it spends twice that amount, $14,946, in the small Texas town of McAllen. These differences are largely due to discretionary decisions by physicians that are influenced by the local availability of hospital beds, imaging centers and other resources—and a payment system that rewards more and more intense use of medical facilities and testing. But this focus on utilization is not only inherently more costly, it tends to ignore the health care outcomes, which should really be the goal of any system of care. And it exacerbates the problem we are already facing with Medicare: out-of-control growth rates. At current trajectory, Medicare will be $660 billion in the red by 2023, highlighting the urgent need to find ways to trim this growth rate. If we could reduce the annual growth in per capita Medicare spending from the national average—3.5 percent—to 2.4 percent, the rate in San Francisco, Medicare could save $1.42 trillion over that period and turn the deficit into a healthy surplus.

So in order to help move us toward this goal and produce a more equitable system of reimbursement, I was pleased to work with a number of concerned Members here in Congress on language in this bill that will enlist the resources of the independent, non-profit Institute of Medicine to examine the existing Medicare geographic payment inequalities for both physicians and hospital payments and address the inequities that are clearly contained in our current system. We are also investing $4 billion per year in 2012 and 2013 to make payment rate adjustments so that no geographic area will be disadvantaged during 2012 and 2013.

I am also pleased that a related provision of this bill calls for an additional study by the Institute of Medicine to conceptualize a system of Medicare payments based on quality outcomes versus the current "fee-for-service." This "High-Value Study" will be completed by April 15, 2011 and the Institute’s recommendations will be submitted to the Secretary of Health and Human Services, who will then have 240 days to submit a final implementation plan, which will then take effect unless Congress passes a resolution of disapproval by the end of May 2012.

These are very important reforms that I believe will help ensure the solvency of Medicare and promote a more equitable system of healthcare for seniors over process. They are among the many aspects of this overall health care reform package that deserve our support, and I am proud
Mr. MANZULLO. Mr. Speaker, America's health care system is in need of reform. The families in the congressional district I represent have seen their health premiums consume more and more of their salary. Employers are faced with the difficult decision regarding whether or not to continue to afford to offer their employees the health coverage they know they need. Many more wish they could offer their employees coverage but the orders just aren't there, not in this economy. Doctors and other health providers have seen their reimbursements decline while their practices are facing increased liability. The liability insurance premiums have skyrocketed due to those who abuse our lawsuit system. Some doctors have reached the conclusion that they can no longer accept Medicare or Medicaid patients.

I have spent my entire tenure in Congress working to reform our health care system to help these families, employers, and health providers. I have worked to pass association health plans only to come up short as a result of Democrat opposition in the Senate.

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38,000 uninsured citizens just in our region would be eligible for insurance under the reformed system.

14,500 small businesses will be allowed to obtain affordable health care coverage and 12,400 among them will receive tax credits to help reduce the costs of their insurance.

102,000 beneficiaries will benefit from an improved Medicare program.

7,600 seniors will benefit from closing the prescription drug donut hole, starting with $250 of cost forgiveness in 2010.

1,700 families will be protected from bankruptcy due to unaffordable health care costs. $120 million in savings will be seen by hospitals and health care providers as a result of reductions in uncompensated care.

The uninsured will receive immediate relief through a temporary insurance program. Individuals receiving COBRA will be allowed to keep their coverage until a more customer friendly, one-stop marketplace for health insurance.)

The Exchange will offer affordability credits and tax credits for individuals and businesses that need them. Health plans will be required to allow young people until their 27th birthday to remain on their parents’ health insurance policy. Moreover, insurance companies will be subject to public review and disclosure of insurance excessive rate increases.

Much needed investments will be made right away in training programs designed to increase the number of primary care doctors, nurses, and public health professionals. Not-For-Profit purchasing collaborative, such as the FrontPath Health Coalition from Northwest Ohio, will be strengthened to achieve careful plan management and cost-savings, and en- couraged as a central provision of Title I.

Community Health Centers will see an increase in funding to allow for a doubling of patients over the next 5 years. A $10 billion fund will be created to finance a temporary reinsurance program to help offset the costs of exchange for health care providers that provide health benefits for retirees age 55–64.

The well being of individuals and our nation will benefit from these reforms. From an economic standpoint, health care costs have stifled growth and the ability to compete in the global marketplace. The 129 percent increase since 2000 in small business premiums alone have smothered their potential and destroyed their ability to cover employees, resulting in an astounding 60 percent of our nation’s entire uninsured population.

Affordable health insurance reform is necessary to cut the costs of doing business, reduce the share of government expenditures spent on health care, help our companies to become more competitive in the world market, unleash the entrepreneurial talents of the American people, and give peace of mind to the middle class and our seniors and others that everything they have worked for will not be taken away if they get sick.

To help reduce the costs of health insurance, I watched our father forced to sell our small family grocery when he became ill. He needed health insurance for our family and took a job at a local auto assembly plant to obtain it for his wife and children. I promised myself when I was elected to Congress that planning legislation to improve the quality and accessibility of health care would be one of my top priorities. Finally, it has become possible to vote on a bill that will do this for millions of our fellow citizens.
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With the mounting economic strain on American families and the rising costs of health insurance to workers, businesses and federal budget, the status quo has proven itself unsustainable, fiscally irresponsible and morally unacceptable. The time has come for this historical change. I stand in support of its promise to millions of people.

Mr. KUCINICH. Mr. Speaker, we have been led to believe that we must make our health care choices only within the current structure of a predatory, for-profit insurance system which does not care about providing health care. We cannot fault the insurance companies for being what they are. But we can fault legislation in which the government incentivizes the perpetuation, indeed the strengthening, of the for-profit health insurance industry, the very source of the problem. When health insurance companies deny care or raise premiums, co-pays and deductibles they are simply trying to make a profit. That is our system.

Clearly, the insurance companies are the problem, not the solution. They are driving up the cost of health care. Because their massive bureaucracy avoids paying bills so effectively, they force hospitals and doctors to hire their own bureaucracy to fight the insurance companies to avoid getting stuck with an unfair share of the bills. The result is that since 1970, the number of physicians has increased by less than 20% while the number of administrators has increased by 3000%. It is no wonder that 31 cents of every health care dollar goes to administrative costs, not toward providing care. Even those with insurance are at risk. The single biggest cause of bankrupcty is malpractice. Health insurance policies that do not cover you when you get sick.

But instead of working toward the elimination of for-profit insurance, H.R. 3962 would put the government in the role of accelerating the privatization of health care. In H.R. 3962, the government is requiring at least 21 million Americans to buy private health insurance from the very industry that causes costs to be so high, which will result in at least $70 billion in new annual revenue, much of which is coming from taxpayers. This inevitably will lead to even lower co-pays, more subsidies, and higher profits for insurance companies—a bailout under a blue cross.

By incurring only a new requirement to cover pre-existing conditions, a weakened public option, and a few other important but limited concessions, the health insurance companies are getting quite a deal. The Center for American Progress’ blog, Think Progress, states “since the President signaled that he is backing away from the public option, health insurance stocks have been on the rise.” Similarly, Senator Max Baucus introduced a bill without a public option. Bloomberg reports that Curtis Lane, a prominent health industry investor, predicted a few weeks ago that “money will start flowing in again” to health insurance stocks after passage of the legislation. Investors.com last month reported that pharmacy benefit managers share prices are hitting all-time highs, with the only industry worry that the Administration would reverse its decision not to negotiate Medicare Part D drug prices, leaving in place a Bush Administration policy.

During the debate, when the interests of insurance companies would have been effectively challenged, that challenge was turned back. The “robust public option” which would have offered a modicum of competition to a monopolistic industry was whittled down from an initial potential enrollment of 129 million Americans to 6 million. An amendment which would have protected the rights of states to pursue single-payer health care was stripped from the bill at the request of the Administration.

Mr. MARKEY. Mr. Speaker, thank you Speaker PELOSI, Chairman WAXMAN, Chairman DINGELL, Chairman RANGEL and Chairman MILLER for your leadership in bringing us to this historic day.

For almost a century, we have been laying the foundation to fight our insurance companies while they fight for their lives. Their insurance policies fail to cover all of the astronomical medical bankruptcies. In 2009, 8 million Americans were driven into bankruptcy in trying to pay the cost of care. No longer will families fear the uncertainty of a catastrophic health event, or fear being driven into bankruptcy in trying to pay for the cost of care. No longer will people have to fear losing their health coverage simply for getting sick. In passing this legislation, we are ending for good when 144 million Americans lose their coverage every day.

The time has come when we, in Congress, faced with a decision to either change the course of this country, to shift its direction to what is accessible and affordable care, or continue down an unsustainable path, one wrought with uncertainty. With so many American families struggling to support themselves, I am proud to support this legislation.

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We support RESEARCH, building on the $10.4 billion down payment in the recovery and reinvestment act for NIH. In this bill, we will invest in comparative effectiveness research to help improve the quality of care and reduce costs.

The Republicans say the Democratic Plan will put the government between you and your doctor, but the doctors who make up the American Medical Association support the Democratic bill, not the Republican Plan. They say it will hurt small businesses but the Main Street Alliance, representing thousands of small businesses around the country, support the Democratic bill, not the Republican Plan. The Republicans claim the Democratic bill will hurt seniors, but the AARP has endorsed the Democratic bill, not the Republican Plan.

There are reasons why the AARP supports the Democratic Plan. The Democratic bill will close the Medicare part D donut hole, the Republican bill does not. We provide support for low-income seniors, they do not. We will extend the solvency of Medicare, they do not.

You know, GOP used to stand for Grand Old Party. It stands for Grandstand, Oppose, and Pretend. They stand with phony claims about non-existent death panels. They oppose any real reform. And with this Substitute they pretend to offer a solution while really doing nothing. GOP—Grandstand, Oppose, and Pretend.

Make no mistake about it; the Republican substitute is not real reform. It does nothing to curb skyrocketing health care costs. It does nothing to provide real insurance coverage to millions who are now uninsured. It does nothing to stop the unfair practices of insurance companies.

Mr. Speaker, there are too many Americans living in fear of a terrorist attack, but not the kind that comes from a gunshot, bomb or box cutter. It’s the kind that may strike during a phone call from the doctor’s office or during a check-up when the doctor delivers devastating news: “You have cancer”; “Your memory loss is early onset Alzheimer’s”; “The numbness is Parkinson’s”; “The Lou Gehrig’s Disease that claimed your grandfather will strike you one day.”

We can fight against the terror of disease by reforming our health care system with better coordination, focusing on prevention, and ensuring that all Americans have access to quality, affordable care. And that’s exactly what our bill will do.

I am pleased that this historic bill includes provisions that I authored, including:

- A Medicare program to coordinate care to severely ill patients by a team of doctors and other health care professionals right in the beneficiaries’ own homes, allowing these frail seniors to be suffering from a pre-existing condition to remain independent as long as possible.
- A provision to allow patients with rare diseases, like cystic fibrosis, to participate in clinical trial research to find a cure for their devastating disease without losing eligibility for the Social Security benefits they depend on.
- A safeguard to ensure that insurance companies don’t game the new health care exchange by cherry-picking only healthy individuals.

Today, we are here to write a new chapter in our century-long effort to provide every American with the health care coverage they need and deserve.

Today we can pass legislation that gives all Americans access to quality, affordable health care. I urge my colleagues to vote “aye” on this bill.

Ms. HERSETH SANDLIN. Mr. Speaker, I believe it’s critical that we control rising health care costs, improve quality and value within our health care system, and that we improve access to health care and affordable health care insurance coverage.

H.R. 3962, the Affordable Health Care for America Act, represents one of the most important votes of the year, on an issue that has been a major priority for the honor of representing South Dakotans in Congress. I have long believed that the strength of our communities in South Dakota depends on the health of our people and that, unfortunately, quality, affordable care remains out of reach for far too many South Dakotans.

I am convinced this Congress and the President will achieve fundamental reform because our country must fix what’s broken in our health care system. The status quo is unsustainable. There is simply too much at stake for South Dakota’s families and businesses, who have either seen their premiums rise sharply year after year, or who still have no access to an affordable plan.

Done right, health care reform will both ensure that more people have access to quality health care and it will control costs, improve the quality and value of care, and it does not include nearly enough cost-containment and deficit reduction measures.

Unfortunately, the House bill misses this critical opportunity. While it does include many good provisions, it is not the right answer for South Dakota, it could threaten existing access to health care and coverage, and it does not include nearly enough cost-containment and deficit reduction measures.

I am concerned by the projected impact of the bill’s Medicaid provisions on South Dakota’s state budget, and the reductions in payments for long-term care under Medicare. I have recently discussed the state’s budgetary situation with Governor Rounds, along with a number of community leaders, business people, and others across South Dakota, and we must take this situation very seriously. The growth in the state Medicaid program due to provisions in the bill is projected 25 to 30 million dollar deficit in the state Medicaid program in 2010, and, after the expiration of the Recovery Act enhancement in the FMAP rate, a 50 to 60 million dollar deficit in FY2011.

Early analysis suggests that the House bill Medicaid provisions would impose at least $87.6 million more in new Medicaid costs on the state than the Senate Finance Committee.

I believe that budget’s impact we have to consider the likelihood that dramatic service cuts would be the end result in South Dakota if the House bill were implemented, and that is a source of serious concern for me. It should be for every South Dakotan.

I have discussed the Democratic long-term care provisions of the House bill with a number of long-term care providers in South Dakota and have serious concerns about how the House bill would affect the future of care in our state for our seniors. While the original House legislation again has been improved in this respect by the addition of some incentive payments under Medicaid, overall, I am concerned that the cuts under Medicare to long-term care are unsustainable, and put undue financial pressure on this essential part of the health care infrastructure of South Dakota. Nursing homes could be denied coverage because of a pre-existing condition that dramatic service cuts would be the end result in South Dakota if the House bill were implemented, and that is a source of serious concern for me. It should be for every South Dakotan.

Another of my top priorities is the Indian Health Care Improvement. A reauthorization that has been incorporated in the broader bill. Together with the nine sovereign Native Tribes I represent, I have worked hard to advance the Indian Health Care reauthorization in the House of Representatives. I share the concerns of the Great Plains Tribal Chairmen’s Association (GPTCA) regarding aspects of the current version of that legislation. The GPTCA is comprised by the elected leaders of the sovereign Indian Tribes and Nations of the Great Plains, including South Dakota. I have consulted closely with the Tribes I represent.

For years, the Tribes and the GPTCA have supported the Indian Health reauthorization and have been disappointed at the great length of time it has taken to bring the legislation to this point in the House. The GPTCA has reviewed the current version of the Indian Health Care Act reauthorization contained in the broader health reform bill and has serious concerns about certain provisions in the bill, principally the fact that urban Indian non-profit organizations are, in various sections outside of Title V of the reauthorization, treated on a par with federally-recognized tribes.

The federal government has a unique relationship with the 562 federally-recognized American Indian and Alaska Native tribes. This government-to-government relationship is established by our founders in the U.S. Constitution, recognized through treaties, and reaffirmed through executive orders, judicial decisions, and congressional action. Fundamentally, this relationship establishes the responsibilities to be carried out by one sovereign to the other. That is why these requirements by nine sovereign Sioux tribes located in South Dakota are essential. I will continue to provide my full support to GPTCA’s requests to improve the reauthorization in conference with the Senate, and to properly fund Indian health services.

Turning again to the broader House health care reform bill, underlying my concerns relating to Medicaid and long-term care and other issues is a fundamental concern about the effect of broader House health care reform bill
on the nation's long-term deficit, and more specifically, my view that it doesn't do enough to start bringing down the deficit and health care costs in the long term. As President Obama noted earlier this year: "If we do nothing to slow these skyrocketing costs, we will eventually be spending more on Medicare and Medicaid combined than the entire federal government program combined. Put simply, our health care problem is our deficit problem. Nothing else even comes close." He's right. Skyrocketing long-term costs will bankrupt the Medicare trust fund by 2017—and that's just part of the problem, in my view.

But when it comes to the net change in the federal budgetary commitment to health care, the House bill is seven times greater in budgetary commitment of dollars than the Senate Finance Committee bill, while failing short of the long-term cost containment in the Senate bill. In my view, any bill with such a significant increase should have a similar commitment to cost containment. Otherwise, we'll find ourselves in the same situation we find ourselves in with Medicare—an essential program for South Dakotans that is going broke because we can't make the tough choices now and are putting those choices off until we face an immediate crisis. That's not reform—that's a recipe for fiscal disaster.

Now, the House bill does include a number of good ideas, for which the vast majority of South Dakotans I have talked to agree. For instance, I strongly support provisions in this bill to require insurance companies to cover people with preexisting conditions, and to end the insurance companies' ability to cancel coverage even when someone becomes sick. These practices must end. I was surprised and dismayed to see that the House Republican proposal that we also will vote on refuses to end the unconscionable practice of denying coverage for preexisting conditions. The Congress will ultimately agree on a bill that ends this practice. In addition, I support establishing health insurance exchanges to provide a transparent and competitive marketplace for individuals and businesses to buy more affordable health care plans. Unfortunately, I'm concerned that the House bill has not come far enough from where it started, and the bill does not yet represent the right approach to long-term costs with a focus on achieving higher quality health care outcomes. This bill meets some of these goals but not all, and I can't support it. I remain steadfastly committed to improving this legislation and I am optimistic that through the legislation process we will achieve what South Dakotans deserve, which is a fiscally responsible and sustainable reform of the health care system that will dramatically improve coverage and quality for all.

Mr. JORDAN of Ohio. Mr. Speaker, many of my colleagues from across the aisle have called this an historic day. I wish it was an historic day!

I wish this was the day that the majority in Congress sat up and listened to the American people... not just the tens of thousands that stood at the steps of our Capitol to speak out in defense of protecting their health care... but the millions from around the country who called our offices, wrote to their newspapers, spoke at town hall meetings... or marched on Washington.

If they did, they would hear their deep and abiding concern for what will happen to their health care if this bill passes. What will happen to seniors, and everyone taking care of their elderly parents or in-laws, when the overpromise of "free health care" meets the economic reality of "rationed care" when the federal government runs short on money?

What happens to Medicare Advantage customers whose services will be cut? What happens to those using Health Savings Accounts whose health freedoms will be infringed upon?

What happens to the small business owner who desperately wants to hire back some employees or expand his business to provide more economic opportunities in his community? What happens when these individuals, upon whose success our nation will rise from this recession, have to pay the hundreds of billions in new taxes to pay for the massive government expansion in this bill?

Mr. Speaker, how bad does it have to get? How bad does it have to get before this Congress starts acting in a way that will help families, create jobs, and make America stronger and better for our children and grandchildren?

How bad does unemployment have to get? Earlier this week, it was announced that our nation has reached an unemployment rate of 10.2 percent, which is the highest unemployment rate in almost 30 years. Yet studies suggest that the taxes, mandates, and federal expansion in this bill will cost our nation another 5.5 million jobs in the private sector.

How bad does the deficit have to get? This year's deficit of over 1 trillion dollars was the highest in history. Yet this trillion-dollar expenditure to take over the nation's health care system will explode the deficit, despite the fuzzy math that we've heard from the other side of the aisle.

The debt... it has reached a nearly insurmountable level of 12 trillion dollars. How bad does it have to get? Even without the massive uncontrolled expenditures involved with this health care bill, the national debt is projected to surpass the size of our economy in the next few years. Since when has the answer to an economic collapse been an explosive expansion of federal government spending in areas that have always been a part of the private sector economy?

The one positive thing I can say about this bill is the pro-life victory we won with the amendment offered by my fellow pro-life colleagues, led by Mr. STUPAK and Mr. PITTS. I was proud to support that amendment because it honored the fundamental truths that life is sacred, life should be protected, and taxpayer money should never be used to take the life of an embryo.

But Mr. Speaker, the bottom line is this: H.R. 3962 is the wrong answer to what ails America's health care system.

It is too expensive. It raises taxes. It expands the reach of the federal government into the personal health care decisions that should be left between patients and their doctors. It is a job killer. It will cause millions of Americans to lose their coverage, while expanding coverage to millions of illegal aliens. This is the newly-enacted pro-life protection that I fought so hard to enact both in this bill and every relevant piece of legislation before this House, it is a bad bill.

Let me close here. We are blessed to live in the greatest country in history. Our country is great, in part, because of something called the American Dream. We're a country where people, through their own hard work, can pull themselves up and reach for their goals and dreams.

Mr. Speaker, the American Dream happens because generations of parents have worked hard and sacrificed so their children can have life a little better than they did. When their children become parents, they sacrifice for their children, and the dream lives on.

This bill is just another example in the recent history of our country of giving in to the pressure for now and sending the bill to the next generation. If we want the American Dream to live on, we must reject this bill and return to the American principles that made our nation that shines.
The Affordable Health Care for America Act is a bill that will provide health care consumers greater stability, lower costs, and improved quality—while at the same time paying down the deficit. According to independent analysis conducted by the non-partisan Congressional Budget Office, the bill reduces the deficit by $109 billion over the first 10 years. And it will continue to reduce the deficit over the second 10 years. This legislation will help the middle class by providing stable, affordable health insurance that people can count on. It will rein in health care costs for families, businesses and the government. It will ensure that if you lose your job, you won't lose your health care. No one should have to worry about whether they can see a doctor when they're sick because they don't have health insurance.

I have heard from countless constituents who have been victims of discrimination by insurance companies, who now reluctantly and frequently shared their experience with me about their inability to obtain health insurance coverage. The father started his own company and applied for health insurance for his family, but three out of the four family members could not be fully covered due to pre-existing conditions. It turns out that he was rejected for coverage because he had two chest colds in the last 6 years and scar tissue in his lungs. For his daughter, the insurance company would only issue a policy that precludes coverage for any injury to any part of her back at any time in the future because of a previous injury of her back. And the same company refused to cover any injury to his son's knee at any time in the future from any cause due to a previous injury. It is unconscionable that the insurance company's policies precluded everyone in his family from coverage.

There are a number of provisions that would help this family, my constituents, and millions of Americans. Among them, the bill would end the practice of discriminating against those with pre-existing conditions, such as diabetes, cancer, a heart condition, or previous injuries. It would prohibit insurance companies from dropping health care coverage because you became sick. The bill eliminates co-pays for preventive and wellness care, and it places annual caps on what Americans pay out-of-pocket for doctor visits and prescription drugs. It would also prohibit insurance companies from dropping coverage entirely for what's called catastrophic illness. And there would be no yearly or lifetime cost caps on what insurance companies cover.

A critical piece of this legislation is the creation of a new Health Insurance Exchange that will allow individuals and small business to comparison shop for affordable and quality health insurance coverage. The Exchange will help reduce the growth in health care spending by encouraging competition on price, quality, and transparency among a number of private health insurance companies and a public health insurance option. The public option will be in the marketplace and anyone who wants to participate is completely voluntary. That is why Consumers Union and Consumer Reports endorsed this bill. With this health care reform
bill that will allow consumers to shop for insurance across state lines, promote choice and competition, and ensure strong consumer protections.

On the question of whether any of the insurance plans offered in the Health Insurance Exchange will cost more than the plans offered in the marketplace, I support the provisions in the Rule that created a mechanism for ensuring that no public subsidies would go to pay for abortions. The non-partisan Congressional Research Service analyzed that provision and found that it prevented individuals from going to pay for any coverage of abortions. The amendment offered by Representative STUPAK goes much further. It would effectively prevent Americans from using their own money to purchase an insurance plan in the Health Insurance Exchange that includes coverage of abortions. That would be a dramatic break with the current practice where most insurance plans provide for such coverage for individuals who choose such plans. Because the Stupak amendment would effectively prohibit individuals from using their own money to purchase such plans in the Exchange, I oppose it.

Mr. Speaker, today we stand at a historic crossroads. We can choose the road that dead-ends in the status quo—where the health insurance industry continues to call the shots and ration our health care—or we can pass health care reform and take the path that leads to a future where every American has access to affordable, quality health care.

Now I understand why the health industry is opposed. But our job is not to protect the profits of the insurance companies. Let’s not protect special interests and the status quo. Let’s move America forward. Let’s vote yes for America.

Ms. CORRINE BROWN of Florida. Mr. Speaker, like the majority of Americans, I am well aware of the desperate need in our country for comprehensive health care reform. In fact, the immediate need for reform became crystal clear to me when, over the August district period, I went to a hospital in Jacksonville to visit a friend. This friend, who had worked in the Duval County school system for over 25 years, was without health insurance, was struggling to support himself, and had no idea how he was going to be able to pay the hospital bill. For the many, many Americans who find themselves in similar situations: for the woman who cannot get insurance coverage because she is diabetic and has a pre-existing condition, to the one in nine children in America without health care, to the millions of middle class American citizens who skip necessary treatments because they cannot afford it, it is for them that the Affordable Health Care for America Act, which will ensure that all Americans are covered and have access to affordable care, is necessary.

Unfortunately, the bill passed the House without any Republican support. Although many pieces of legislation this session have advanced in a bipartisan manner, particularly in my committees of specialization, Veterans Affairs and Transportation, health care has not been an issue of bipartisan agreement. In 2003, the Republican Party pushed through a horrible Medicare Prescription drug law that was voted along party lines, in which the Republicans voted for the drug law, I voted against it, because which there is a wide gap in coverage that forces the co-payer to pay for much of their own prescription drug costs. Fortunately, the bill on the Floor today will begin to close this loophole. Similarly, today’s bill in the House as well as the Senate health care bill, are advancing without any Republican support. Social Security was created in 1935 by Franklin D. Roosevelt as part of the New Deal, Medicare, in 1965, and Medicaid, in 1965, through Title XVIII of the Social Security Act. All of these programs were created by Democrats without the votes of the majority of Republicans.

One aspect of health care reform of utmost importance is the transition of the existing prescription drug benefit for Medicare beneficiaries to a voluntary plan, providing for Disproportionate Share Hospitals (DSH), like Shands Jacksonville (and Gainesville), who provide healthcare to uninsured and/or individuals with limited incomes. Disproportionate Share Hospitals are invaluable, as they are the one true safety net for the working poor nationwide. I fought hard to keep DSH funding in the Budget Reconciliation negotiations during the Clinton years, and have been working throughout the entire process to ensure that their funding was not stripped in the health care bill before us today.

Another key issue addressed in this bill is that it prevents insurance companies from denying people coverage based on pre-existing medical conditions. Indisputably, denying a health insurance plan to someone merely because they’re likely to need health care runs contrary to the underlying reason for providing medical insurance and medical care in the first place. So the bill before the House today opens doors to quality medical care to those who were shut out of the system for much too long, and also makes prevention a key piece of this legislation’s goal, since it puts a renewed emphasis on preventive care, expands access to screenings and other treatments, and even promotes wellness in the workplace.

Indeed, for nearly a century leaders from all over the political spectrum, beginning with President Theodore Roosevelt, have called and fought for health care and health insurance reform. Finally today, the House of Representatives, the People’s House, is about to deliver on the promise of making affordable, quality health care available to all Americans.

The Affordable Health Care for America Act is founded on key principles of American success: opportunity, choice, competition, and innovation. Among the many positive things this bill does, a few items that stand out is that it will provide coverage to nearly all our nation’s citizens, while at the same time reducing the deficit by $32 billion over the first 10 years. It will also require the Secretary of Health and Human Services to negotiate drug prices for Medicare beneficiaries; begin to close the prescription drug hole immediately; create a new, voluntary insurance program to make long-term care more affordable; and repeal the anti-trust exemption for health insurance companies.

For Floridians in particular, where more than one in five residents do not have health insurance, and for my constituents in Florida’s third congressional district and minority communities nationwide, the need for health care reform is obvious. For the African American community and Hispanics, groups who make up nearly half of the estimated 50 million uninsured, this is imperative. In addition, health care costs have become outright unsustainable, and experts predict that in the near future, one-fifth of our nation’s GDP will go towards health care spending.

The benefits for my district, Florida’s third, are numerous. In fact, the Affordable Health Care Act will: improve employer-based coverage for 300,000 residents; provide credits to make health insurance for 122,000 households; improve Medicare for 93,000 beneficiaries, including closing the prescription drug donut hole for 6,600 seniors; allow 20,100 small businesses to obtain affordable health care coverage and provide tax credits to help those health care costs; and provide coverage for 138,000 uninsured residents; protect up to 1,400 families from bankruptcy due to unaffordable health care costs; reduce the cost of uncompensated care for hospitals and health care providers by $145 million. For too long, health care has been a privilege, not a right in America. And for years our nation’s leaders have fought to bring the promise of quality, affordable health care to every American.

Today is a groundbreaking moment in this historic effort. Indeed, we are now closer than ever to guaranteeing every American access to quality, affordable health insurance and giving middle-class families and businesses relief from crushing costs, while simultaneously reducing our nation’s deficit.

Ms. MCCOLLUM. Mr. Speaker, today we are making history. Today the U.S. House of Representatives is making health care in the United States of America more affordable and more accessible for millions of our citizens. This legislation may not be perfect, but it is very good. It will make our country stronger, our economy more productive, and every American family healthier. Our goal is to achieve universal coverage so that every Minnesotan and every American has the ability to access quality, affordable health care. The Affordable Health Care for America Act (H.R. 3962) comes closer than ever before to realizing that goal by extending health insurance coverage to 96 percent of Americans.

This bill will have immediate and lasting benefits for millions of Americans. It will give families the confidence and security that comes with knowing they will be able to access health care, affordable health care, for them or a family member is sick. And it places affordable health care coverage within reach for millions of American families who are asking for our help.

As I have often said, I believe that health care should be a right for all Americans. Critics of making health care a right often say we already have universal health care since people can go to the emergency room and access care if they really need it. This flawed logic is the worst example of worst case. Health care in America is broken and must be fixed.

Our health care system is broken when we live in the wealthiest, most powerful country in the world, but health care is a privilege available only to those with enough money to afford it, or for those of us fortunate enough to have a job that provides health insurance.

Our health care system is broken when 60 million people in this country have no health insurance coverage or are under-insured—more than 85 percent of whom are from working families.

Our health care system is broken when families are forced to postpone or skip necessary
care because premiums have increased more than 90 percent in the last nine years for Minnesota families.

Our health care system is broken when our country spends $2.4 trillion a year for health care—almost twice as much per person as any other country—but we rank 37th in the world in health care outcomes.

Our health care system is broken when you can be denied coverage for being sick, for having a baby, or for suffering from domestic violence.

Our health care system is broken when 45,000 people die in the United States each year because they lack health insurance and cannot access needed care.

We can and must do better. Today we have an opportunity to save these lives and make affordable health care insurance a reality for every American.

My constituents and all citizens across this country need to know what is in this bill to help American families and workers. This legislation will make quality health care more affordable and more accessible for every patient. It will protect families from falling into bankruptcy due to unaffordable costs by limiting out-of-pocket costs, lifting lifetime limits on coverage and ending premiums.

First and foremost, if you love your doctor and like your current insurance, you are free to keep what you have. This legislation does not require you to make any changes. Yet, the ranks of the insured are shrinking more every year and the numbers of satisfied citizens are falling. Millions of Americans have too little insurance, too few choices, and no options left. For those Americans—for most Americans—this legislation is a lifeline to the security they have longed for and deserved.

This is a chance to give every American the peace of mind that insurance companies can no longer deny coverage for pre-existing conditions, or cancel your coverage when you are sick and need it the most.

It is a chance to give public insurance an option to guarantee that Americans will have an affordable choice among insurance providers and keep private insurers honest.

It improves health care for patients and their families by making investments to increase the number of primary care providers, improve access to primary care, and support a patient-centered approach that focuses on quality and emphasizes prevention.

For our seniors, this legislation will strengthen Medicare by eliminating the waste, fraud and abuse that diverts health care dollars away from care and into the pockets of crooked companies. It will immediately begin closing the "donut hole" in the Medicare prescription drug benefit to make prescriptions more affordable. And it will ensure the financial stability and solvency of Medicare for 45 million seniors.

For our children, it will help expand coverage and ensure that the youngest Americans receive quality coverage that includes essential benefits such as vision and oral services. And it will extend coverage for young people by allowing them to remain on their parent's insurance until their 27th birthday.

The Affordable Health Care for America Act does all these things while meeting President Obama's call for new costs to be covered. In fact, the farther by reducing the deficit by $109 billion over the next 10 years.

This comprehensive health care legislation is ambitious by necessity. I have confidence every one of these reforms will be implemented successfully because of what my state of Minnesota has accomplished. Through a combination of smart investments and an enduring commitment to care for all of our friends and neighbors, my state proved a high-quality, low-cost health care system is possible. Minnesota is the highest in the nation for quality of care and rates of insured citizens—almost 92 percent. And Minnesota attains these high standards with some of the lowest costs in the country. Unfortunately, other states—working with fewer resources than most other states—versed because of the Medicare geographic payment disparity. Medicare's outdated and unfair reimbursement system pays Minnesota doctors and hospitals at some of the country's lowest rates, despite the fact they produce some of the country's best patient outcomes. The current system rewards the amount of services provided rather than the quality of care patients receive.

Patients, providers, health plans, hospitals, and unions have all told me that ending this unfair treatment of Minnesota and other states is the most important issue for Minnesotans in the national debate on health care reform. While Minnesota's health care system is excellent today, the broken Medicare payment system threatens to undermine it in years to come.

This health care reform legislation is our last best chance to fix this problem, achieve fairness for Minnesotans, and make evidence-based, quality care the standard wherever you live in the United States. That is why I worked to help unite my House colleagues who represent 17 different states in a new Quality Care Coalition. Together with my coalition co-chairs Representatives Bruce Braley, Ron Kind and Jay Inslee, we created the political will we have always needed but never had to address this problem. After more than 20 coalition meetings over the course of 6 months and a series of intensive negotiations with House Leadership, our coalition secured an agreement to end the unfair treatment of high quality, low-cost states such as Minnesota. And by securing fairness for our states, we will be helping to deliver better quality for all patients in every state.

This agreement places America on a path to reward high quality, evidence based, cost-effective health care by making fundamental improvements in the delivery system. H.R. 3962 directs the highly-regarded Institute of Medicine to develop recommendations on how to modernize the Medicare payment system so it rewards value and quality. This will transform the Medicare payment system to ensure better care for patients, lower health care costs over the long-term, and will help secure a better future for our patients, families, and seniors.

While the legislation we vote on today would make unprecedented reforms, I will continue working to improve the bill before it returns to the House for a final vote. To be truly comprehensive, health care reform legislation must reach all Americans, including the 15 million citizens employed in the nonprofit sector. Achieving parity between small nonprofit and for-profit employers in this legislation is one issue the coalition is also concerned with the burden this bill places on the medical device industry to generate revenue and potentially negative impact such a tax would have on patients, workers, and small businesses. I look forward to working with House Leadership and the conference committee to help address these issues and strengthen this legislation.

Still, H.R. 3962 remains a historic achievement, providing a legislative framework of Minnesota's families and families across this country. It modernizes Medicare and covers the uninsured. It invests in prevention instead of paying for disease. For these reasons and many more, the Affordable Health Care for America Act has the support of over 300 state and local labor organizations including the American Nurses Association, American Medical Association, SEIU, AFL-CIO, and AARP. Organizations representing millions of Americans back this legislation because they know our health care system is broken and change cannot wait another year.

Still, there are critics of health care reform that are fighting desperately to maintain the status quo. It is disappointing to see Republicans choose health care profiteers and insurance companies over reforms that Americans want. Republicans have offered politics and posturing but no real solutions. They have no serious alternative to H.R. 3962 to control costs, expand access and improve quality. They have made killing health reform and killing America's chance at affordable, quality health care another political goal. The American people deserve better.

I would like to thank Speaker Pelosi, Majority Leader Hoyer, Majority Whip Clyburn and Caucus Chair Larson for their extraordinary leadership to bring affordable, quality health care to all Americans. Thanks are owed to the three committee chairmen—Chairman Waxman, Chairman Rangel, and Chairman Miller—who held dozens of hearings throughout the year and crafted a historic bill. I would also like to thank Chairman Dingell for his dedicated service in introducing health care legislation for over 50 years to bring health care coverage for all Americans.

I would especially like to thank Speaker Pelosi for her attention to the concerns of the Quality Care Coalition and all of the diverse interests of the Caucus. Vice Chairman Becerra also has my gratitude for the vital role he played in negotiating this agreement to move health care reform toward high quality, cost-effective care.

Today is a historic step toward making health care reform a reality, but it is not the end. I urge the Senate to stay focused and committed so an equally strong bill meets H.R. 3962 in conference committee. I am committed to sending a health care bill to the President's desk that will bring meaningful reform for American families, seniors and businesses. With passage of this legislation, health care will no longer be a privilege for those who can afford it.

I urge my colleagues to support H.R. 3962 and guarantee that affordable, quality health care will be accessible for every Minnesota family.

Mr. McCaul. Mr. Speaker, in the 72 hours we were allowed, Republicans weeded through thousands of pages of bureaucratic provisions, mandates, programs and spending. Despite its monstrous size, this health care takeover has come down to a few clear, evident points: it raises taxes, raises premiums, increases health care costs, and dumps trillions of dollars of debt on our children and...
grandchildren. Small businesses and families will bear the weight of this bill for generations.

We all agree that health care reform is urgently needed, but this bill destroys the American health care system as opposed to improving it. Instead of incentivizing the private market to offer more affordable health care coverage options, it punishes small businesses and their employees. It threatens jail time for individuals who do not purchase insurance and could soon lead to the rationing of care, depriving Americans of life-saving treatments that are not deemed “cost-effective.” Even though I have experienced this in health care debate, as a registered nurse, I oppose this proposal and have shared concerns of the many clinics and hospitals that will be forced to reduce or deny services.

The over 2,000 page spending plan imposes nearly $800 billion in new taxes on individuals, families and small businesses. It places mandates on both individuals and employers which, according to the President’s Economic Advisor, will result in the loss of up to 5.5 million jobs. These mandates will also place mandates on both individuals and employers who purchase health care. In the face of both a recession and efforts to help millions of people lose their jobs, we have shared concerns of the many clinics and hospitals that will be forced to reduce or deny services.

I have spoken to many health care professionals in my State as well as held town halls with my constituents, and both have expressed not only their opposition, but their fear, of this government takeover of health care. We are not listening to Americans, and we are missing the opportunity to use insight from the experts in the field to enact meaningful reform. This bill is not what Americans have asked for.

Mr. PLATTS. Mr. Speaker, I rise today in opposition to Speaker NANCY PELOSI’s health care reform bill H.R. 3962. I plan to vote against this legislation for numerous substantive reasons, including my concerns about its trillion dollar plus cost to taxpayers, its mandates on individuals and employers, its deep cuts to Medicare, and the strong likelihood that H.R. 3962 will impose new taxes on certain employer-provided health benefits and on medical devices such as wheelchairs and walkers. In total, H.R. 3962 includes more than $700 billion in new taxes.

Unbelievably, in the name of health care reform, H.R. 3962 cuts Medicare benefits by more than $400 billion and raises Medicare premiums, making access to comprehensive health care to the elderly and our Nation’s senior citizens. Additionally, over time, H.R. 3962 will move countless Americans involuntarily from private health insurance to government-run health care.

I have long maintained that there is no “silver bullet” for health care reform. We should aim to build upon the current health care system in a variety of ways, making health insurance more affordable and more accessible. In other words, Congress should fix what is broken in our nation’s health care system and be certain not to break it.

Congress should adopt insurance reforms to end the practice of denying coverage due to pre-existing conditions and ensure the portability of one’s health insurance. Additionally, Congress should allow small businesses to band together to negotiate insurance coverage for their employees, just as large corporations and labor unions are already allowed to do.

Congress should also allow individuals to purchase health insurance across state lines from a competitive, nation-wide market and should enact responsible medical malpractice reform to control health care costs. I plan to join with my fellow Republicans in voting for an alternative legislative proposal that includes such reforms.

The full Senate has yet to act on a health care bill of its own. Hopefully, when it does so, the Senate will adhere to the principle of: “First, do no harm.”

Ms. LINDA T. SÁNCHEZ of California. Mr. Speaker, I rise on behalf of the nearly 50 million Americans who don’t have health insurance.

On behalf of parents who have to choose between taking their sick child to the doctor and paying the electric bill on time.

On behalf of working adults who are being locked out of their parents to Alzheimer’s, and yet can’t afford the quality care their parents need.

In a Nation as prosperous as ours, it is a shame and a tragedy that so many families suffer, watching their loved ones die, when timely tests or early care could have prevented it.

American families have waited too long for the freedom and security that universal health care can provide.

I strongly support H.R. 3962, the Affordable Health Care for America Act because this legislation tells families yes.

Yes, they can afford high quality health care.

Yes, they can get health insurance even if they have a pre-existing condition.

Yes, they can expect to be treated fairly by insurance companies, regardless of their gender, age, or medical condition.

And yes, we can pass health reform that protects and strengthens our economy by encouraging development and use of health information technology, generic drugs, and advanced medical devices.

It’s well past time for Congress to make sure that an unforeseen illness or accident doesn’t mean economic ruin for American families. To stop the abuses of health insurance companies, who play games instead of paying for health care. To ensure that Americans have the freedom to change jobs or to become entrepreneurs, instead of being locked into a job they hate because it is the only way they can afford healthcare.

I worked to make sure this bill bars insurance companies from charging women more just because they are women.

I worked to make sure that this bill creates Collaborative Care Networks, to ensure that doctors, hospitals, and other health care providers work together to provide working families, lower income Americans, and those with chronic conditions the high quality coordinated care they need to stay healthy and out of emergency rooms.

I worked to make sure this bill includes, among the choices it offers consumers, a public option that will focus on health care, not profits.

I’m proud of my work on this bill, because it means American families and businesses will have the peace of mind that comes with knowing they can access affordable, quality care when they need it.

It means that my son Joaquin can grow up in a country that is a little fairer, a little more humane, and a little more secure than the one I grew up in.

I urge my colleagues on both sides of the aisle to vote for children and families by supporting this bill.

Mr. KANJORSKI. Mr. Speaker, I rise today in support of H.R. 3962, the Affordable Health Care for America Act.
The House has taken an important first step today to improve the affordability and accessibility of health care. While today’s health care legislation is not perfect, action to address this important issue is absolutely necessary. If we do nothing to reform health care, health care costs are expected to double over the next ten years, just as they have over the last ten years.

Insured Americans pay on average $5,000 per year just to administer health insurance, more than double the administrative costs paid in any country which has a government-run health care system. The McKinsey Global Institute estimates that $91 billion a year is wasted on excessive insurance administrative costs.

Because about 60 percent of all Americans under the age of 65 receive insurance through their employers, much of this waste is burdening American companies. American companies competing in the global economy cannot afford this economic disadvantage. The bill we voted on today attempts to reduce the costs of insurance to employers and employees by providing greater competition among insurers. According to a study by the Massachusetts Institute of Technology, a family of four would save $1,260 in annual health insurance premiums if this bill is enacted. It is estimated that 96 percent of all Americans will have access to affordable health insurance under this bill. While I believe that caring for our fellow citizens is a moral imperative, it also makes economic sense to have as many people covered by insurance as possible. Families USA estimates that every insured American family pays over $1,000 per year in premiums just to cover the medical expenses of the uninsured, who obtain urgently needed health care through inefficient means such as visits to hospital emergency rooms.

As we face the threat of pandemics such as the current swine flu, it is in the best interest of all of our health to make sure that sick people are treated quickly and affordably so that infectious diseases are not spread. What is even more distressing is that many detailed provisions in this complex legislation, it is important to note what the bill does not do. The only effect it will have on senior citizens who rely on Medicare is it will reduce their out-of-pocket costs for prescription drugs, supported by AARP and the recent endorsement of the bill. The bill does not use tax dollars to pay for abortions. It does not require our smallest businesses to pay for insurance coverage for their employees. It will not result in the federal government controlling the delivery of health care; in fact, the bipartisan Congressional Budget Office (CBO) estimates that only six million Americans will choose to enroll in the government-sponsored insurance plan, the so-called “public option.” It does not add to the federal deficit. CBO estimates that the bill will reduce the deficit by $109 billion over the first ten years.

Finally, I want to praise the House leadership for including in this bill a provision which will help to fund the education of the next generation of doctors, some of whom I hope will be educated by our region’s own medical college. We all share the goal of keeping American citizens healthy in the most humane and efficient means possible. I believe this bill is a reasonable first step toward reaching this goal. In closing, I appreciate the opportunity to share my thoughts about this important legislation.

Mr. TIAHRT. Mr. Speaker, I rise in strong opposition to H.R. 3962. I cannot and will not support this government takeover of our health care system that will restrict choice, ration care, increase the cost of health care, greatly increase government spending, and lead to the destruction of the world’s best medical care.

Americans are fed up with Washington’s out of control spending, with more and more power over their daily lives being put in the hands of nameless, unaccountable bureaucrats, and with the systematic shift of the United States Government towards a government run health care system. One wonders where the bills will go when the government is in control. The government takeover of health care will result in 5.5 million job losses at a time when unemployment is already over 10 percent.

The Democrats ignored these sentiments and introduced H.R. 3200 and the two other legislative efforts under the spurious label of comprehensive reform in order to get away from unsavory town hall meetings. The discontent has now come to a full boil.

This spring, summer and fall the American people have spoken loudly and clearly about what they do and do not want in health care reform. The Democrats ignored these sentiments and introduced H.R. 3200 and the two other legislative efforts under the spurious label of comprehensive reform. The American people do not want higher taxes, the American people do very much want to keep their health insurance and increase their choices and access for those who do not have insurance.

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for some of my friends on the other side of the aisle, this bill will create high-paying, high-quality jobs in healthcare delivery, technology and research in the United States.

First, this bill will create enormous demand for healthcare workers, especially in the area of primary care. There are millions of uninsured people in this country who currently have no insurance will allow them to see primary care providers and receive the wellness and preventive care they have been denied for too long. This influx of new patients will need doctors, nurses and other health care professionals, while reducing overall healthcare costs because they will not need much more expensive hospitalizations. I support channeling resources that for too long have been used to treat people once they become sick into jobs and services that will prevent people from getting sick in the first place.

Second, this bill will continue the efforts we began in the stimulus package to deploy new health information technologies that better manage both the quality of care people receive and the cost at which they receive it. New technologies will help manage the demands on the health system to provide high-quality and cost-effective health care will create new opportunities and markets for our brightest technology minds. They will be incentivized to create and develop products that will create jobs—jobs in hardware production, software development, and these jobs in this country. We cannot and must not allow these opportunities in this country, and I intend to work with the Secretary of Health and Human Services, the Commissioner of the FDA, and like-minded colleagues in Congress to ensure that these important research and manufacturing jobs stay right here in the United States.

Third, this bill will create high quality research opportunities in this country. The Energy and Commerce Committee enacted a framework for allowing biosimilar competition in this country, and this new class of medicines will help lower costs and bring competition to one area that is key to the future of our healthcare system. Biotechnology is on the cutting edge of efforts to reducing costly invasive procedures and allowing our constituents to live healthier and more productive lives. The creation of this new class of medicines comes with requirements for new clinical research and testing, especially in the area of whether a new biosimilar can be interchange-able with an innovator’s product. This research will create high quality and high paying jobs and it is important that we keep this research in our country, and these jobs in this country. We cannot allow these research opportunities to leave this country, and I intend to work with the Secretary of HHS and the Commissioner of the FDA to ensure they stay in the United States.

Mr. Speaker, I do not look at this bill as one of cost or drain on the economy of our country like so many of its opponents on the other side of the aisle. I see this bill as an exciting opportunity to create the kind of jobs we so desperately need in this country while at the same time improving the lives of all Americans. This bill will improve health care, create jobs and grow our economy.

Mr. COSTELLO. Mr. Speaker, today is a historic day in the House of Representatives, and will be one of a handful of votes that can be deemed the most important of our careers. We are considering today how to improve the provision of health care in America. Spiraling costs, insurance limitations and a lack of insurance coverage continue to impact families, our economy, and ultimately our way of life. It is for this reason that after careful consideration, I will vote in favor of H.R. 3962.

As the health care debate has developed this year, I have held meetings with individuals, families, health care providers, business owners and other groups. What everyone can agree on is that our health care system is broken and needs attention. At the simplest level, we need to put an emphasis on preventive medicine. As the old saying goes, an ounce of prevention is worth a pound of cure. We treat too many people in emergency rooms instead of doctors’ offices, and often when they are sickest and care is the most expensive. H.R. 3962 moves us toward preventive care in a variety of ways, but chiefly through providing for the expansion of health care coverage in America. Having insurance will allow them to see a doctor on a regular basis and detect health problems earlier.

Most importantly today, passing H.R. 3962 keeps the process of health care reform moving forward. Today is a very important step, but there is still a long way to go. As we all know, the Senate is working on its version of health care reform legislation, and that bill is likely to be very different from this one, but I am confident we can craft a final product that incorporates the best ideas and makes our health care system better.

Mr. Speaker, I am glad that we slowed our process down and took some additional time before bringing it to the floor. This is not a perfect bill, but I believe it is a positive difference for the entire country. Over 300 organizations have endorsed it, including AARP, the American Heart Association and the American Medical Association. I urge my colleagues to vote for H.R. 3962, and keep us moving towards a healthier America.

Ms. LINDA T. SANCHEZ of California. Mr. Speaker, I strongly support H.R. 3962, the Affordable Health Care for America Act, which delivers on a promise Americans have been waiting for since the New Deal, a promise that our families, and these families need, when they need it, without facing economic ruin.

I have previously spoken about the ways this bill will help ensure access to affordable, high quality health care for American families. But another significant benefit of this legislation which has not received much attention is its promotion of high-paying research, high tech, and manufacturing jobs.

Contrary to the claims that this is a “job killing bill,” in fact this bill will create high quality and cost-effective health care will create thousands of jobs here in the United States.

First, this bill will increase demand for healthcare workers, including doctors, nurses, nurse practitioners, physician assistants, home health workers, and more. More affordable insurance means more families getting the primary and chronic care they need instead of waiting until they need an emergency room. And it means more middle class American jobs that can’t be exported.

Second, this bill continues the investments begun in the American Recovery and Reinvestment Act, also known as the stimulus bill, to expand the use of health information technology.

Health IT will help better manage the quality and cost of care patients receive by eliminating duplicative tests and ensuring that patients don’t receive the wrong medicine or the wrong dose. And investment in health IT creates jobs—jobs in hardware production, software design, and computer training. When we invest in quality health care for all Americans, we are investing in jobs.

Finally, this bill will promote more of what America already does so well: medical research. By allowing more Americans access to health insurance, this bill will increase the demand for advanced medical technologies that are manufactured right here in America.

And by creating a process for the Food and Drug Administration to approve so-called “biosimilar” drugs, this bill will encourage competition in the cutting edge field of biologic drugs. This new class of medicines will help treat and make more Americans at lower costs. And the promise of protection for intellectual property and an FDA structure to approve biosimilars will result in increased investment in this industry, which already provides thousands of high-paying jobs in California and across the country.

I hope to work with the Secretary of Health and Human Services, the Commissioner of the FDA, and like-minded colleagues in Congress to ensure that these important research and manufacturing jobs stay right here in the United States.

In sum, this bill preserves and promotes the strength of the American health care system: innovation. And it fixes the shortcomings: spending too much while caring for too few.

If we fail to pass this bill, we fail American families, and we fail the American economy. As a champion of both, I strongly support this bill.

Mr. ALEXANDER. Mr. Speaker, after months of meeting with constituents and business leaders, as well as hosting town halls and roundtable discussions, I can say that American public has clearly stated their opposition to this government takeover of health care.

H.R. 3962, the Affordable Health Care for America Act, states in section one that this legislation “builds on what works in today’s health care system, while repairing what’s broken.” I agree that improvements need to be made to drive down medical costs, but placing individuals under one bureaucratic umbrella does not build on what works or make any repairs. The bill includes the “public option,” cuts Medicare and Medicare Advantage programs, and raises taxes on middle class families. In addition, the bill does not pay for the increased costs nor does it adequately address defensive medicine. And, in the midst of states struggling with fiscal constraints, it will burden them with more unfunded mandates from the federal government.

In the President’s address to Congress on Sept. 9, President Obama said, “Nothing in our plan requires you to change what you have.” A study by the Lewin Group shows that two out of every three people would lose their current coverage, including up to 114 million people who would receive it through their employer or other current coverage if a government-run plan “competes” with private companies. I don’t see the choice in this.

Medicare cuts total $162 billion. As a result, Medicare Advantage plans will drop out of the program, limiting seniors’ choices and causing many to lose their current health care coverage. Medicare Advantage has been successful in providing seniors with choice, selection and value. This is especially true for residents of rural America, where seniors have previously not had sufficient private alternative coverage. Currently, over 600,000 seniors are Medicare beneficiaries in Louisiana, while 10,694 seniors in the 5th District are enrolled in the Medicare Advantage program.
The bill includes taxes on individuals who do not purchase government–forced health insurance. It also imposes new taxes on businesses who cannot afford to fund government–forced health coverage for their workers, therefore violating the bill’s new employer mandate and triggering an additional 8 percent payroll tax.

The bill also prohibits the reimbursement of over–the–counter pharmaceuticals from Health Savings Accounts (HSAs), Medical Savings Accounts, Flexible Spending Arrangements (FSAs), and Health Reimbursement Arrangements (HRAs), increases the penalties for non–qualified HSA withdrawals from 10 percent to 20 percent, and places a cap on FSA contributions. Because at least 8 million individual holders insurance policies eligible for HSAs, and millions more participate in FSAs, all these individuals would not be able to keep the coverage they have without facing tax increases.

The grand total amount of tax increases included in this legislation equals approximately $729.5 billion over ten years. Imposing these new tax increases in the middle of a recession—when unemployment numbers we haven’t seen since 1983—will only harm the economy and kill jobs.

This bill intends to ensure that generic biologic companies will have to do some research before the FDA will approve them for use in the United States. This dramatically increases patient safety as generics come to market. Likewise, keeping research and trials in the country means more jobs at home. I hope this is included in discussions the affordable care debate continues in the coming months.

The CBO has also said that this bill will increase seniors’ Medicare prescription drug premiums by 20 percent over the next decade. While the cost of living continues to rise during these tough economic times, I know that many cannot afford this increase. Medicare finances are rapidly deteriorating and we should be working on real solutions that ensure the long–term financial stability of Medicare.

Choice is not an option in this government takeover. The current system was genuinely concerned for the well–being and options that the people of this nation have. I do not believe H.R. 3962 best represents what the American people are asking for.

I agree that improvements need to be made to our system currently in place. However, a solution should be built upon the principle that—with financial help from the government—individuals will choose the coverage that best meets their needs. As I will say again, I will not support any type of reform plan that raises taxes, ration health care, eliminates employer–sponsored health benefits for working families, or allows government bureaucrats to make decisions that should be made by families and their doctors.

Mr. VISCONTI. Mr. Speaker, I am proud to support the Affordable Health Care for America Act, a bill that will significantly improve our healthcare system.

For too long, our healthcare system has allowed millions of Americans to go uninsured, tolerated egregious and abusive business practices by big insurance and pharmaceutical companies, and ignored skyrocketing costs. It has diminished our nation’s collective health and future growth potential. The Affordable Health Care for America Act represents a significant effort to address the inequities of our current healthcare system.

Specifically, the Affordable Health Care for America Act strengthens the healthcare market for those who are uninsured or are dropped from their existing insurance. For those without insurance, the Affordable Health Care for America Act would establish a public health insurance option to compete with—not replace—private insurance plans. The public option would aim to provide more Americans with healthcare coverage and would be financed through its premiums. The measure would allow the Secretary of Health and Human Services to negotiate physician and hospital rates for the public option and would prohibit insurance companies from denying coverage based on a pre–existing condition.

Importantly, the measure would repeal the prohibition on negotiating with pharmaceutical companies and would require the Secretary of Health and Human Services to negotiate the prices of prescription medications for Medicare beneficiaries. It is my sincere hope that these negotiations will ameliorate the high out–of–pocket costs for prescription medications faced by our seniors. Additionally, the Affordable Health Care for America Act would provide savings to the Medicare programs by improving payment accuracy to Medicare Advantage.

The Affordable Health Care for America Act would reduce the costs to small businesses, America’s economic engine, by establishing a Health Insurance Exchange where these businesses will benefit from large group rates and a greater choice of insurance options for their employees. Further, the measure would provide tax credits to eligible small businesses for assistance with the costs of providing health insurance to their employees.

Finally, the Affordable Health Care for America Act is not only fully paid for, but according to the non–partisan Congressional Budget Office it would reduce the deficit by $104 billion over the next ten years and would continue to reduce the deficit in the following decade.

Through these provisions and others I believe that the Affordable Health Care for America Act will accomplish my goals for healthcare reform, namely to give more security and stability to those who have health insurance, to provide affordable, quality options to those who do not have health insurance, and to lower the cost of healthcare for families, businesses, and society.

Although this bill may not be perfect, it will improve our healthcare system. It is the result of a lengthy, transparent process that has helped the bill evolve and improve at each step of the way. I will be watching closely to monitor the legislation’s progress.

Voting for comprehensive healthcare reform at last long was a gratifying experience. I believe that a generation from now people will ask the question, what was so wrong with our current healthcare system, with the power to dictate who receives healthcare?

Mr. REYES. Mr. Speaker, this is a momentous occasion for the American people, particularly for the hundreds of thousands of El Pasoans who have unjustly struggled without health insurance in the world’s wealthiest nation. The Affordable Health Care for America Act, as passed by the House, will dramatically improve the quality of life for so many families in our community, who will finally have access to quality affordable health coverage.

I am particularly pleased this legislation incorporates a provision that will help our community, along with Majority Leader STENY HOYER, and others worked to include that will support the development of our medical school. The measure will allocate $100 million each year through fiscal year 2015 to the Department of Health and Human Services to help develop medical schools in federally–designated health professional shortage areas for construction, equipment, curriculum and faculty development. This is an exciting opportunity for our community.

The House passage of the Affordable Health Care for America Act is one of the most significant legislative victories for the people of El Paso. Our community has one of the highest concentrations of America’s uninsured population, with over 230,000 residents without health coverage, one in three people. Texas has the highest rate of children and adults without health insurance in the entire nation. The status quo is unacceptable, and we can no longer afford to pass this growing problem to future generations.

While our community is spending a greater share of property taxes to pay for individuals without health coverage, insurance companies have continued to engage in practices that protect their bottom lines. For too long, insurers have been the gatekeepers to our health care, without a conscience to receive health care and who does not.

Americans with pre–existing conditions and serious illnesses are too often denied coverage or are dropped from their existing insurance plans for developing a serious illness or reaching their coverage limit. We are denied access to the medical care they need.

When people lack access to quality affordable preventative care, they end up in our

CONGRESSIONAL RECORD — HOUSE
November 7, 2009
Mr. ETHERIDGE. Mr. Speaker, I rise today to oppose language in the Republican substitute that threatens the Speaker, I rise today to oppose language in the Republican substitute that threatens the

provide affordable, quality healthcare to every country.

The Affordable Health Care for America Act will dramatically reduce the number of people without insurance. First, it prohibits insurance companies from denying coverage due to “pre-existing conditions.” It requires that every American obtain health coverage, and provides “affordability credits” to individuals and families with incomes up to 400 percent of the federal poverty level (currently $43,430 for individuals and $88,200 for a family of four).

The legislation also requires that most employers provide coverage. It includes exemptions for small businesses with payrolls of less than $250,000. The legislation includes provisions for those small businesses that elect to provide coverage for their employees. The bill creates an “insurance exchange,” that will offer affordable health insurance plans for individuals without employer-provided or government-provided insurance (such as Medicaid and Medicare). This exchange will include a public option to encourage competition with private insurers to keep prices low for consumers.

This bill also brings much needed relief and peace of mind for those who do have insurance coverage, as all Americans will no longer have to worry about the possibility of financial ruin due to a serious illness. It caps annual out-of-pocket expenses at $10,000 for families and $5,000 for individuals, and prohibits insurance companies from imposing lifetime limits on an individual’s coverage.

Our local community leaders have expressed their support for health insurance reform, and both the city and the county have passed unanimous resolutions in support of reform. New standards of care for Medicare for America Act is endorsed by over 300 national organizations and associations, including the AARP, the American Medical Association, the American Cancer Society, the American Heart Association, and many other medical professional organizations.

The passage of this landmark legislation by the House of Representatives is an historic achievement and reflects the commitment and determined leadership of President Obama and the Democratic Congress to follow through on a key promise to help middle class families, who have endured years of rising healthcare costs. I commend my colleagues for their determination to pass this truly historic legislation that will lower healthcare costs for millions of Americans. I am committed to enacting comprehensive health care reform that contains costs, protects patient choice, and assures quality, affordable care for all Americans. As the only North Carolina Member on the House Ways and Means Committee, a Member of the Budget Committee, and a supporter of fiscal responsibility, I am pleased that this legislation is fully paid for and according to the Congressional Budget Office will reduce the deficit both in the short and long term.

Working families and small businesses are facing crushing health care costs that threaten their lives and livelihoods. Health care costs will reach $2.5 trillion in 2009, more than we are expected to spend on the wars in Iraq and Afghanistan this decade. Families already have experienced health care costs doubling in the past 10 years. Without reform, health care costs will skyrocket in the next decade. Independent analysis has predicted that family premiums will be $1,000 to $9,000 lower in the ability of insurance companies to place annual or lifetime limits on coverage. Choice will be reinforced with one-stop comparison insurance shopping through a health insurance exchange.

During this economic downturn, the House of Representatives has passed their Medicare Prescription Drug bill, they put a provision in there known as the “donut hole” which is clearly a provision that has unfairly burdened the pocketbooks of seniors, decreasing out-of-pocket costs by $500 immediately, cutting copayments in half in the short term, and fully closing it over the next 10 years. H.R. 3962 also provides better and more timely payments to doctors who accept Medicare and attacks waste, fraud, and abuse in Medicare ensuring more money goes to benefits and improving senior health and quality of life.

Too many people have choices limited by insurance companies and financial decisions, rather than by patients and doctors. H.R. 3962 will expand individual choice and prevent insurers from denying benefits that doctors recommend. This bill will put caps on out-of-pocket health expenses, and remove the “prescription drug donut hole” which has unfairly burdened the pocketbooks of seniors, decreasing out-of-pocket costs by $500 immediately, cutting copayments in half in the short term, and fully closing it over the next 10 years. H.R. 3962 also provides better and more timely payments to doctors who accept Medicare and attacks waste, fraud, and abuse in Medicare ensuring more money goes to benefits and improving senior health and quality of life.

Mr. Speaker, as this bill moves to the Senate, I promise to work with my colleagues in the Senate to ensure that this legislation is fully paid for and according to the Congressional Budget Office will reduce the deficit both in the short and long term.

Mr. Speaker, as this bill moves to the Senate, I promise to work with my colleagues in the Senate to ensure that this legislation is fully paid for and according to the Congressional Budget Office will reduce the deficit both in the short and long term.
H. R. 3962 is fiscally responsible and will improve the health and health care of people across my district, North Carolina, and the country. I am pleased to be able to vote in favor of this historic legislation.

Ms. FOXX. Mr. Speaker, small business owners, big business owners, and employees. My business has drastically cut expenses, delayed capital investments and decreased our work force to stay competitive. If H.R. 3962 is passed by Congress it will force us to close down our business and end the paychecks for the 56 employees who depend on our company to feed their families.

Mr. LUJAN. Mr. Speaker, as I came to the floor tonight I was reminded of a constituent, Aunt Adrian, who we lost to cancer last year and who couldn’t afford insurance, she spent the last few months worrying about bills, rather than gett better. This story didn’t have to end this way.

We reached this point today because people have had enough.

People will have been ignored and shunned, because they are sick; People who have lost their homes and all they have because a health insurance company slammed a door on them and denied them coverage they thought they had. People who deserve to be treated fairly and with dignity.

We are here today not to frighten and scare the American people with things that are untruthful.

But to act, to make a difference, to have the courage and will to put the people first.

And I now know that we do have the courage and the will to get this done, Aunt Adrian and the American people deserve no less.

Ms. RICHARDSON. Mr. Speaker, I rise today to support H.R. 3962, the Affordable Health Care for America Act of 2009, because this bill is good for seniors, good for women, good for small businesses, and good for all Americans.

I would like to thank Speaker PELOSI, House Majority Leader HOYER, Congressman DINGELL, Congressman RANGEL, and Congressman WAXMAN for their skill and leadership in bringing this historic bill to the floor. I would also like to thank my colleagues who have worked so hard to bring about a workable solution to one of the most critical challenges in the history of our nation.

President Theodore Roosevelt proposed national health insurance in 1908 because he could not stand by and watch American families go bankrupt when their children fell ill. Forty years later in 1948, President Truman proposed it again. Under the leadership of Lyndon B. Johnson and a Democratic Congress, Medicare was enacted in 1965 which provides health care for our senior citizens. Thirty years later, Congress passed the State Children’s Health Insurance Plan which expanded affordable coverage to millions of poor children.

Today, this seventh day of November in the year two thousand and nine, we are final chapter in the remarkable history of this country. Today, we extend to tens of millions of our fellow citizens the security that comes from knowing that they will have health care that is there when they need it and won’t bankrupt their families. Today, we keep faith with those who came before us and those who will come after us. Today, we will pass the Affordable Health Care for Americans Act of 2009 and change America for the better.

The health care system we have now is not working for middle and working class families, not working for small businesses, not working in a global economy, not working for taxpayers or for the uninsured. There are 54 million Americans who are uninsured who need us to reform this broken system. 1 in 5 Californians are uninsured or underinsured. These numbers are staggering and if we do nothing, they will only grow worse.

Mr. Speaker, House Republicans have offered a bill that they claim solves the broken health care system, but the reality is quite different from what their rhetoric makes it out to be. This health care substitute leaves affordable health insurance out of reach for millions of Americans. It will allow discrimination based on gender, age, and pre-existing conditions to prevail in the insurance industry. It will do nothing to protect consumers. It is not the answer.

Mr. Speaker, the Affordable Health Care for Americans Act is a better bill. It is the answer to the broken health care system. This bill provides American families with stability and peace of mind. Never again will they have to choose week to week with their livelihood. This bill provides American families with higher quality health care. It leaves important health decisions up to patients and doctors, not to insurance companies. This bill provides American families with greater choice. It creates a high-quality, robust, public health insurance option for families who choose from. Finally, this bill lowers costs for American families. It eliminates co-pays and deductibles for preventive care while putting an annual cap on out-of-pocket expenses for American families. In other words, it provides the real-world solutions to the problems faced by real American families today. The Republican bill is fantasy. It is not grounded in reality. Now, we need to stop playing politics and focus on actually improving people’s lives. H.R. 3962 will reform the health care system so that it provides quality, affordable care that will not be taken away. This bill eliminates discrimination based on gender and pre-existing condition. It eliminates the prescription drug donut hole for seniors. It ends the era of no and begins the era of yes for millions of Americans seeking coverage.

As FDR once said, the test of our progress is whether we add more choices of products, but I am certain that the response to this is that it is done properly and safely.

Mr. BOOZMAN. Mr. Speaker, the Pelosi Health Care Bill is a bad bill disguised as health care reform. I have heard my constituents and the American people and they say they don’t want this government takeover. They want the right to make their own health care choices. I agree that we need health care reform because the costs are too high. There...
is nothing more frustrating as a medical professional then when my patients can't afford the prescriptions I write for them. The Majority plan will put Washington between me and my patients and this is unacceptable.

We all deserve access to quality and affordable health care. Unfortunately, the proposal doesn't guarantee that we will accomplish this. This government takeover will increase taxes, take away health care choices Americans deserve to make and create more bureaucratic red tape. We don't want reforms that come with higher costs while the quality and access to health care continues to erode.

The cost is a staggering $1.2 trillion and to think that won't impact our national deficit and state budgets is unrealistic. The increased price for greatly expanding Medicaid will be an unfunded mandate to Arkansas taxpayers that at the bare minimum will cost $205 million and could be as high as $596 million. This is an unfunded mandate that we cannot force Arkansans to pay. Health reform should not end up costing hardworking Americans. Our citizens deserve better.

Mr. Speaker, today I will vote in strong opposition to H.R. 3962, the Affordable Health Care for America Act.

This government takeover of health care is filled with tax increases, job killing mandates, Medicare cuts, bureaucratic additions, and entitlement expansions. This bill will only support higher health care premiums and a growth in long-term health care costs.

Despite this bill's many faults, I support the bill's language establishing a market for biosimilars which balances the desire to provide cheaper biologics with the need to ensure that patients can continue incentivizing investment in research and development. The bipartisan language approved by the House Energy and Commerce Committee earlier this year would create an FDA approval process that allows for the continued development of biosimilar products.

This language appropriately protects intellectual property rights by encouraging the creation of new technologies and helps protect patients from possibly dangerous, insufficiently tested biosimilars. Because biologics are more complex and hard to change during formulation, it is of the utmost importance that we only support a process that provides for a safe biosimilar market.

It is critical at this time of 10.2 percent nationwide unemployment that the federal government allow job creating industries, like biotechnology, to continue to invest and create jobs. It is unfortunate that the Majority wrapped up a good biosimilar bill in a bad health care bill, but I hope that we have the opportunity to support the Eshoo-Inslee-Barton biosimilar provisions in a separate legislative vote.

Mr. MCCARTHY of California. Mr. Speaker, I rise today to express my strong opposition to H.R. 3962. Specifically, I am very concerned about how the House Democratic Leadership's go-it-alone take on health care legislation will affect the biotech industry, which needs to continue a source of innovation and job creation in California.

Californians know very well how the burden of heavy taxes and regulations can harm small businesses and innovation, as our state economy continues to lag and continues to have an unemployment rate much higher than the national average. On top of state taxes and regulatory burdens, H.R. 3962 would only add on to the devastating burdens facing our biotech industry, through its $20 billion excise tax on medical devices and by establishing a pathway for follow-on biologics that could harm innovation and American jobs.

As one of the biotech leaders in our country, Californians stand to lose from biopharmaceutical companies and has created more than 271,000 jobs. The proposed excise tax, whose purpose seems to be solely to raise revenue, is a job killer and would stifle innovation. It will ultimately result in making it more difficult for millions of Americans to have access to life-saving and innovative medicines that they need for their health and well-being.

Further, H.R. 3962 would establish a new pathway for follow-on biologics that could slow advances to new life-saving therapies, and ultimately reduce the number of American jobs. The bill does not expressly require clinical trials for follow-on biologics to be completed in the United States, which could allow for these studies to be conducted overseas. Over the past decades, many innovator biologics have demonstrated to be safe, reliable and life-changing in clinical trials and research done by dedicated researchers here in America. As unemployment has now crossed 10 percent nationally, and is over 12 percent in California, I hope that we could continue to foster the creation of jobs and research here at home.

These are some of the many concerns I have with H.R. 3962, which is why I instead support the Republican health care alternative. The alternative excludes the unnecessary and burdensome excise tax in H.R. 3962, and also includes a responsible pathway for follow-on biologics by including provisions from the Pathways for Biosimilars Act, which I am a proud cosponsor of. By passing the Republican alternative, we can ensure that the American biotech industry can continue to lead the world in innovative therapies and that the necessary research and clinical testing in the field can continue to be done domestically so we can continue to create good-paying American jobs.

Californians, and all Americans, need Washington to pass strong, pro-consumer health care solutions. But we need solutions that strike a balance in reducing health care costs, strengthening health care access, and allowing health innovators, like our biotech industry, to continue to research and improve therapies for patients. That is why I support the Republican health care alternative—it addresses the needs of patients and ensures that we keep good-paying jobs in America.

Mr. BONNER. Mr. Speaker, I rise today to state my objection—in the strongest way I know how—to Speaker Pelosi's health care bill.

This bill represents everything I have fought against during my years in public service. It raises taxes by hundreds of billions of dollars, it hides deficit spending with dubious accounting gimmicks, and it will vastly expand the federal government's scope and size in every aspect of our daily lives and take even greater control over one sixth of our nation's economy.

Among other things, this bill piles crushing mandates on small businesses, it wrings hundreds of billions of dollars out of our doctors, hospitals, and other providers. It decimates the popular Medicare Advantage program, which millions of seniors depend on. Moreover, it will be the mother of all unfunded mandates on state budgets which—like my home state of Alabama—are already stretched thin because unlike the federal government, most states actually balance their budgets.

Mr. Speaker, over the past several months I have heard from hardworking Alabamians who have called, written, and e-mailed my office. In August, my staff and I held 19 town meetings throughout Alabama's First District where more than 5,000 people came out to voice their opposition to this massive takeover of our health care system.

Our friends and colleagues, the vast majority of the people I work with—and have heard from—are unambiguous—they do not want this bill.

In fact, most Alabamians—and, I believe, most Americans—want to preserve what's best about our health care while lowering costs and improving access. That's why I will not only be opposing H.R. 3962, but I am proud to support the Republican substitute. My Republican colleagues and I believe this bill would lower costs in both the short term and the long term, and honor our pledge for fiscal responsibility while broadening access to quality health care through lower costs and more competition.

Mr. Speaker, I only have one vote but I will cast that vote against this legislation that The Wall Street Journal correctly designated "the worst bill ever," and I humbly urge my colleagues to do the same.

Ms. HIRONO. Mr. Speaker, the U.S. Congress has been grappling with how to provide all our citizens with access to affordable, quality health care since the time of President Harry Truman. H.R. 3962 represents a critical milestone in the effort to reform our health care system.

For those who have it, health insurance is not something you can take for granted. Every day 14,000 Americans lose their health insurance coverage because of pre-existing conditions like asthma, pregnancy, arthritis, or diabetes. Millions more have no health insurance at all, including 54,000 people who live in Hawaii's Second Congressional District.

In his health care speech before Congress and the nation, President Obama appealed to the best part of us—to act unselfishly, and to put ourselves in the shoes of others. He asked us to imagine what it must be like for those who don't have insurance—to live in a State of helplessness should illness strike you or the ones you love.

H.R. 3962 is a bill that will provide for comprehensive health care reform that will protect consumers, hold insurance companies accountable, rein in health care costs, reduce the deficit, and cover 36 million uninsured Americans. In supporting this bill, I want to highlight three key points. First, for Hawaii the bill includes the Hirono Amendment that provides an exemption for Hawaii's Prepaid Health Care Act of 1974, which is our nation's first and only employer mandate law of its kind. Second, the bill will provide health insurance coverage for the largest number of Americans while still reducing our deficit.

And third, the bill strengthens and improves the Medicare program for our seniors.
First, there is a mistaken perception that everything and everyone in Hawaii is exempted under H.R. 3962. That is not so. The Hirono Amendment only exempts Hawaii’s Prepaid Health Care Act (PHCA) and those who come under it (certain full-time employees and their employers). It does not apply to employees, seniors on Medicare, those without health insurance, government employees, or those covered by collective bargaining agreements. Therefore, H.R. 3962 would apply to them.

I know it is easier to talk in terms of the State of Hawaii being exempt from the bill, but that is wrong. The distinction between PHCA being exempt and the whole State being exempt is a critical distinction to make.

PHCAs—those with incomes to contribute at least 50 percent of the premium cost for single health care coverage, and the employee must contribute the balance, provided the employee’s share does not exceed 1.5 percent of his or her wages. Because of rising health care costs, an H.R. 3962 would require employers to cover 72.5 percent of premium costs for single health care coverage.

Hawaii consistently ranks among the highest nationally in terms of insurance coverage and lowest in regard to the number of uninsured. This is largely due to PHCA. Private and public health insurance cover an estimated 92 percent of our population of 1.3 million people. Of those with private insurance, 93 percent are covered through employment-based plans. Lawrenceaye, an economist at the University of Hawaii, estimates that per capita health expenditures in Hawaii are seven percent lower than the national average. Dr. Boyd believes that wider health insurance coverage and support for preventive health care lead to this outcome. The Hirono Amendment would provide maximum flexibility for Hawaii once a federal health care reform bill becomes law. Hawaii will be able to decide for itself to retain PHCA or come completely under the new federal law.

Second, H.R. 3962 will ensure that 96 percent of Americans will have health insurance coverage. The non-partisan Congressional Budget Office (CBO) estimates that the cost of enacting H.R. 3962 will be $894 billion, consistent with the $900 billion limit established by President Obama. The bill is fully paid for. About half of the cost of H.R. 3962 is paid for by targeting waste, fraud, and inefficiency in the federal Medicaid and Medicare programs. The other roughly half of the cost of the bill is paid for through a surcharge on the wealthiest American’s—those with incomes above $1 million for couples and $500,000 for singles; therefore, 9.97 percent of Americans will not be touched by this surtax.

While H.R. 3962 will be paid for, CBO also estimates that it reduces the deficit by over $100 billion in the first 10 years, and continues to reduce the deficit in subsequent years. Leading economists from educational institutions across our nation have concurred with CBO’s findings and support the idea that health care reform promotes our country’s economic health.

Finally, I want to address the importance of health care reform to seniors. Some of the most damaging misinformation that has circulated over the past several months on health care reform is the use of scare tactics targeted at seniors. The cynical irony is that the misinformation targeting seniors is largely perpetuated by the same people who fought the establishment of Medicare and wanted to privatize Social Security.

The truth is that H.R. 3962 will lower prescription drug costs for people in the doughnut hole; give the Secretary of Health and Human Services the authority to negotiate lower drug prices on behalf of Medicare beneficiaries; and extend the solvency of the Medicare Trust fund by five years.

Closing the doughnut hole is an especially critical issue for Hawaii, as we have the nation’s largest percentage—96 percent compared with 26 percent—of Medicare beneficiaries who fall into this gap of prescription drug coverage. In its first year, H.R. 3962 will reduce the doughnut hole by $500 per beneficiary, provide a 50 percent discount on brand-name prescription drugs, and phase out the doughnut hole by 2019.

It is remarkable that in just the past two days, over 300 groups representing Americans from all walks of life—doctors, farmers, seniors, consumers, cancer and diabetes patients—have rejected the unsustainable status quo and have endorsed H.R. 3962. In its endorsement of the bill, Consumers Union—publisher of the independent, non-partisan Consumer Reports—called the health care status quo a “consumer crisis with its crippling costs, its unreliability, and lack of access,” and strongly endorsed the House of Representatives health care plan to create “a more secure, affordable health care system.” Other groups endorsing the House bill include the: American Medical Association, American Nurses Association, AARP, AFL-CIO, AFSCME, Americans for Democratic Action, American Cancer Society, American Diabetes Association, Asian & Pacific Islander American Health Forum, Association of Asian Pacific Community Health Organizations, National Association of Community Health Centers, National Education Association, Campaign for Tobacco-Free Kids, and from my district, Lanai Community Health Center.

Now is the time to end insurance discrimination based on pre-existing conditions or gender. Now is the time to begin to close the Medicare doughnut hole for America’s seniors. Now is the time to bring change to a broken system.

I urge my colleagues to vote in support of H.R. 3962.

Aloha and mahalo.

Mr. THORNBERY. Mr. Speaker, most of us agree that immediate action is needed in our health care system, especially in the way we pay for health care. Health insurance costs have been increasing faster than many people can pay, and too many of us do not have health insurance.

At the same time, many aspects of our health care system are the best in the world. We need to work step-by-step to make needed improvements while we protect those parts that are improving the quality and length of our lives.

The bill before us, H.R. 3962, takes a very different course. It cuts over $400 billion from Medicare and Medicaid, increases various taxes, and fines individuals and businesses that do not sign up for the government-approved insurance, all to pay for massive new programs, including a government-run health insurance plan.

I believe that this bill will not only fail to stem the growing cost of health insurance; it will make health insurance significantly more expensive for the 85 percent of Americans who are currently insured. And it will severely affect those on Medicare and Medicaid. It will also present the largest, most intrusive growth of government into our lives in many years.

The alternative bill is a better approach. It focuses on lowering insurance costs, and CBO agrees that it will do so by up to 10 percent. At the same time, it makes it easier for those with pre-existing conditions to obtain coverage. CBO judges that the alternative bill would reduce the federal deficit by $68 billion over the next ten years.

Unfortunately, other ideas have never been allowed to be considered. This bill has been railroaded through this House from the beginning. That is not the way to deal with an issue as important as health care. H.R. 3962 must be stopped so common sense health insurance reform can begin.

Mr. TIJAHRT. Mr. Speaker, I rise today to express my opposition to both the rule and to the massive government takeover of health care that is before us today. There are a large number of issues that I could raise, but right now, I would like to focus on one of the most blatant examples of disregard for the will of the American people found within this bill. The bill includes abortions paid for by federal dollars.

For more than 30 years, the United States federal government has not been in the business of providing funding for abortion. Since 1976 the Hyde amendment has struck a delicate, but respectful balance between those who support abortion and those who do not. While it does not make abortion illegal, it protects those who oppose abortion from being forced to support it with their taxpayer dollars.

This is a fair compromise that should be included in the H.R. 3962.

Public opinion is clear on this issue. A number of polls have been conducted in the last couple of months showing Americans do not support federal funding of abortion. A Rasmussen Reports poll from September found that only 13 percent of Americans support abortion coverage by government-backed health insurance. A Public Option Strategies poll from September found that only 8 percent of Americans would be more likely to support a health care bill if it included federal funding for abortions. A whopping two-thirds of Americans oppose using federal dollars to pay for abortions, according to the September InterNational Communications Research poll. This is every other aspect of this health care bill—the American people do not want it, but Democrat leadership is attempting to ram it down our throats anyway.

This is why I support the Stupak-Pitts amendment. Their amendment would extend the same restrictions found in the Hyde amendment to cover this bill as well. It does not outlaw or prohibit abortion, or restrict those who wish to have an abortion from seeking one. But it does prevent federal dollars from being used to pay for those abortions.

I am pleased that we will be allowed to debate the Stupak-Pitts amendment, even without assurance that should it pass, the House would retain the language in conference, and
I hope that my colleagues vote in favor of the amendment. The Republican bill clearly states that abortions will not be paid for with taxpayer dollars. I urge my colleagues to vote for the Republican bill and against H.R. 3962.

Mr. ENGEL. Mr. Speaker, I rise in strong support of the Affordable Health Care for All Americans Act. In my 21 year career, this is by far one of the most important votes I will take. I have spent the past ten months meeting with the people of Bronx, Rockland and Westchester Counties and have had heartbreakingly many conversations with me about the inadequacies of healthcare.

On this historic day, our Congress honors our country, honors our citizens, and honors our moral imperative to provide all Americans with comprehensive, affordable access to quality health care.

This is the reason so many of us get up day after day after day. It is the reason why so many of us sought public office, and it is the reason why our constituents sent us to Congress—to right the wrongs of our broken healthcare system and steer our country back in the right direction.

Never again will families worry late into the night over whether their pre-existing medical conditions will prevent their loved ones from getting access to health care coverage they so desperately need.

Never again will insurance companies be allowed to drop coverage for those who have paid their premiums diligently, only to lose it when they get sick and need it most.

Never again will families have to worry that if they lose their jobs, they will also lose their healthcare coverage.

The underlying bill provides comprehensive reform for our nation’s healthcare system and puts our nation back on the road to fiscal responsibility by reducing the deficit by $30 billion in the first 10 years.

Regardless of who you are, or where you live, this bill provides significant benefits to all citizens.

If you have health insurance, you can keep your doctor and your health plan. You like it, you keep it. It’s that simple.

But for those that don’t have health insurance, it is a different story. Of the 46 million Americans that are uninsured, 85 percent of them are in working families. Millions of Americans desperately want to purchase health insurance and can’t. They’ve been priced out of a basic desire to keep them and their families healthy. 53 percent of Americans postpone care or medication because of cost.

60 percent of bankruptcies were related to medical debt. It’s unfair, unsustainable and un-American to allow this failed health care system to continue.

Insurance companies have a chokehold on the market and we are breaking through that today. If you don’t have health insurance, or lose your health insurance, the new health insurance exchange will provide a one stop comparison shopping market place for you of private health insurance or a new public health insurance option.

While in my heart of hearts I believe a single payer system would be the best reform of our nation’s health care, I have worked tirelessly over the last year to enact a strong public option. The public option included in the bill will undoubtedly inject competition into the market for better prices and coverage of quality health insurance.

No longer will women be considered second class citizens when it comes to healthcare coverage. H.R. 3962 supports women’s health care by ending the designation of pregnancy, domestic violence and caesarean sections as pre-existing conditions, and eliminating out-of-pocket expenses for preventive services including mammograms, baby and well-child care visits. It also prohibits plans from charging women more for health coverage than men, and guarantees coverage for maternity care.

H.R. 3962 invests in Medicare. Our seniors will see improved benefits, free preventive care, better primary care and lower drug costs. The donut hole, in which seniors pay monthly premiums for drug coverage without a drug benefit, will finally be closed. I have been fighting for this since the day we enacted the Medicare Prescription drug benefit.

Young adults will have more access to affordable healthcare than ever before. Our bill allows adults to stay on their parents’ healthcare plans until their 27th birthday. This measure alone will cover one out of three uninsured young adults.

Additionally, small business owners will be granted access to affordable large group rates in the new insurance exchange and tax credits to help businesses insure employees across the 17th district and our nation. I met with the Rockland Small Business Association this summer and fought to make health insurance reform workable for small businesses. 98.8 percent of small business owners will pay no surcharge and 86 percent of America’s businesses are exempt from the shared responsibility requirement. In fact, businesses with payrolls of $500,000 or below are completely exempt from provisions in H.R. 3962.

Throughout this year, and in my role as the Senior New Yorker on the Energy & Commerce health subcommittee, I have worked hand and hand with Chairmen WAXMAN, RANGEL, MILLER, Majority Leader HOYER and Speaker PELOSI to improve the underlying bill for New York State and people nationwide.

Here are just a few of the provisions I was successful in including in the underlying bill. I am proud to have reformed the Medicaid program to serve people with HIV. Under current Medicaid rules, low-income people with HIV must wait until they are disabled by AIDS before they can get covered by Medicaid. In the House bill, states could cover all people with HIV infection under state disability income and resource levels until January 1, 2013, when the new health insurance exchange is operational, at an enhanced federal match.

I worked to protect the ability of eight states, including NY, to finance Short Term Health care programs in Medicaid. These community-based long term care programs provide comprehensive health care services in day settings.

Beneficiaries are given nursing, case management, clinical management, medical, diagnostic, social, rehabilitative, recreational and personal care services on a routine, daily basis.

Since my time in the New York State Assembly when I was the Chair of the Assembly Committee on Alcohol and Drug Abuse, I have been championing for mental health and substance abuse services. I worked to strengthen our capacity to serve people affected by these disorders through Federally Qualified Behavioral Health Centers. My provision will establish national standards of care for persons with serious mental illness and addiction disorders. Furthermore, new reporting and accountability standards for mental health care will better integrate its providers and services within the larger healthcare system.

Many people have a family member, or are friends with someone who has autism. I worked with Rep. DOYLE, the Co-Chairman of the Congressional Caucus on Autism on several provisions dear to me. We ensured that individuals with autism and their families understand that all people with autism are prohibited by including behavioral health treatments as part of the essential benefits package in the House health reform bill.

There is currently a shortage of appropriately-trained personnel who can assess, diagnose, treat and support patients with Autism Spectrum Disorders (ASD). These professionals require the most up-to-date practices to best care for those with autism and their families. And so we included a provision for the training for professionals working with children and adults with autism.

I advocated to improve the healthcare for maternity and newborn care in the Medicaid program. H.R. 3962 will extend important child health quality improvement provisions to traditionally covered people, families and newborns and other covered adults younger than age 65. As a result of my provision, the Secretary of Health & Human Services will collect data and make recommendations on improving care for these key populations.

Finally, I was tireless in my advocacy for the Disproportionate Share Hospital (DSH) program, which assists with the cost of caring for uninsured and underinsured people at hospitals. These payments ensure that hospitals are not in financial distress from serving low-income people.

We stand here as proud Americans determined and ready to transform a broken health care system into a model of care worldwide. The cost of inaction is too great. Today, we answer the call of history, and vote for health insurance reform for America. Our nation’s future depends on it.

Mr. SCOTT of Virginia. Mr. Speaker, all afternoon we have heard about the “freedom” to be uninsured. Seniors in my district do not want us to repeal government run Medicare so that they can enjoy a “freedom” to be uninsured, and those without insurance now do not view themselves as enjoying some “freedom”; they want insurance.

The Republican substitute responds to the comprehensive Affordable Health Care for America act with a bill that fails to reduce cost, fails to cover uninsured Americans, and it may study—but it does not help—those with pre-existing conditions. It does, however, attack innocent victims of medical malpractice.

One recent study showed that medical malpractice represents less than one-third of one percent of all health care costs. And yet the Republican substitute seeks to blame our broken health care insurance system on innocent victims of medical malpractice.

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For the victims, the bill limits the ability to hire a lawyer, complicates the lawsuit, shifts the costs of medical malpractice from the doctor to the victims’ own private insurance, and in some cases covers the injured victims to lose the right to sue before they even know they’ve been injured. I’d like to share some specific examples of the egregious provisions included in the Republican substitute.
Under the Republican substitute, a young child whose life is forever devastated by medical malpractice can lose all right to sue on his or her eighth birthday—long before he or she reaches legal age to make his or her own decision.

Under the Republican substitute, when two or more wrongdoers act together, and one of them is able to flee or put their assets out of reach, the innocent victim is left short, while the other wrongdoer is shielded from full responsibility. They call this the “fair share rule.” Under the Republican substitute, it is much more difficult for a medical malpractice victim to get a lawyer’s help to fight against the insurance companies, because the bill permits a court to reduce the fee paid to the victim’s lawyer—after the case has been fought and won. This provision penalizes victims with winning cases. One would think the purpose of this provision is to save the insurance carrier money and thereby reduce malpractice premiums; however, insurance carriers are not responsible for the victim’s lawyer’s fee. Insurance carriers are responsible for the defendant’s lawyer’s fees, so permitting a court to reduce the fee paid to defendant’s lawyers would actually save money and reduce premiums. The substitute does not allow that. This makes no sense. Under current practice, the victim’s lawyers already don’t get paid if the victim loses. They might not get paid even if the victim wins.

Under the Republican substitute, if the victim has health insurance that helps pay for the victim’s care while the victim is waiting for the wrongdoer to be held accountable, the wrongdoer can escape legal accountability for that part of the cost entirely. The wrongdoer gets to shift the cost onto the victim’s own health insurance. That’s the Republican approach to health insurance reform—saddling the victim’s insurer with the cost of someone else’s negligence, while letting the wrongdoer off the hook.

Under the Republican substitute, the only time punitive damages would ever be available is when the wrongdoer has maliciously injured the victim that is, when the wrongdoer has committed an intentional, sentient felony. Even then—even in cases of the most heinous violence imaginable—the Republican substitute caps punitive damages.

The Republican substitute is empty of any meaningful health insurance reform, and it is utterly callous to malpractice victims. None of these unfair provisions were passed during previous attempts when the Republicans controlled the House, the Senate and the White House, and they should not be passed now. The substitute should be defeated.

In contrast, my bill—the Affordable Health Care for America Act reduces the number of uninsured, increases accessibility of health care, controls skyrocketing costs, and addresses the denial of coverage based on pre-existing conditions. This legislation will put us on a new path where health care will be affordable and accessible to everyone at a luxury for some, and I am proud to support this historic health insurance reform legislation.

Ms. NORTON. Mr. Speaker, I support the Affordable Health Care for America Act because of the extraordinary step forward it brings to the nation and to my district, the District of Columbia. First, I took steps to assure that the Affordable Health Care for America Act we expect to pass tonight would treat the District equally with the 50 states (although it does not do so for the territories). Consequently, the bill will provide coverage for 14,000 uninsured D.C. residents and affordable credits to help up to 134,000 D.C. families pay for coverage; will improve employer-based coverage for 363,000 District residents by distance; will reduce malpractice premiums for all Americans, guarantees affordable coverage for patients with pre-existing conditions, protects seniors, Medicare benefits, includes no tax increases, empowers the doctor-patient relationship, and reduces the budget deficit.

I also want to point out that I offered five amendments to the healthcare bill, but none were made in order. The first amendment would have removed the onerous medical device tax from the bill and replaced it with unemployment stimulus funds. It made no sense to me that this bill taxes innovation and our medical device manufacturers. Using President Obama’s economic measuring stick, as many as 5.5 million jobs could be lost from the taxes in this bill.

The bill raises taxes on small businesses, individuals and medical devices like pace-makers and stents. Indeed, this bill would impose $729.5 billion in higher taxes. $135 billion in taxes will be levied on business. $20 billion in taxes will be levied on medical device manufacturers. Using President Obama’s economic measuring stick, as many as 5.5 million jobs could be lost from the taxes in this bill.

Mr. Speaker, in the bill before us there is no provision in this bill to allow small businesses to pool together, no protection for those who work in the community, at a massive cost of more than $1 trillion. And it’s important to note, that like nearly every other entitlement program, the costs from this bill will only skyrocket.

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Mr. Speaker, like many of my colleagues on both sides of the aisle, I believe that status quo in our nation’s health care is unacceptable. We need real reform in this country that will lower costs and keep health care decisions in the hands of patients and their doctors.

This bill would establish a new government run bureaucracy and a public-plan that will drastically expand the role of government into personal health care, costing more than $1 trillion. And its important to note, that like nearly every other entitlement program, the costs from this bill will only skyrocket.

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I am proud that the final version of this legislation includes numerous provisions I have long advocated for and worked with my colleagues to achieve. While the initial draft of the Affordable Health Care for America Act gradually closed the donut hole for Medicare prescription drug coverage over 15 years, I am pleased to have worked with the Speaker to successfully reduce the timeline in which this critical reform will take place. The donut hole will now begin to close immediately and will close completely by 2019, providing much needed assistance and relief to seniors starting in 2011.

Likewise, I am also pleased that the Affordable Health Care for America Act eliminates lifetime caps, provisions of many health insurance plans that limit the total dollars in benefits that the insurance plan will pay out over the lifetime of an enrollee in the plan. I authored a letter, signed by 23 of my colleagues, urging this lifesaving provision to become effective immediately. I am pleased that the elimination of lifetime caps on insurance has been made effective in 2010, so that none of the 25,000 individuals whose lifetime caps each year will die waiting for the provisions to take place.

A key aspect of this legislation that is of particular importance to me is the extension of the mental health parity protections established in law last year. As you may recall, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act. Not only are these protections extended to all plans in the Health Insurance Exchange, but mental health and substance use benefits are a part of the essential benefits package created by this legislation. For 67 percent of adults and 80 percent of children needing mental health care that do not receive it, this victory cannot be understated. I commend my colleagues and my fellow citizens for their leadership in recognizing that the health of the mind truly cannot be separated from the health of the body. Today marks a new day and a giant leap forward towards our transition from a “sick care” system to one which is preventive, collaborative, and patient-centered.

Along these lines, I have also worked closely with my colleagues to ensure that mental health care professionals have the tools that are needed to recognize mental health and substance use in their patients. This means ensuring that mental health and substance use education be required of all OBRA health and substance use screening tools, from a “sick care” system to one which is preventive, collaborative, and patient-centered.

I will continue to work with my colleagues to ensure that our health care professionals have the tools that are needed to recognize mental health and substance use in their patients. This means ensuring that mental health and substance use education be required of all health care professionals and integrated into the medical curricula, continuing medical education, and licensing examinations. It also includes addressing the drastic shortages of child and adolescent mental health professionals by providing loan forgiveness and matching grants to professionals to develop, expand, and improve training programs for professionals who serve children and adolescents. Language to this effect is included in
some of the Senate healthcare reform legislation, and I will work with my colleagues to ensure that these critical provisions are retained. Again, I commend my colleagues, the leadership, and my fellow Americans for their steadfast effort, diligence, and tremendous stewardship towards realizing the dreams of quality, affordable health care for all Americans.

Mr. SMITH of New Jersey. Mr. Speaker, like most Americans, I believe we urgently need health care reform that provides every American access to high-quality medical care. During the long and painful illnesses of both my parents, I had to fight with their health management organization to get them the care they deserved. Their HMO put my family through months of frustration and anguish. I know I’m not alone—tens of millions of Americans have gone through this as well. It’s not right, and it’s time to change that. Americans need more protection, power, and say in their health care programs, and they need us to reform the system to make it more affordable for everyone.

Regrettably, H.R. 3962, the bill before the House tonight, not only falls short, but it will make most people’s health care worse, and it will cost us all. For this reason I strongly oppose the bill—H.R. 3962. After carefully studying H.R. 3962, I am concerned that the bill is actually a step backwards—many patients will have less, not more, access to and say over their health care if H.R. 3962 is enacted. I firmly believe, and must reform our health care system and provide better solutions for those currently uninsured or underinsured. But we must do so without jeopardizing the quality of health care for these currently insured people and families, not the people who will see their own health care access and quality seriously eroded under the bill.

H.R. 3962 will:

Limit patient access by establishing federal bureaucracies with new authority to determine what medical treatments and services will be covered at, what costs patients will pay—Americans will be so disadvantaged that this bill makes those who don’t purchase “acceptable” coverage (as defined by the federal government) subject to criminal fines and imprisonment up to 5 years.

Cause most Americans to lose access to their current health insurance coverage and force them into a nationally uniform public plan. It will do this by subsidizing a government-run “public plan” that will ultimately drive private health plans out of business. Most Americans don’t want to lose their current insurance, and they trust the public plan even less than they trust private insurance, which at least has to compete for customers, and permits those who lose their doctors. This would hit my constituents especially hard—according to the Urban Institute, approximately 90% of the people in my district currently have health coverage;

Slash payments to health-care providers, threatening the continued existence of many hospitals, home health and skilled nursing facilities serving New Jersey residents.

Madam Speaker, throughout my career in Congress, I have been a steadfast supporter of Medicare for our senior citizens and the disabled. I have fought several times to preserve and protect Medicare even when I stood alone in my own party rejecting a proposal to cut $270 billion from Medicare in 1995.

That is why I find it absolutely unacceptable that H.R. 3962 cuts Medicare by a whopping $500 billion. Proponents argue that some funding will be returned through other avenues. But even if that were true, Medicare will still be drastically cut by a net of $219.4 billion, in their “best case scenario.”

The bill also guts Medicare Advantage plans, which offer additional coverage to over 11 million seniors—15,983 in my district alone—who choose Medicare Advantage plans as the coverage that best meets their needs. I will not vote for massive cuts in Medicare. These cuts will wreak havoc on our nation’s health care system and everyone it serves, particularly the seniors and disabled. We need reform legislation that respects all human life, the most vulnerable among us which includes the frail and the disabled of all ages.

Finally, this bill will hinder economic recovery and job creation during a major recession. Just yesterday the nation’s unemployment rate rose above 10 percent for the first time since 1983, and if you include those who have stopped looking for jobs and those who only find part-time work, the rate is 17.5 percent. The bill does additional harm by:

Raising taxes on individuals and small businesses by $729.5 billion;

Failing to reform our costly and unfair system of medical malpractice lawsuits, which inflates health care costs by billions of dollars each year, exceeding 10% of all health care expenditures;

Mandating a $34 billion expansion of state Medicaid payments—in order to cover this massive increase in state spending, like New Jersey will have to cut other services; and

Costing the taxpayer, according to the Congressional Budget Office (CBO), $1.3 trillion over ten years and using budget gimmicks and tax increases to cover that cost.

I must mention two other serious problems with the bill:

It does not adequately protect the freedom of conscience of health care providers opposed to abortion, and sets up mechanisms that ration care by creating government “waist lists” if there are insufficient funds to pay expenses; and

It does not require patients to verify their identity, which, according to the CBO, means that millions undocumented immigrants will receive free health care, unfairly subsidized by taxpaying citizens.

It is truly unfortunate that the Democratic leadership did not work to put forth a health care reform bill that addressed these concerns. We need a proposal that advances solutions rather than creates new problems. Let me be clear, I take a back seat to no one when it comes to working to ensure that the federal government accepts its role and is doing its part in helping people and providing a health care safety net for those in desperate need of health care support. I am proud of my record, voting to defeat cuts to and expand existing federal health care programs, while working to protect patient rights and the delivery of quality medical care. These efforts include:

Medicare/Medicaid/SCHIP. I support providing our senior citizens a high level of benefits under the Medicare program. On one occasion, I voted against a $270 billion reduction in Medicare spending. One reason I cannot support the current health care legislation is because it makes over $500 billion in cuts to Medicare. To expand health insurance to more uninsured low-income children, I voted in 1997 for legislation creating the State Children’s Health Insurance Program (SCHIP) and voted last year to expand the program. SCHIP and Medicare/Medicaid together care for more than 16 million low-income children, as well as 16 million adults, 6 million seniors, and 10 million persons with disabilities. That is why I have been so adamant about protecting those programs.

Community Health Centers. Federally designated community health centers are another effective means to get affordable health care to underserved communities. The health centers program includes community, migrant, homeless, and public housing health centers and provides primary and preventive care to more than 18 million individuals at over 3,700 sites located in every state and U.S. territory. I have been a consistent supporter of increased funding for the community health centers program. A significant factor in the success of community health centers is that they are managed at the community level with a concern for serving their clients in their local neighborhoods.

Veterans Health Care. As former Chairman of the House Committee on Veterans’ Affairs, I fought successfully (and sometimes nearly alone) to provide increased medical services and funding for veterans health care programs. I wrote several laws to boost and expand veterans health care, including the Department of Veterans Affairs Health Care Programes Enhancement Act (PL 107–135), which expanded and enhanced veterans’ healthcare services and reduced out-of-pocket costs for low income veterans by 80 percent and continues to help disabled veterans obtain the tools they need to live fuller lives. I also wrote the law, the Veterans Health Programs Improvement Act of 2004 (PL 108–422), that created 5 poly-trauma centers within the VA, and an additional 17 networked sites, that specializes in treating complex injuries—including severe brain injury—associated with combat injuries from Iraq and Afghanistan.

Health Care Caucuses. Working with my colleagues across the aisle, I have co-founded and currently co-chair important bipartisan health care working groups, i.e. caucuses, which aim to educate Members of Congress and increase federal resources and research on treatments and cures for specific diseases, some which effect New Jersey residents disproportionately. For instance, I serve as co-chairman of the bipartisan Congressional Alzheimer’s Task Force; the Coalition for Autism Research and Education; the Spina Bifida Caucus; and the Lyme Disease Caucus. Each caucus has served as an effective forum to advance legislation that helps families combat health care challenges.

Patients Rights. As far back as 2001, I co-sponsored and voted for the Patient Protection Act which contained critical patient protections to help put doctors and patients back in control of their health care decisions, rather than bureaucrats at managed care companies. Unfortuante, while the bill passed the House and the Senate, they were never signed into law.

Insurance Reform. I voted for the Health Insurance Portability and Accountability Act of
One of the goals of responsible health care reform should be to provide credible health insurance coverage for everyone, strengthening the health care safety net so that no one is left out, and incentivizing quality and innovation, as well as healthy behaviors and prevention. This means that the current private health insurance market will have to be reformed to put patients first, and to eliminate denials for pre-existing conditions and lifetime caps and promoting portability between jobs and geographic areas, including across state lines.

While we have had some significant successes in these critical areas expanding—freqently after much toil—it is indisputable that more comprehensive changes are needed, including major reforms of the private health insurance market.

The goal of responsible health care reform should be to provide credible health insurance coverage for everyone, strengthening the health care safety net so that no one is left out, and incentivizing quality and innovation, as well as healthy behaviors and prevention. This means that the current private health insurance market will have to be reformed to put patients first, and to eliminate denials for pre-existing conditions and lifetime caps and promoting portability between jobs and geographic areas, including across state lines. The tax code should be modernized to promote affordability and individual control, provide assistance to low-income and middle-class families. Medicare requires reform to be more efficient and responsive, with sustainable payment rates.

Of course responsible health care reform will respect basic principles of justice: it will put patients and their doctors in charge of medical decisions, not insurance companies or government bureaucrats. It will also ensure that the lives and health of all persons are respected regardless of stage of development, age or disability.

The Republican alternative amendment does these things. It focuses on lowering health care premiums for families and small businesses, increasing access to affordable, high-quality care, and promoting healthier lifestyles—without increasing taxes or adding to the crushing debt Washington has placed on our children and grandchildren and without cutting Medicare. It also establishes a real conscience protection for health care providers and it requires verification of citizenship and identity.

I oppose H.R. 3962 because in many ways it jeopardizes coverage for those who already have it, especially seniors and the disabled. At the same time it exercises far too much top-down government control, forcing everyone to toward a government plan, controlling exactly what sort of care will be offered. For this reason I support the Republican alternative amendment. It moves significantly in the right direction while applying the wisdom of Hippocrates’ first principle of medicine: doing no harm.

SEC. 265. LIMITATION ON ABORTION FUNDING.
(a) In general.—No funds authorized or appropriated by this Act (or an amendment made by this Act) may be used to pay for any abortion or to cover any part of the costs of any health plan that includes coverage for abortion, except in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy itself, or unless the pregnancy is the result of an act of rape or incest.

(b) Option to Purchase Separate Supplemental Coverage or Plan.—Nothing in this section shall be construed as prohibiting any nonfederal entity (including an individual or a State or local government) from purchasing separate supplemental coverage for abortions for which funding is prohibited under this section, or a plan that includes such abortions, so long as—

(1) such coverage or plan is paid for entirely using only funds not authorized or appropriated by this Act; and

(2) such coverage or plan is not purchased using:

(A) individual premium payments required for a Exchange-participating health benefits plan towards which an affordability credit is applied; or

(B) other nonfederal funds required to receive a federal payment, including a State’s or locality’s contribution of Medicaid match funds.

(c) Option To Offer Separate Supplemental Coverage or Plan.—Notwithstanding section 303(b), nothing in this section shall restrict any nonfederal QHP offering entity from offering separate supplemental coverage for abortions for which funding is prohibited under this section, or a plan that includes such abortions, so long as—

(1) premiums for such separate supplemental coverage or plan are paid for entirely with funds not authorized or appropriated by this Act;

(2) administrative costs and all services offered through such supplemental coverage or plan are provided at premiums collected for such coverage or plan; and

(3) any nonfederal QHP offering entity that offers an Exchange-participating health benefits plan that includes coverage for abortions for which funding is prohibited under this section also offers an Exchange-participating health benefits plan that is identical in every respect except that it does not cover abortions for which funding is prohibited under this section.
language we have had since 1997. So I ask my colleagues, Democrats and Republicans alike, let us stand together on the principle of no public funding for abortion, no public funding for insurance policies that pay for abortion. Stand with us, protect our role, and let’s keep current law. I reserve the balance of my time.

Ms. DeGETTE. Mr. Speaker, I rise to claim the time in opposition to the Stupak-Pitts amendment.

The SPEAKER pro tempore. The gentleman from Colorado is recognized for 10 minutes.

Ms. DeGETTE. I yield myself 3 minutes, Mr. Speaker.

Mr. Speaker, to say that this amendment is a wolf in sheep’s clothing would be the understatement of a lifetime. The proponents say it simply extends the Hyde amendment, just a clarification of current law. Nothing could be further from the truth.

If enacted, this amendment will be the greatest restriction of a woman’s right to choose to pass in our careers. The base bill contains language we have had since 1997. So I urge my colleagues to stand with the majority of Americans, to oppose establishing a Federal Government program that will directly fund abortion on demand, to keep the government out of the business of promoting abortion as health care, and support this amendment.

I reserve the balance of my time.

Ms. DeGETTE. I yield 1 minute to the distinguished gentlelady from Connecticut (Ms. DeLAURO).

Ms. DeLAURO. This amendment undermines the thoughtfully crafted and balanced language in the bill that already prohibits Federal funds from being used to pay for abortion. It attempts an unprecedented overreach of Government out of the business of pro-life legislation consistent with the majority of the American people.

The best vote for life we could make today would be to pass the critical reforms in the GROIA to stop Federal dollars from funding for abortions consistent with supporting health care reform legislation consistent with the principles of the Hyde amendment, which will keep in place all other Federal health care programs, including Medicaid, Medicare, SCHIP, and veterans care. It prohibits Federal funding for abortions consistent with legislation that has been in place since the 1970s. It is ironic, actually, because most of the people who support the amendment claim to oppose government interference in health care, yet this amendment is government interference and a decision that should be made between a woman and her physician.

If this amendment passes, it will be the most morally offensive legislation that actually restricts coverage of a legal medical procedure. Not one other legal medical procedure is singled out in this legislation for rationing.

I urge my colleagues to vote “no” on this devastating amendment.

Mr. PITTS. Mr. Speaker, I yield 30 seconds to the gentleman from Indiana, Chairman Mike Pence.

Mr. PENCE. Mr. Speaker, I rise in strong opposition to this amendment. Most of the people who support the amendment do not spend one Federal dollar on abortions. This Stupak-Pitts amendment goes much further. It says that as part of their basic coverage, the public option cannot offer abortions to anyone, even those purchasing the policies with 100 percent private money. The amendment further says that anyone who purchases insurance in the exchange and who receives premium assistance cannot get insurance coverage for a legal medical procedure even with the portion of their premium that is their own private money.

Well, the proponents say women can just purchase supplemental insurance for abortions. This very notion is offensive to women. No one thinks that women will have an unplanned pregnancy or a planned pregnancy that goes wrong. Would we expect to have people buy supplemental insurance for cancer treatment just in case maybe they might get sick? Like it or not, this is a legal medical procedure, and we should respect those who need to make this very personal decision.

Once again, the base bill contains language that preserves the Hyde amendment. Let’s keep our eyes on the goal here, providing safe medical treatment for 36 million Americans. Let’s not sacrifice reproductive rights today in pursuit of another goal. I reserve the balance of my time.

Mr. PITTS. Mr. Speaker, I yield myself 1 1/2 minutes.

I rise in support of this bipartisan amendment. Polls have repeatedly shown that the public does not support Federal funding of abortion, yet that is exactly what is in this bill. Current law actually prohibits many Federal health care plans from paying for abortion. It also prevents taxpayer subsidies from flowing to benefit packages that include abortion. However, the Stupak amendment included in this legislation would have the opposite effect. Under this option, funds will flow from premium payments and affordability credits into the U.S. Treasury account, and that account will then reimburse for abortion services. Every dollar in the public option is a Federal dollar. Let me be clear, if the government plan covers abortion, that amounts to Federal funding for abortion. It’s that simple.

Our amendment would maintain the principles of the Hyde amendment, something that the large majority of Americans support.

I urge my colleagues to stand with the majority of American people, to oppose establishing a Federal Government program that will directly fund abortion on demand, to keep the government out of the business of promoting abortion as health care, and support this amendment.

I reserve the balance of my time.

Ms. DeGETTE. I yield 1 minute to the distinguished gentlelady from Connecticut (Ms. DeLAURO).

Ms. DeLAURO. This amendment undermines the thoughtfully crafted and balanced language in the bill that already prohibits Federal funds from being used to pay for abortion. It attempts an unprecedented overreach of Government out of the business of promoting abortion as health care, and support this amendment.

I reserve the balance of my time.

Mrs. DAHLKEMPER. Mr. Speaker, I rise in support of this bipartisan amendment which will keep in place current Federal law on abortion funding in H.R. 3962, the Affordable Health Care for America Act.

Mr. Speaker, our amendment does not change current law regarding abortion. It does not prohibit women from making a choice to which they are entitled under the law. What this amendment does do is make the House’s health care reform legislation consistent with other Federal health care programs, including Medicaid, Medicare, SCHIP, and veterans care. It prohibits Federal funding for abortions consistent with legislation that has been in place since the 1970s.

Ms. DeGETTE. I am now delighted to yield 1 minute to the gentlelady from California (Mrs. CAPPS).

Mrs. CAPPS. Mr. Speaker, I rise in strong opposition to this amendment. Contrary to what its sponsors and their supporters say, the underlying bill does prohibit Federal funding for abortion. It is written clearly and plainly on page 246, line 11, “prohibition of use of public funds for abortion coverage.” But apparently that isn’t good enough for people whose goal really is to strip women of their right to choose altogether despite purporting to just want to maintain the status quo. So instead we have this amendment which restricts a woman’s right to access a legal medical procedure in this country.

It is ironic, actually, because most of the people who support the amendment claim to oppose government interference in health care, yet this amendment is government interference and a decision that should be made between a woman and her physician.

If this amendment passes, it will be the most morally offensive legislation that actually restricts coverage of a legal medical procedure. Not one other legal medical procedure is singled out in this legislation for rationing.

I urge my colleagues to vote “no” on this devastating amendment.

Mr. STUPAK. Mr. Speaker. I yield 45 seconds to the gentleman from Pennsylvania, Mrs. DAHLEKEMPER from Pennsylvania to speak on the bill. She has been a stalwart on this issue, and I appreciate her support on this issue.
I urge my colleagues to prevent Federal dollars from funding abortions. Take a stand for life, support the Stupak-Pitts amendment, and vote “no” on Pelosi's health care.  

Ms. DEGETTE. I yield 1 minute to the distinguished gentlelady from New York (Mrs. LOWEY).  

Mrs. LOWEY. I rise in strong opposition to this amendment. This is a disappointing distraction from the bill before us.  

Under current law, no taxpayer funds can be used to cover abortion. While I believe abortion should be legal and safe, I have worked for years with colleagues on both sides of this issue to make this procedure rare. If we want to reduce abortions, we should provide women health coverage for reproductive care, contraceptive to prevent unintended pregnancies, and prenatal care to ensure healthy pregnancies.  

This amendment threatens the rights and health of women to seek a legal procedure covered by the premiums they will pay out from their own pocket. The underlying bill would uphold current law which states that no Federal funds can support abortion. Therefore, I urge my colleagues to oppose this unnecessary and reprehensible amendment.  

Mr. STUPAK. Mr. Speaker, may I inquire as to how much time we have remaining?  

The SPEAKER pro tempore. The gentleman from Michigan has 2 1/4 minutes remaining. The underlying bill would uphold current law which states that no Federal funds can support abortion. Therefore, I urge my colleagues to oppose this unnecessary and reprehensible amendment.  

Mr. STUPAK. Mr. Speaker, I am delighted to yield 1 minute to the gentlelady from California (Ms. LEE).  

Ms. LEE of California. Mr. Speaker, this amendment inserts the Federal Government into the medical decisions that a woman makes with her doctor.  

As a person of faith who was raised in the Catholic Church, I have the deepest respect for Mr. STUPAK and Mr. PITTS. I know personally the moral dilemmas women face in making personal decisions about abortion, but I’ll tell you one thing, I remember the days of back alley abortions, and this amendment takes us one step back to those dark days.  

This amendment goes way beyond the Hyde amendment that denies Federal funds for abortion and attempts to dictate to women how to spend their own money. It is simply outrageous. It is outrageous. It further places the religious views, mind you, of some into our public policy. Again, we’re a democracy; we’re not a theocracy. The separation of church and state requires us as legislators to never cross this line and it allows personal religious views to be personal. We should not, as Members of Congress, compromise this separation. And low-income women especially will be hurt by this amendment. Reject it.  

Ms. DEGETTE. Mr. Speaker, at this time, I yield 30 seconds to the gentlelady from Washington, Vice Chairwoman CATHY MCMORRIS RODGERS.  

Ms. MCMORRIS RODGERS. Mr. Speaker, many have stood before me from both sides of the aisle to ensure that Federal taxpayer dollars do not fund abortion, whether it’s Medicaid, whether it’s the Federal Government’s own health program. Today, I stand to ensure that this policy is included in the health care bill that is being rammed through this Congress.  

If we are talking about health care reform for women and children, then protect their rights should start at the moment their life begins. Two-thirds of women recently polled representing all parties, races, and marital statuses object to government funding of abortion.  

I urge my colleagues to support this amendment.  

Mr. STUPAK. Mr. Speaker, I yield 1 minute to Mr. ELLSWORTH from Indiana, who has been a champion on this issue and has worked hard to get this amendment to where we are here today.  

Mr. ELLSWORTH. Thank you, Mr. STUPAK.  

Mr. Speaker, I rise today to urge the passage of this vital amendment. Since this debate started, my goal has been to ensure Federal taxpayer dollars are not used to pay for abortions and to provide Americans with pro-life options on this exchange. I have been proud to work with Mr. STUPAK and all my colleagues and the Catholic Bishops to make the goal a reality.  

Getting to this point has not been very easy, but today we’re on the brink of passing health care reform that honors and respects life at every stage, including the unborn. If this amendment passes today, I will support this bill.  

It is time to fix what’s broken in our health care system and begin to fulfill the promises we’ve made to Americans that we represent. That’s why I urge Members on both sides of the aisle to vote for this amendment.  

Ms. DEGETTE. Mr. Speaker, I am pleased to yield 1 minute to the distinguished gentleman from New York (Mr. NADLER).  

Mr. NADLER of New York. Mr. Speaker, I rise in opposition to the Stupak amendment. Despite significant efforts made by the underlying bill to level the playing field for women and to end discrimination against them in the health insurance market, this amendment adds a new discriminatory measure against women. Under this proposal, if a woman is of low or moderate income and receives tax credits to help her afford the premiums for a health insurance plan she purchases on the exchange, she cannot choose a plan that covers abortion services. And if she chooses the public option, she cannot receive abortion coverage at all, even if she receives no help of any kind and pays for the plan entirely by herself.  

The provision inserted in the underlying bill by our colleague, Representative CAPPS, extends the Hyde amendment in current law by ensuring that no Federal dollars can be used to fund abortions. That should be sufficient. This is a bill to extend health care to all Americans. It should not be used as a political football to try to change existing laws regarding abortion coverage.  

Mr. Speaker, I reiterate my opposition to this discriminatory amendment and ask my colleagues to vote “no.”  

Mr. RYAN of Wisconsin. Mr. Speaker, this amendment goes far beyond the Hyde amendment that denies Federal funds for abortion and attempts to dictate to women how to spend their own money. It is simply outrageous. It further places the religious views, mind you, of some into our public policy. Again, we’re a democracy; we’re not a theocracy. The separation of church and state requires us as legislators to never cross this line and it allows personal religious views to be personal. We should not, as Members of Congress, compromise this separation. And low-income women especially will be hurt by this amendment. Reject it.  

Ms. DEGETTE. Mr. Speaker, I am now pleased to yield 1 minute to the distinguished gentleman from New York (Mr. NADLER).  

Mr. Speaker, I rise in opposition to the Stupak amendment. Despite significant efforts made by the underlying bill to level the playing field for women and to end discrimination against them in the health insurance market, this amendment adds a new discriminatory measure against women. Under this proposal, if a woman is of low or moderate income and receives tax credits to help her afford the premiums for a health insurance plan she purchases on the exchange, she cannot choose a plan that covers abortion services. And if she chooses the public option, she cannot receive abortion coverage at all, even if she receives no help of any kind and pays for the plan entirely by herself.  

The provision inserted in the underlying bill by our colleague, Representative CAPPS, extends the Hyde amendment in current law by ensuring that no Federal dollars can be used to fund abortions. That should be sufficient. This is a bill to extend health care to all Americans. It should not be used as a political football to try to change existing laws regarding abortion coverage.  

Mr. Speaker, I reiterate my opposition to this discriminatory amendment and ask my colleagues to vote “no.”  

Mr. STUPAK. Mr. Speaker, I continue to reserve the balance of my time.

Ms. DEGETTE. Mr. Speaker, I continue to reserve the balance of my time.
Mr. PITTS. Mr. Speaker, I yield 30 seconds to the gentlewoman from Minnesota, MICHELE BACHMANN.

Mrs. BACHMANN. Mr. Speaker, it all begins with life and with protecting the most vulnerable among us, the unborn. Life is the watershed issue of our generation. How can one claim to call the destruction of innocent human life “health care”?

Orwellian statements aside, it is the duty of government to preserve and protect human life. If we do nothing else today other than choose life.

Ms. DEGETTE. I inquire of the Speaker as to the time remaining.

The SPEAKER pro tempore. The gentleman from Michigan has 1 1⁄4 minutes remaining. The gentleman from Pennsylvania has 2 minutes remaining.

Ms. DEGETTE. Mr. Speaker, I yield 30 seconds to the distinguished gentleman from Illinois (Mr. QUIGLEY).

Mr. QUIGLEY. Mr. Speaker, the health care reform that we are considering today makes a strong statement that everyone in this country deserves access to health care.

For over 8 months, this body has strived to overcome the health care inequities that affect our country, but this amendment disrupts that sense of equality. This amendment says that only women who can afford insurance deserve access to reproductive health care. This amendment says that women who have a little help paying for health care have to surrender their right to privacy.

This amendment will serve only to hurt low-income women, and it will restrict their ability to access reproductive health care. This amendment says that women who pay to keep their money cannot afford to buy their own insurance and pay for their own health care.

I urge my colleagues to oppose this amendment.

Ms. SCHAKOWSKY. No matter how many times it is said, our health reforms does not allow one Federal dollar for abortions.

This Stupak-Pitts amendment would make abortion coverage virtually inaccessible for most women in the new exchange. It does so by:

(1) Banning abortion coverage in the exchange for women who receive subsidies, except by separate rider that they could only purchase with their own, private funds.

(2) Making it highly unlikely that women buying insurance in the exchange with their own money could obtain abortion coverage.

It is an outrage that at time when we are making historic changes—expanding America's access to health care—a group of legislators are bonding together to deprive women of the very health care they both need and deserve.

Ms. DEGETTE. Mr. Speaker, I yield for a unanimous consent request to the distinguished gentlewoman from New York (Mrs. MALONEY).

(Mrs. MALONEY asked and was given permission to revise and extend her remarks.)

Mrs. MALONEY. Mr. Speaker, I rise in strong opposition to the Stupak/Pitts amendment which plainly discriminates against women, puts women's health at risk, and marks an unprecedented restriction on people who pay for their own health insurance.

The commonsense Capps Compromise which was agreed to during debate in the Energy and Commerce Committee ensures that taxpayers will not be paying for abortion and respects the status quo and consensus.

It prohibits federal funds from being used for abortion but still allows women to use their own money to buy the coverage they need.

Despite this effort to address concerns raised by pro-life Members, Representatives from my state voted against Senator Stupak and Mr. Pitts decided to further restrict women's access to care by offering their shortsighted, dangerous, and discriminatory amendment to H.R. 3962.

The Stupak/Pitts amendment would make abortion coverage virtually inaccessible for most women in the new exchange. It does so by:

(1) Banning abortion coverage in the exchange for women who receive subsidies, except by separate rider that they could only purchase with their own, private funds.

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It is an outrage that at time when we are making historic changes—expanding America's access to health care—a group of legislators are bonding together to deprive women of the very health care they both need and deserve.

Ms. DEGETTE. Mr. Speaker, I yield for a unanimous consent request to the distinguished gentlewoman from New York (Ms. SCHAKOWSKY).

Ms. SCHAKOWSKY. No matter how many times it is said, our health reforms does not allow one Federal dollar for abortions.

This Stupak-Pitts amendment goes way beyond current law. It says a
woman cannot purchase, using her own dollars, coverage that includes abortion services. Even middle class women who are using exclusively their own money will be prohibited from purchasing a plan including abortion coverage, and this is in every single public or private plan in the new health care exchange. Her only option is to buy a separate insurance policy that covers an abortion, a ridiculous and unworkable approach since no woman plans an unplanned pregnancy. The amendment is a radical departure from current law, and it will result in millions of women losing the coverage they already have. Our bill is about lowering health care costs for millions of women and their families. It is not about further marginalizing women by forcing them to pay more for their care.

This amendment is a disservice and an insult to millions of women throughout the country. I urge a “no” vote on this amendment.

The SPEAKER pro tempore. The Chair will remind the gentlewoman from Colorado that she has the right to close.

The gentleman from Michigan has 1½ minutes remaining. The gentleman from Pennsylvania has 1½ minutes remaining. The gentlewoman from Colorado has 30 seconds remaining.

Mr. STUPAK. Mr. Speaker, I yield 15 seconds to the gentleman from Illinois (Mr. LIPINSKI), to state how current laws are maintained with the Stupak amendment.

Mr. LIPINSKI. Mr. Speaker, I thank my colleagues, especially Mr. STUPAK, for their perseverance as we work together on this amendment. Every year for over three decades, including this past July, we have approved the Hyde amendment.

I ask my colleagues again tonight: do the same thing, and approve the Hyde amendment.

Ms. DEGETTE. Mr. Speaker, I reserve the balance of my time.

Mr. PITTS. Mr. Speaker, I yield to the gentleman from Texas (Mr. GOHMERT) for a unanimous consent request.

(Mr. GOHMERT asked and was given permission to revise and extend his remarks.)

Mr. GOHMERT. Mr. Speaker, I rise in support of the wonderful work in the Stupak amendment, addressing things like the money on page 110 for abortions.

Mr. PITTS. Mr. Speaker, I yield the balance of the time to the Chair of the Pro-Life Caucus in support of this bipartisan amendment, the gentleman from New Jersey, Chris SMITH.

Mr. SMITH of New Jersey. This week, another Planned Parenthood clinic director resigned after watching an ultrasound of an actual abortion in progress.

Self-described as extremely pro-choice but now pro-life, Abby Johnson said she watched an unborn child ‘crumple’ before her very eyes as the infant was vacuumed and dismembered by a suction device 20 to 30 times more powerful than a household vacuum cleaner.

Ms. Johnson said and told ABC News, “I could see the baby try to move away... I just thought, ‘What am I doing?’ ‘Never again.’”

Mr. Speaker, abortion not only kills children; it harms women physically and psychologically, and it risks significant harm to subsequent children.

Recently, the Times of London reported, “Women who have had abortions have twice the level of psychological problems and three times the level of depression as women who have given birth or never been pregnant.” The Times said “senior obstetricians and psychiatrists say new evidence has uncovered a clear link between abortion and mental illness. . . .”

Numerous studies show that the risk of preterm birth to children born to women who have had abortions increases. It skyrocketed. One abortion preterm birth goes up by 35 percent, two abortions a staggering 93 percent. One of the leading causes of mental and motor retardation is prematurity.

We have and are going to have more disabilities. If we truly don’t want to see more abortions and if we want to reduce them, don’t fund it.

The Guttmacher Institute has said, formerly the research arm of Planned Parenthood, that prohibiting Federal funds for abortion reduces abortion by 25 percent.

Millions of people are alive today because of the Hyde amendment, because funding was not there to effectuate their demise. Vote for the Stupak-Pitts amendment. It will save lives.

The SPEAKER pro tempore. The gentleman from Michigan has 1 minute remaining.

Mr. STUPAK. Mr. Speaker, to close on this side, I yield 1 minute to the gentlewoman from Ohio (Ms. KAPTUR).

Ms. KAPTUR. I thank the gentleman.

With respect for all of my colleagues, I rise in support of the Stupak amendment, which maintains existing Federal law, the Hyde amendment, on the compelling issue of abortion.

For 34 years, citizens of conscience have weighed in on this important moral and legal issue. Let me repeat: This amendment reaffirms long-standing existing law and nothing more. It represents the broad consensus of the American people after 34 years of consideration on this issue. This is what it says:

“No Federal funds ‘authorized under this act may be used to pay for any abortion or cover any part of the costs of any health plan that includes coverage of abortion,’ except in the cases of the life of the mother, rape or incest.”

The amendment does no more, no less. It is similar to language that applies in Federal law on Medicaid, Medicare, Veterans Affairs, the CHIP program, and the Federal Health Employment Service Program, which is a model for how this language should be applied. It has been tried, tested and proven. The inclusion of this amendment clarifies the bill’s language on the potential fungibility of premium dollars.

I urge my colleagues to support the amendment and the bill.

Ms. DEGETTE. Mr. Speaker, I yield for a unanimous consent request to the gentlewoman from California (Mrs. Davis).

(Mrs. DAVIS of California asked and was given permission to revise and extend her remarks.)

Ms. DAVIS of California. Mr. Speaker, I rise in opposition to this amendment.

Ms. DEGETTE. Mr. Speaker, I yield for a unanimous consent request to the gentlewoman from Texas (Ms. JACKSON-LEE).

(Ms. JACKSON-LEE of Texas asked and was given permission to revise and extend her remarks.)

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise in strong opposition to this amendment.

This amendment critically threatens women throughout America, and is unquestionably a ban on abortion coverage. H.R. 3962 already provided for no federal dollars to be used for abortion—now this bill denies women the reimbursement for insurance to provide them good health care.

This amendment acutely threatens the personal liberties of our country’s most vulnerable women. It negatively affects these women’s health and wellbeing, and financial security. This amendment will disproportionately affect women of color. According to the Center for Disease Control, “the abortion ratio for black women (467 per 1,000 live births) was 2.9 times the ratio for white women (158 per 1,000), and the ratio for women of the heterogeneous “other” race category (319 per 1,000) was 2.0 times the ratio for white women. The abortion rate for black women (28 per 1,000 women) was 3.1 times the rate for white women (nine per 1,000), whereas the abortion rate for women of this race was 18 per 1,000 women) was 2.0 times the rate for white women.” We should not be so naïve to believe that these statistics represent anything less than the reality that minority women have less financial and personal autonomy. Women who decide to abort a pregnancy are not acting on whim or caprice. Rather, the decision to abort is a painful decision process borne out of necessity. I do not support these higher statistics among minority women, however their lives should not be jeopardized because of botched abortions. Each woman of faith who value the value of life of abortion is very dear to me. I must begin by saying that I am not pro-abortion, I am pro-choice. The early termination of a fetus is a terribly sad and unfortunate event, and the decision to abort is a long and difficult one. Situations arise in which a woman is forced to make the very tough decision about something very private and personal. In situations like this I believe strongly in a woman’s right to choose. It is her body and any law prohibiting women from having total control over their bodies is in violation of our constitutional rights.

I have always supported a woman’s right to choose. The decision to have a baby is something between a woman, her family, her faith
and her doctor. This is an instance where the federal government does not need to be involved. It is my hope that society will continue to be progressive in their decisions, and if a woman decides to terminate her pregnancy, there are places that she can go to have the procedure done safely, with no discrimination and with a reasonable fee.

The Supreme Court in 1973, in the landmark case of Roe v. Wade, ruled that a woman’s right to have an abortion is a constitutionally protected right. Judge Blackmun wrote that “a statute that criminalizes abortion is violative of the Due Process Clause of the Fourteenth Amendment and the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman’s attending physician.”

The Stupak-Pitts amendment effectively reverses a woman’s control over her body. According to a 2002 study by the Guttmacher Institute, 90 percent of private policies currently cover abortion services. If this amendment is adopted, it will instantly modify the insurance coverage for the millions of women whose current insurance plans include coverage for abortion. These women entered into their insurance contracts with the guarantee that potential abortions would be covered. Yet, if this amendment is passed, every women covered under the new health care system would have to purchase supplemental insurance or pay out of pocket. It is estimated that one third of Americans will have an abortion in their lifetime. If this amendment is adopted, thousands of women will be unable to afford a procedure for unpredictable and unwanted pregnancies. This would essentially be a ban on abortion for these women.

This is an unacceptable violation of a woman’s personal sovereignty. I strongly oppose this amendment.

Ms. DEGETTE. Mr. Speaker, the gentleman from Pennsylvania said exactly what the intention is here. The intention is not simply to expand the Hyde amendment. The base bill does that. The base bill says that no Federal funds will be used in this bill for abortion.

It is the intention of our opponents to effectively stop a legal medical procedure from all plans that are in the exchange, even plans that are paid for with private dollars. This is the first time it would expand the Hyde exception to the private sector market. Mr. Speaker, it would not only affect the poor. It would affect the middle class.

Vote “no” on this ill-conceived amendment.

Ms. CHU. Mr. Speaker, I rise today in strong opposition to this amendment.

Ms. HIRANO. Mr. Speaker, I rise today in strong opposition to the Stupak Amendment, an amendment that is anti-choice and anti-women.

Earlier this week, I spoke about the importance of health care reform to women. If there was ever a group that has a lot at stake in reform, it is women. Health insurance companies today essentially treat being a woman as a pre-existing condition and charge them more for it. H.R. 3962 put an end to the unjustifiable insurance practices of gender-rating—treating women differently based on gender and previous c-section as pre-existing conditions—and not covering comprehensive maternity care. The men of this country would rise up in protest if they faced this kind of disparate treatment based on conditions particular to their gender.

The Stupak Amendment would effectively deny low-income women abortion coverage through insurance plans in the health insurance exchange. This is not discriminatory, but dangerous to women’s health. Women without abortion coverage will be forced to postpone abortion care while attempting to raise the necessary funds—a delay that can exacerbate both the costs and the health risks of the procedure.

As a woman, I find it frankly insulting that the amendment would make women purchase additional insurance coverage for a legal medical procedure. We aren’t asking individuals to purchase additional coverage in case they get cancer or in case they get diabetes. We aren’t flagging out any other legal medical procedures to be treated in this manner.

Women do not plan to have unintended pregnancies or pregnancies with complications that limit their access to abortion. Legal and safe abortions are procedures to be treated in this manner. The sponsors of the amendment have consistently failed to highlight that the bill already contains a compromise that stipulates that state laws regarding abortion procedures are not pre-empted. The bill already states that no federal funds—neither tax nor cost sharing tax credits—can be used to pay for abortion procedures.

Before taking this vote, I urge my colleagues to support this amendment to think about the women in their lives, their mothers, sisters, daughters, granddaughters. Would they put the lives of these women at risk? Would they take away their fundamental rights of choice and freedom? Would they want to limit their access to the legal medical procedures? I ask these questions of my colleagues because in voting in support of the Stupak Amendment, they are answering yes to all these questions.

I urge my colleagues to join me in voting “no” on the amendment.

Ms. HARMAN. Mr. Speaker, It is going to be very difficult for me to vote for a health care bill that contains the Stupak amendment on abortion.

Far from codifying the Hyde language, which has been included in House appropriations bills since 1976, the Stupak amendment would essentially make it impossible for most women to use their own funds to purchase insurance to pay for abortions. This is not chipping away at a woman’s right to choose; this is an outright assault on my constitutional rights—and it is wrong.

I respect the right of any woman or man to oppose abortion. But, in return, I expect those who are anti-choice to respect my views. My views are that abortion is safe and rare—but that a woman’s constitutional right to privacy as articulated in Roe v. Wade is inviolable.

I am old enough to remember the days of back alley abortions. Some women I know had them. I cannot bear the idea that the 111th Congress would restore that horror.

The Stupak Amendment is insulting and destructive. Its passage would pair us with the government of Afghanistan in sending women’s rights back to the Stone Age. I intend to vote for this bill, but if it contains the Stupak amendment when it emerges from Conference Committee, my conscience demands that I reconsider my support.

Ms. McCOLLUM. Mr. Speaker, every member of this House has the right to their own opinions and views on issues related to health care reform—including women’s reproductive health care issues. However, as comprehen- sionists, we do not believe that only the House floor for a vote, Congress must not violate the first tenant of the entire reform effort, which is to ensure that no one loses healthcare coverage they currently have.

Today we have an amendment on the floor that bans federal reimbursement of health care services for women who pay for their own health insurance. This amendment is wrong, it is dangerous, and it should be defeated.

The opportunity to meet the health care needs of all Americans is the strength of the bill we are debating. I want every American to have access to affordable, quality health care. This amendment and the work of many special interest groups to use this amendment to undermine health care reform is a transparent political game that puts Americans at risk. Single issue political games must not be used to deny health care to millions of Americans.

I would like to submit for the RECORD a statement by a broad coalition of Minnesota religious leaders who call health care reform a matter of social justice that should not be undone by a single issue. These religious leaders understand the complex personal decision making that goes into health care choices, but they also know that Americans without access to comprehensive health care are at risk. All single issue games must not be used to deny health care to millions of Americans.

Ms. HARMAN. Mr. Speaker, I rise today in strong opposition to this amendment.

Ms. HARMAN. I am old enough to remember the days of back alley abortions. Some women I know had them. I cannot bear the idea that the 111th Congress would restore that horror.

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Today we have an amendment on the floor that bans federal reimbursement of health care services for women who pay for their own health insurance. This amendment is wrong, it is dangerous, and it should be defeated.

These religious leaders are an inspiration to me. They are helping to frame the social, economic, moral and spiritual importance of passing health care reform legislation in Congress.

November 7, 2009.

As more Americans lose jobs and insurance coverage, health care reform is becoming a mov- ing to final votes in Congress. Instead of working toward the reform that is so desperately needed, some groups, including the United States Conference of Catholic Bishops, are working overtime to ensure that women are denied the comprehensive health care they currently have.

With all the hyperbole, we have lost sight of the original goal of health reform: to ex- pand access to health care, improve quality, and reduce costs—specifically reproductive health care costs.

Our faith traditions are abundantly clear about living in community with others and being responsible for them. Our traditions share the common core of serving those most in need. We join with others in expressing the need for us to return to the core of our faith traditions and realize that providing access to safe and quality health care makes sense morally, ethically, spiritually, and fi-

nancially.

The President has repeatedly stated that no one should lose the coverage she or he currently has under health care reform. But, if dangerous amendments put forth by the vocal minority in Washington are not defeated, women will lose their benefits, plain and simple.
It's simply untrue that abortion coverage will be mandated under the proposed new health plan. Simply put, Federal money would not pay for abortion care.

In addition, the Stupak Amendment would allow women to keep the benefits they currently have, and it stops the current policy of restricting federal funding for abortions and ensures that women will have the benefits they have and will have access to insurance that covers abortion if they want it. Further, it expressly prohibits the use of federal funds to pay for abortions.

This is an even-handed compromise supported by people on both sides of the issue. While reasonable people disagree over the issue of abortion, no woman wants her health to be the object of political gamesmanship in this debate. That's why the Caps proposal was created. It's a common sense approach to health care reform that move forward with the support of the mainstream on all sides of the issue.

As a member of Congress, I support policies that are just and compassionate and prioritize the needs of those who are poor and marginalized in our society. In this religious congregation, our health care system should be inclusive and respectful of diverse religious beliefs and decisions regarding childbearing. A health care system that serves all persons with dignity and equality will include comprehensive reproductive health services.

Health care reform is far too important a social issue to be left to the overheated rhetoric. It's time to move forward for the good of American women and families.

Members and Friends of the Minnesota Religious Coalition for Reproductive Choice; Rev. Judith Allen Kim, Presbytery of the Twin Cities Area; The Rev. Norma Burton, Linden Hills United Church of Christ, Minneapolis; Kelli Clement, Candidate for Minnesota, UXU; Rev. Doug Donley, University Baptist Church, Minneapolis; Rev. Dr. Rob Eller-Isaacs, Co-Ministers, Unity Church Unitarian, St. Paul; Rev. Dr. Kendyl Gibbons, Sr. Minister, First Unitarian Society of Minneapolis; Rev. Dr. Dr. John Eller-Isaacs, Co-Ministers, Unity Church Unitarian, St. Paul; Rev. Dr. John Eller-Isaacs, Sr. Minister, First Unitarian Society of Minneapolis; Rev. Walter Eller-Isaacs, Walker Community United Methodist Church, Minneapolis; Rev. Meg Riley, Unitarian Universalist Association; Rev. T. Michael Rock, Robbinsdale United Church of Christ; Kviy Todd Roska, United Church of Christ in New Brighton; Rev. Dr. Dr. Kendyl Gibbons, Sr. Minister, First Unitarian Society of Minneapolis; Rev. Walter Eller-Isaacs, Walker Community United Methodist Church, Minneapolis; Rev. Meg Riley, Unitarian Universalist Association; Rev. T. Michael Rock, Robbinsdale United Church of Christ; Kviy Todd Roska, United Church of Christ in New Brighton; Rev. Dr. Dr. Kendyl Gibbons, Sr. Minister, First Unitarian Society of Minneapolis; Rev. Walter Eller-Isaacs, Walker Community United Methodist Church, Minneapolis; Rev. Meg Riley, Unitarian Universalist Association; Rev. T. Michael Rock, Robbinsdale United Church of Christ; Kviy Todd Roska, United Church of Christ in New Brighton; Rev. Dr. Dr. Kendyl Gibbons, Sr. Minister, First Unitarian Society of Minneapolis; Rev. Walter Eller-Isaacs, Walker Community United Methodist Church, Minneapolis; Rev. Meg Riley, Unitarian Universalist Association; Rev. T. Michael Rock, Robbinsdale United Church of Christ; Kviy Todd Roska, United Church of Christ in New Brighton; Rev. Dr. Dr. Kendyl Gibbons, Sr. Minister, First Unitarian Society of Minneapolis; Rev. Walter Eller-Isaacs, Walker Community United Methodist Church, Minneapolis; Rev. Meg Riley, Unitarian Universalist Association; Rev. T. Michael Rock, Robbinsdale United Church of Christ; Kviy Todd Roska, United Church of Christ in New Brighton; Rev. Dr. Dr. Kendyl Gibbons, Sr. Minister, First Unitarian Society of Minneapolis; Rev. Walter Eller-Isaacs, Walker Community United Methodist Church, Minneapolis; Rev. Meg Riley, Unitarian Universalist Association; Rev. T. Michael Rock, Robbinsdale United Church of Christ; Kviy Todd Roska, United Church of Christ in New Brighton; Rev. Dr. Dr. Kendyl Gibbons, Sr. Minister, First Unitarian Society of Minneapolis; Rev. Walter Eller-Isaacs, Walker Community United Methodist Church, Minneapolis; Rev. Meg Riley, Unitarian Universalist Association; Rev. T. Michael Rock, Robbinsdale United Church of Christ; Kviy Todd Roska, United Church of Christ in New Brighton; Rev. Dr. Dr. Kendyl Gibbons, Sr. Minister, First Unitarian Society of Minneapolis; Rev. Walter Eller-Isaacs, Walker Community United Methodist Church, Minneapolis; Rev. Meg Riley, Unitarian Universalist Association; Rev. T. Michael Rock, Robbinsdale United Church of Christ; Kviy Todd Roska, United Church of Christ in New Brighton; Rev. Dr. Dr. Kendyl Gibbons, Sr. Minister, First Unitarian Society of Minneapolis; Rev. Walter Eller-Isaacs, Walker Community United Methodist Church, Minneapolis; Rev. Meg Riley, Unitarian Universalist Association; Rev. T. Michael Rock, Robbinsdale United Church of Christ; Kviy Todd Roska, United Church of Christ in New Bright
DIVISION II—EXPANDING ACCESS TO HEALTH CARE

TITLE I—EXPANDING ACCESS AND LOWERING COSTS FOR SMALL BUSINESSES

Sec. 201. Rules governing association health plans.
Sec. 203. Enforcement provisions relating to association health plans.
Sec. 204. Cooperation between Federal and State authorities.
Sec. 205. Effective date and transitional and other provisions.

TITLE II—TARGETED EFFORTS TO EXPAND ACCESS

Sec. 211. Extending coverage of dependents.
Sec. 212. Allowing auto-enrollment for employees in sponsored coverage.

TITLE III—EXPANDING CHOICES BY ALLOWING AMERICANS TO BUY HEALTH CARE COVERAGE ACROSS STATE LINES

Sec. 221. Interstate purchasing of Health Insurance.

TITLE IV—EXPANDING HEALTH SAVINGS ACCOUNTS

Sec. 231. Saver’s credit for contributions to health savings accounts.
Sec. 232. Higher fund for premiums for high deductible health plans.
Sec. 233. Requiring greater coordination between HDHP administrators and HSA account administrators so that enrollees can enroll in both at the same time.
Sec. 234. Special rule for certain medical expenses incurred before the establishment of account.

DIVISION C—ENACTING REAL MEDICAL LIABILITY REFORM

Sec. 301. Encouraging speedy resolution of claims.
Sec. 302. Compensating patient injury.
Sec. 303. Maximizing patient recovery.
Sec. 304. Additional health benefits.
Sec. 305. Punitive damages.
Sec. 306. Authorization of payment of future damages to claimants in health care lawsuits.
Sec. 307. Definitions.
Sec. 308. Effect on other laws.
Sec. 309. State flexibility and protection of states’ rights.
Sec. 310. Applicability; effective date.

DIVISION D—PROTECTING THE DOCTOR-PATIENT RELATIONSHIP

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DIVISION E—INCENTIVIZING WELLNESS AND QUALITY IMPROVEMENTS

Sec. 501. Incentives for prevention and wellness programs.

DIVISION F—PROTECTING TAXPAYERS

Sec. 601. Provide full funding to HHS OIG and HCFA.
Sec. 602. Prohibiting taxpayer funded abortions and conscience protections.
Sec. 603. Improved enforcement of the Medicare and Medicaid secondary payer provisions.
Sec. 604. Strengthen Medicare provider enrollment standards and safeguards.
Sec. 605. Tracing banned providers across State lines.

DIVISION G—PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS

Sec. 701. Licensure pathway for biosimilar medicinal products.
Sec. 702. Fees relating to biosimilar biological products.
Sec. 703. Amendments to certain patent provisions.

DIVISION A—MAKING HEALTH CARE COVERAGE AFFORDABLE FOR EVERY AMERICAN

TITLE I—ENSURING COVERAGE FOR INDIVIDUALS WITH PREEXISTING CONDITIONS AND MULTIPLE HEALTH CARE NEEDS

SEC. 101. ESTABLISH UNIVERSAL ACCESS PROGRAMS TO IMPROVE HIGH RISK POOLS AND REINSURANCE MARKETS.

(a) STATE REQUIREMENTS.—
(1) IN GENERAL.—Not later than January 1, 2010, each State shall—
(A) subject to paragraph (3), operate—
(i) a qualified State reinsurance program described in subsection (b); and
(ii) qualifying State high risk pool described in subsection (c)(1); and

(b) QUALIFIED STATE REINSURANCE PROGRAM.—
(A) IN GENERAL.—(i) The pool described in subsection (b) must—

(c) QUALIFYING STATE HIGH RISK POOL.—

(D) PROVIDE COVERAGE.—
(1) IN GENERAL.—A qualifying State high risk pool described in paragraph (2) of this section means a current section 2745 qualified high risk pool that meets the following requirements:

(E) THE POOL MUST BE ALLOWED TO RECEIVE COVERAGE THROUGH THE POOL.

(F) THE POOL MUST ALLOW FOR COVERAGE OF INDIVIDUALS WHO ARE SEEKING COVERAGE THROUGH THE POOL.

(G) PROVIDE COVERAGE FOR PREVENTIVE SERVICES AND DISEASE MANAGEMENT FOR CHRONIC DISEASES.

(H) VERIFICATION OF CITIZENSHIP OR ALIEN QUALIFICATION.—

(I) CONDITION OF PARTICIPATION.—As a condition of a State receiving such funds, the Secretary shall require the State to certify, to the satisfaction of the Secretary, that such State requires all applicants for coverage in the qualifying State high risk pool to provide satisfactory documentation of citizenship or nationality in a manner consistent with section 1902(k) of the Social Security Act.

(J) RECORDS.—The Secretary shall keep such records and accumulating documentation of citizenship or nationality only has to be made once for any individual under this paragraph.

SEC. 206. RELATION TO SECTION 2745.—As of January 1, 2010, a pool shall not be treated as a qualified high risk pool under section 2745 of the Public Health Service Act unless the pool is a qualifying State high risk pool described in paragraph (1).

(K) WAIVERS.—In order to accommodate new and innovative programs, the Secretary may waive such requirements of this section for qualified State reinsurance programs and for qualifying State high risk pools as the Secretary deems appropriate.

(L) FUNDING.—In addition to any other amounts appropriated, there is appropriated—

(M) DEFINITIONS.—In this section:
(1) HEALTH INSURANCE COVERAGE; HEALTH INSURANCE ISSUER.—The terms “health insurance coverage” and “health insurance issuer” have the meanings given such terms in section 2791 of the Public Health Service Act.

(2) CURRENT SECTION 2745 QUALIFIED HIGH RISK POOL.—The term “current section 2745 qualified high risk pool” has the meaning given the term “qualified high risk pool” under section 2745(g) of the Public Health Service Act as in effect as of the date of the enactment of this Act.

(3) SECRETARY.—The term “Secretary” means Secretary of Health and Human Services.

(4) STANDARD RISK RATE.—The term “standard risk rate” means a rate that—

(A) is determined under the State high risk pool by considering the premium rates charged by other health insurance issuers offering health insurance coverage to individuals in the insurance market served;

(B) is established using reasonable actuarial techniques; and

(C) reflects anticipated claims experience and expenses for the coverage involved.

(5) STATE.—The term “State” means any of the 50 States or the District of Columbia.

SEC. 102. ELIMINATION OF CERTAIN REQUIREMENTS FOR GUARANTEED AVAILABILITY IN INDIVIDUAL MARKET.

(a) In General.—Section 2741(b) of the Public Health Service Act (42 U.S.C. 300gg–41(b)) is amended—

(1) in paragraph (1)—

(A) by striking “(1)(A)” and inserting “(1)”; and

(B) by striking “and (B)” and all that follows up to the semicolon at the end;

(2) by adding “and” at the end of paragraph (2);

(3) in paragraph (3)—

(A) by striking “(1)(A)” and inserting “(1)”; and

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

(4) by striking paragraphs (4) and (5).

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 103. NO ANNUAL OR LIFETIME SPENDING CAPS.

Notwithstanding any other provision of law, a health insurance issuer (including an entity licensed to sell insurance with respect to a State or group health plan) may not apply an annual or lifetime aggregate spending cap on any health insurance coverage or plan offered by such issuer.

SEC. 104. PREVENTING UNJUST CANCELLATION OF INSURANCE COVERAGE.

(a) Clarification Regarding Application of Guarantees of Individually Negotiated Health Insurance Coverage.—Section 2742 of the Public Health Service Act (42 U.S.C. 300gg–42) is amended—

(1) in its definition, by inserting “, continuing in force, including prohibition of rescission,” after “guaranteed renewable”;

(2) in subsection (a), by inserting “, including without rescission,” after “continue in force”; and

(3) in subsection (b)(2), by inserting before the period at the end the following: “, including intentional concealment of material facts regarding a health condition related to the condition for which coverage is being claimed.”

(b) Opportunity for Independent, External Third Party Review in Certain Cases.—Subpart I of part B of title XXVII of the Public Health Service Act is amended by adding at the end following new section:

SEC. 2746. OPPORTUNITY FOR INDEPENDENT, EXTERNAL THIRD PARTY REVIEW IN CERTAIN CASES.

“(a) NOTICE AND REVIEW RIGHT.—If a health insurance issuer determines that the coverage may be nonrenewed or not renewed, the issuer shall provide the individual with notice of such proposed nonrenewal, discontinuation, or rescission and an opportunity for a review of such determination by an independent, external third party under procedures specified by the Secretary.

“(b) INDEPENDENT DETERMINATION.—If the individual requests such review by an independent, external third party of a nonrenewal, discontinuation, or rescission of health insurance coverage, the coverage shall remain in effect until such third party determines that the coverage may be nonrenewed, discontinued, or rescinded under section 2742(b)(2).”.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply after the date of the enactment of this Act with respect to health insurance coverage issued before, on, or after

TITLE II—REDUCING HEALTH CARE PREMIUMS AND THE NUMBER OF UNINSURED AMERICANS

SEC. 111. STATE INNOVATION PROGRAMS.

(a) Paying the Cost of Health Insurance Premiums.—

(1) PAYMENTS TO STATES.—

(A) FOR PREMIUM REDUCTIONS IN THE SMALL GROUP MARKET.—If the Secretary determines that a State has reduced the average per capita premium for health insurance coverage in the small group market in year 3, in year 6, or in year 9 (as defined in subsection (c)) below the premium baseline for such year (as defined paragraph (2)), the Secretary shall pay the State an amount equal to the product of—

(i) bonus premium percentage (as defined in paragraph (3)) for the State, market, and year; and

(ii) the maximum State premium payment amount (as defined in paragraph (4)) for the State, market, and year.

(B) FOR PREMIUM REDUCTIONS IN THE INDIVIDUAL MARKET.—If the Secretary determines that a State has reduced the average per capita premium for health insurance coverage in the individual market in year 3, in year 6, or in year 9 below the premium baseline for such year, the Secretary shall pay the State an amount equal to the product of—

(i) bonus premium percentage (as defined in paragraph (3)) for the State, market, and year; and

(ii) the maximum State premium payment amount (as defined in paragraph (4)) for the State, market, and year.

(2) PREMIUM BASELINE.—For purposes of this subsection, the term “premium baseline” means a market in a State—

(A) for year 1, the average per capita premiums for health insurance coverage in such market in the State in such year; or

(B) for a subsequent year, the baseline for the market in the State for the previous year under this paragraph increased by a percentage specified in accordance with a formula established by the Secretary, in consultation with the Congressional Budget Office and the Bureau of the Census, that takes into account at least the following:

(i) GROWTH FACTOR.—The inflation in the costs of inputs to health care services in the year.

(ii) HISTORIC PREMIUM GROWTH RATES.—Historic growth rates, during the 10 years before year 1, of per capita premiums for health insurance coverage.

(iii) DEMOGRAPHIC CONSIDERATIONS.—Historic average changes in the demographics of the population covered that impact on the rate of growth of per capita health care costs.

(3) BONUS PREMIUM PERCENTAGE DEFINED.—

(A) IN GENERAL.—For purposes of this subsection, the term “bonus premium percentage” means, for the small group market or individual market in a State for a year, such percentage as determined in accordance with the following table based on the State’s premium performance level (as defined in subparagraph (B)(i)) for such market and year:

<table>
<thead>
<tr>
<th>Bonus Premium Percentage</th>
<th>For Year 3 If the Premium Performance Level of the State Is</th>
<th>For Year 4 If the Premium Performance Level of the State Is</th>
<th>For Year 9 If the Premium Performance Level of the State Is</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 percent</td>
<td>at least 8.5%</td>
<td>at least 11%</td>
<td>at least 13.5%</td>
</tr>
<tr>
<td>50 percent</td>
<td>at least 6.38%, but less than 8.5%</td>
<td>at least 10.38%, but less than 11%</td>
<td>at least 12.88%, but less than 13.5%</td>
</tr>
<tr>
<td>25 percent</td>
<td>at least 4.25%, but less than 6.38%</td>
<td>at least 9.75%, but less than 10.38%</td>
<td>at least 12.25%, but less than 12.88%</td>
</tr>
<tr>
<td>0 percent</td>
<td>less than 4.25%</td>
<td>less than 9.75%</td>
<td>less than 12.25%</td>
</tr>
</tbody>
</table>

(B) PREMIUM PERFORMANCE LEVEL.—For purposes of this subsection, the term “premium performance level” means, for a State, market, and year, the percentage reduction in the average per capita premiums for health insurance coverage for the State, market, and year, as compared to the premium baseline for such State, market, and year.

(4) Maximum State Premium Payment Amount.—For purposes of this subsection, the term “maximum State premium payment amount” means, for a State for the small group market or individual market in a State for a year, the product of—

(A) the percentage (as determined by the Secretary) of the number of nonelderly individuals lawfully residing in all the States who are enrolled in health insurance coverage in the respective market in the year, who are residents of the State; and

(B) the amount available for obligation from amounts appropriated under subsection (d) for such market with respect to performance in such year.

(5) METHODOLOGY FOR CALCULATING AVERAGE PER CAPITA PREMIUMS.—
(A) ESTABLISHMENT.—The Secretary shall establish, by rule and consistent with this subsection, a methodology for computing the average per capita premiums for health insurance coverage for the small group market and for the individual market in each State for each year beginning with year 1.

(B) ADJUSTMENTS.—Under such methodology, the Secretary shall provide for the following adjustments (in a manner determined appropriate by the Secretary):

(1) EXCLUSION OF ILLEGAL ALIENS.—An adjustment so as not to take into account enrollees who are not lawfully present in the United States and their premium costs.

(2) TREATING STATE PREMIUM SUBSIDIES AS PREMIUM COSTS.—An adjustment so as to increase per capita premiums to remove the impact of premium subsidies made directly by a State to reduce health insurance premiums.

(3) CONDITIONS OF PAYMENT.—As a condition of receiving a payment under paragraph (1), a State must agree to submit aggregate, non-individually identifiable data to the Secretary, in a form and manner specified by the Secretary, for use by the Secretary to determine the State's premium baseline and uninsured performance level for purposes of this subsection.

(b) PROGRAMS THAT REDUCE THE NUMBER OF UNINSURED

(1) IN GENERAL.—If the Secretary determines that a State has reduced the percentage of uninsured nonelderly residents in year 5, year 1, or year 9, below the uninsured baseline (as defined in paragraph (2) for the State for the year, the Secretary shall pay the State an amount equal to the product of:

(A) bonus uninsured percentage (as defined in paragraph (3)) for the State and year; and

(B) the maximum uninsured payment amount (as defined in paragraph (4)) for the State and year.

(2) UNINSURED BASELINE.—

(A) IN GENERAL.—For purposes of this subsection, and for purposes of paragraphs (B) through (D), the term “uninsured baseline” means, for a State, the percentage of nonelderly residents in the State who are uninsured in year 1.

(B) Rulemaking.—The Secretary shall establish, by rule, the methodology for computing the average per capita premiums for health insurance coverage for the small group market and for the individual market in each State for each year beginning with year 1.

(C) EXCLUSION OF ILLEGAL ALIENS.—Such methodology shall exclude individuals not lawfully present in the United States.

(D) CONDITIONS OF PAYMENT.—As a condition of receiving a payment under paragraph (B), a State must agree to submit aggregate, non-individually identifiable data to the Secretary, in a form and manner specified by the Secretary, for use by the Secretary in determining the State’s uninsured baseline and uninsured performance level for purposes of this subsection.

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

(1) GROUP HEALTH PLAN.—The term “group health plan” has the meaning given such term in section 9832(a) of the Internal Revenue Code of 1986.

(2) HEALTH INSURANCE COVERAGE.—The term “health insurance coverage” has the meaning given such term in section 9832(b)(1) of the Internal Revenue Code of 1986.

(3) INDIVIDUAL MARKET.—Except as the Secretary may otherwise provide in the case of small group health plans that have fewer than 2 participants as current employees on the first day of a plan year, the term “individual market” means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

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

(5) SMALL GROUP MARKET.—The term “small group market” means the market for health insurance coverage under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by an employer who employed on average at least 2 but not more than 50 employees on business days during a calendar year.

(6) STATE.—The term “State” means any of the 50 States and the District of Columbia.

(7) YEARS.—The terms “year 1”, “year 2”, “year 3”, and similar subsequently numbered years mean 2010, 2011, 2012, and subsequent sequentially numbered years.

(d) APPROPRIATIONS; PAYMENTS.—

(1) PAYMENTS FOR REDUCTIONS IN COST OF HEALTH INSURANCE COVERAGE.

(A) SMALL GROUP MARKET.—

(i) IN GENERAL.—From any funds in the Treasury not otherwise appropriated, there is appropriated for payments under subsection (a)(1)(A):

- (I) $18,000,000,000 with respect to performance in year 3; and
- (II) $5,000,000,000 with respect to performance in year 6; and
- (III) $2,000,000,000 with respect to performance in year 9.

(ii) AVAILABILITY OF APPROPRIATED FUNDS.—Funds appropriated under clause (i) shall remain available until expended.

(B) INDIVIDUAL MARKET.—Subject to clause (ii), from any funds in the Treasury not otherwise appropriated, there is appropriated for payments under subsection (a)(1)(B):

- (I) $7,000,000,000 with respect to performance in year 3; and
- (II) $2,000,000,000 with respect to performance in year 6; and
- (III) $5,000,000,000 with respect to performance in year 9.

(ii) AVAILABILITY OF APPROPRIATED FUNDS.—Funds appropriated under clause (i) shall remain available until expended.

(B) UNINSURED PERFORMANCE LEVEL.—For purposes of this subsection, the term “bonus uninsured percentage” means, for a State for a year, such percentage as determined in accordance with the following table, based on the uninsured performance level (as defined in subparagraph (B)) for such State and year:

<table>
<thead>
<tr>
<th>Bonus Uninsured Percentage for a State</th>
<th>For Year 5 if the Uninsured Performance Level of the State is</th>
<th>For Year 9 if the Uninsured Performance Level of the State is</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 percent</td>
<td>at least 15%</td>
<td>at least 20%</td>
</tr>
<tr>
<td>50 percent</td>
<td>at least 7.5% but less than 10%</td>
<td>at least 13.75% but less than 15%</td>
</tr>
<tr>
<td>25 percent</td>
<td>at least 5% but less than 7.5%</td>
<td>at least 12.5% but less than 13.75%</td>
</tr>
<tr>
<td>0 percent</td>
<td>less than 5%</td>
<td>less than 7.5%</td>
</tr>
</tbody>
</table>

(III) EXCLUSION OF ILLEGAL ALIENS.—Such methodology shall exclude individuals not lawfully present in the United States.

(IV) AVAILABILITY OF APPROPRIATED FUNDS.—Funds appropriated under clause (i) shall remain available until expended.

(D) APPROPRIATIONS; PAYMENTS.—

(1) PAYMENTS FOR REDUCTIONS IN COST OF HEALTH INSURANCE COVERAGE.

(A) SMALL GROUP MARKET.—

(i) IN GENERAL.—From any funds in the Treasury not otherwise appropriated, there is appropriated for payments under subsection (a)(1)(A):

- (I) $18,000,000,000 with respect to performance in year 3; and
- (II) $5,000,000,000 with respect to performance in year 6; and
- (III) $2,000,000,000 with respect to performance in year 9.

(ii) AVAILABILITY OF APPROPRIATED FUNDS.—Funds appropriated under clause (i) shall remain available until expended.

(B) INDIVIDUAL MARKET.—Subject to clause (ii), from any funds in the Treasury not otherwise appropriated, there is appropriated for payments under subsection (a)(1)(B):

- (I) $7,000,000,000 with respect to performance in year 3; and
- (II) $2,000,000,000 with respect to performance in year 6; and
- (III) $5,000,000,000 with respect to performance in year 9.

(ii) AVAILABILITY OF APPROPRIATED FUNDS.—Funds appropriated under clause (i) shall remain available until expended.

(A) IN GENERAL.—From any funds in the Treasury not otherwise appropriated, there is appropriated for payments under subsection (b)(1)—
(i) $10,000,000,000 with respect to performance in year 5.
(ii) $3,000,000,000 with respect to performance in year 7; and
(iii) $2,000,000,000 with respect to performance in year 9.

(B) AVAILABILITY OF APPROPRIATED FUNDS.—Funds appropriated under subparagraph (A) shall remain available until expended.

(3) PAYMENT TIMING.—Payments under this section shall be made in a form and manner specified by the Secretary in the year after the performance year involved.

SEC. 112. HEALTH PLAN FINDERS.

(a) STATE PLAN FINDERS.—Not later than 12 months after the date of the enactment of this Act, each State or States entering into a contract with a private entity to develop and operate a plan finder website (referred to in this section as a “State plan finder”) shall provide information to all individuals in such State on plans of health insurance coverage that are available to individuals in such State (in this section referred to as a “health insurance plan”). Such State may not operate a plan finder itself.

(b) MULTI-STATE PLAN FINDERS.—

(1) IN GENERAL.—A private entity may operate a multi-State plan finder that operates under this section in the States involved in the same manner as a State plan finder would if such State were a single State.

(2) SHARING OF INFORMATION.—States shall regulate the manner in which data is shared between plan finders to ensure consistency and accuracy of the information about health insurance plans contained in such finders.

(c) REQUIREMENTS FOR PLAN FINDERS.—Each plan finder shall meet the following requirements:

(1) The plan finder shall ensure that each health insurance plan in the plan finder meets the requirements for such plans under subsection (d).

(2) The plan finder shall present complete information on the costs and benefits of health insurance plans (including information on monthly premium, copayments, and deductibles) in a uniform manner that—

(A) uses the standard definitions developed under subsection (g); and

(B) is designed to allow consumers to easily compare such plans.

(3) The plan finder shall be available on the internet and accessible to all individuals in the State or, in the case of a multi-State plan finder, in all States covered by the multi-State plan finder.

(4) The plan finder shall allow consumers to search and sort data on the health insurance plans in the plan finder on criteria such as coverage of specific benefits (such as coverage for mental management services or pediatric care services), as well as data available on quality.

(5) The plan finder shall meet all relevant laws and regulations, including laws and regulations related to the marketing of insurance products. In the case of a multi-State plan finder, the finder shall meet such laws and regulations for all of the States involved.

(6) The plan finder shall meet solvency, financial, and privacy requirements established by the National Health Care Coordinator and its related health information exchange goals.

(g) PLAN FINDER DEFINED.—For purposes of this section, the term ‘plan finder’ means a State plan finder under subsection (a) or a multi-State plan finder under subsection (b).

(h) STATE PLAN.—In this section, the term ‘State’ means, in respect of such term for purposes of title XIX of the Social Security Act,

SEC. 113. ADMINISTRATIVE SIMPLIFICATION.

(a) OPERATING RULES FOR HEALTH INFORMATION TRANSACTIONS.—

(1) DEFINITION OF OPERATING RULES.—Section 1171 of the Social Security Act (42 U.S.C. 1320d–2) is amended by adding at the end the following:

“(9) OPERATING RULES.—The term ‘operating rules’ means the necessary business rules and guidelines for the electronic exchange of information that are defined by a standard or its implementation specifications as adopted for purposes of this part.”

(2) OPERATING RULES AND COMPLIANCE.—Section 1173 of the Social Security Act (42 U.S.C. 1320d–2) is amended—

(A) in subsection (a)(2), by adding at the end the following new paragraphs:

“(J) Electronic funds transfers;”;

and

(B) by adding at the end the following new subsections:

“(g) OPERATING RULES.—

(1) IN GENERAL.—The Secretary shall adopt a single set of operating rules for each transaction described in subsection (a)(2) with the goal of creating as much uniformity in the implementation of health care transaction standards as possible. Such operating rules shall be consensus-based and reflect the necessary business rules affecting health plans and health care providers in a manner in which they operate pursuant to standards issued under Health Insurance Portability and Accountability Act of 1996.

(2) OPERATING RULES IMPLEMENTATION.—In adopting operating rules under this subsection, the Secretary shall rely on recommendations for operating rules developed by an established nonprofit entity, as selected by the Secretary, that meets the following requirements:

“(A) The entity focuses its mission on administrative simplification and technology standards.

“(B) The entity demonstrates an established multi-stakeholder and consensus-based process for development of operating rules, including representation by or participation from health plans, health care providers, vendors, relevant Federal agencies, and other standard development organizations.

“(C) The entity has established a public set of guiding principles that ensure the operating rules and process are open and transparent.

“(D) The entity coordinates its activities with the HIT Policy Committee and the HIT Standards Committee (as established under title XVII of the Public Health Service Act) and complements the efforts of the Office of the National Healthcare Coordinator and its related health information exchange goals.

“(E) The entity incorporates national standards, including the transaction standards issued under Health Insurance Portability and Accountability Act of 1996.

“(F) The entity supports non-discrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory practices.

“(G) The entity allows for public review and updates of the operating rules.

“(H) REVIEW AND RECOMMENDATIONS.—The National Committee on Vital and Health Statistics shall—

“(A) review the operating rules developed by a nonprofit entity described under paragraph (2); and

“(B) determine whether such rules represent a consensus view of the health care industry and are consistent with and do not alter current standards; and

“(C) evaluate whether such rules are consistent with electronic standards adopted for health information technology; and

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(D) submit to the Secretary a recommenda-
tion as to whether the Secretary should adopt such rules.

(4) IMPLEMENTATION. —

(A) IN GENERAL.—The Secretary shall adopt operating rules under this subsection, by regulation in accordance with subparagraph (C), following consideration of the rules and operating rules described in paragraph (2) and the recom-
mandation submitted by the National Committee on Vital and Health Statistics under (D) and having ensured consultation with providers.

(B) ADOPTION REQUIREMENTS: EFFECTIVE DATES.

(i) ELIGIBILITY FOR A HEALTH PLAN AND HEALTH CLAIM STATUS.—The set of operating rules for transactions for eligibility for a health plan and health claim status shall be adopted not later than July 1, 2011, in a manner ensuring that such rules are effective not later than January 1, 2013, and may allow for the use of a machine readable identification card.

(ii) ELECTRONIC FUNDS TRANSFERS AND HEALTH CARE PAYMENT AND REMITTANCE ADVICE.—The set of operating rules for electronic funds transfers and health care payment and remittance advice shall be adopted not later than January 1, 2012, in a manner ensuring that such rules are effective not later than December 31, 2013.

(iii) OTHER COMPLETED TRANSACTIONS.—The set of operating rules for the remainder of the completed transactions described in subsection (a)(2), including health claims or equivalent encounter information, enrollment and disenrollment in a health plan, health plan premium payments, and referral certification and authorization, shall be adopted not later than July 1, 2014, in a manner ensuring that such rules are effective not later than January 1, 2016.

(C) EXPEDITED RULEMAKING.—The Secretary shall promulgate an interim final rule applying any standard or operating rule recommended by the National Committee on Vital and Health Statistics pursuant to paragraph (3). The Secretary shall accept public comments on any interim final rule published under this subsection for 60 days after the date of such publication.

(B) SERVICE CONTRACTS.

(i) REVIEW AND AMENDMENT OF STANDARDS AND RULES.—

(1) ESTABLISHMENT.—Not later than January 1, 2014, the Secretary shall establish a review committee (as described under paragraph (4)).

(2) EVALUATIONS AND REPORTS.—

(A) HEARINGS.—Not later than April 1, 2014, the Secretary shall hold hearings. The Secretary, acting through the review committee, shall conduct hearings to evaluate and review the existing standards and operating rules that are described under paragraph (1).

(B) REPORT.—Not later than July 1, 2014, and not less than biennially thereafter, the review committee shall provide recommendations for updating and improving such standards and rules. The review committee shall recommend a single set of operating rules per transaction standard and maintain the goal of creating as much uniformity as possible in the implementation of the electronic standards.

(3) INTERIM FINAL RULEMAKING.—

(A) IN GENERAL.—Any recommendations to amend existing standards and operating rules that have been approved by the review committee and reported to the Secretary shall be promulgated by the Secretary through promulgation of an interim final rule not later than 90 days after receipt of the committee’s report.

(B) PUBLIC COMMENT.—The Secretary shall accept public comments on any interim final rule published under this paragraph for 60 days after the date of such publication.

(II) EFFECTIVE DATE.—The effective date of any amendment to existing standards or operating rules that is adopted through an interim final rule published under this para-
graph shall be 25 months following the close of such public comment period.

(4) REVIEW COMMITTEE.—

(A) DEFINITION.—For the purposes of this subsection, the term ‘review committee’ means a committee within the Department of Health and Human services that has been designated by the Secretary to carry out this subsection, including—

(i) the National Committee on Vital and Health Statistics; or

(ii) any appropriate committee as determined by the Secretary.

(B) COORDINATION OF HIT STANDARDS.—In developing recommendations under this subsection, the review committee shall consider the standards approved by the Office of the National Coordinator for Health Information Technology.

(i) PENALTIES.—

(1) PENALTY FEE.—

(A) IN GENERAL.—Not later than April 1, 2013, the Secretary shall promulgate an interim final rule that the Secretary shall promulgate an interim final rule under this subsection, including—

(i) an amount equal to $20 per covered life under such plan if such plan has knowingly provided inaccurate or incomplete information in a statement of certification or documentation of compliance with the standards (and their operating rules) as described under paragraph (1) of such subsection.

(B) FEE AMOUNT.—Subject to subparagraphs (C), (D), and (E), the Secretary shall assess a penalty fee against a health plan in the amount of $1 per covered life until certification is complete. The penalty shall be assessed per person covered by the plan for which its data systems for major medical policies are not in compliance and shall be imposed against the health plan for each day that the plan is not in compliance with the requirements under subsection (h).

(C) ADDITIONAL PENALTY FOR MISREPRESENTATION.—A health plan that knowingly provides inaccurate or incomplete information in a statement of certification or documentation of compliance with the standards (and their operating rules) as described under paragraph (1) of such subsection shall be increased on an annual basis by the annual percentage increase in total national health care expenditures, as determined by the Secretary.

(E) PENALTY LIMIT.—A penalty fee assessed against a health plan under this subsection shall not exceed, on an annual basis:

(iii) an amount equal to $20 per covered life under such plan; or

(II) an amount equal to $10 per covered life under the plan if such plan has knowingly provided inaccurate or incomplete information in a statement of certification or documentation of compliance with the standards (and their operating rules) as described under subparagraph (C).

(F) DETERMINATION OF COVERED INDIVIDUALS.—The Secretary shall determine the number of covered lives under a health plan based upon any relevant state law provisions that have been submitted to the Secretary by the State.
“(2) NOTICE AND DISPUTE PROCEDURE.—The Secretary shall establish a procedure for assessment of penalty fees under this subsection that provides a health plan with reasonable notice and an opportunity for a hearing on the facts and to make appropriate representations and objections. Such procedure shall include—

(a) a deadline for filing a notice of a proposed assessment of a penalty fee not later than May 1, 2014, and annually thereafter, the Secretary shall provide the Secretary of the Treasury with a report identifying those health plans that have been identified by the Secretary in the penalty fee report provided under paragraph (3);

(b) Notice.—Not later than August 1, 2014, and annually thereafter, the Secretary of the Treasury shall provide notice to each health plan that has been assessed a penalty fee by the Secretary under this subsection.

(3) PAYMENT DUE DATE.—Payment by a health plan for a penalty fee assessed under this subsection shall be made to the Secretary of the Treasury not later than November 1, 2014, and annually thereafter.

(4) UNPAID PENALTY FEES.—Any amount of a penalty fee assessed against a health plan under this subsection for which payment is not made by the due date provided under subparagraph (C) shall be—

(i) increased by the interest accrued on such amount, as determined pursuant to the Internal Revenue Code of 1986, and

(ii) treated as a past-due, legally enforceable debt owed to a Federal agency for purposes of section 6551(a) of the Internal Revenue Code of 1986.

(5) ADMINISTRATIVE FORFEITURE.—Any fee charged or allocated for collection activities conducted by the Financial Management Service will be passed on to a health plan on a pro-rata basis and added to any penalty fee collected therefrom.

(b) Prolonging of Rules.

(1) UNIQUE HEALTH PLAN IDENTIFIER.—The Secretary shall promulgate a final rule to establish a unique health plan identifier (as defined in section 3801(b) of the Social Security Act (42 U.S.C. 1320c-2(b))) based on the input of the National Committee of Vital and Health Statistics. The Secretary may do so on an interim final basis and such rule shall be effective not later than October 1, 2012.

(2) ELECTRONIC FUNDS TRANSFER.—The Secretary shall promulgate a final rule to establish a standard for electronic funds transfers (as described in section 171.2(l)(2)(J) of the Social Security Act, as added by subsection (a)(2)(A) of the Social Security Protection Act (42 U.S.C. 1320d-2(b))) based on the input of the National Committee of Vital and Health Statistics. The Secretary may do so on an interim final basis and shall adopt such standard not later than January 1, 2012, in a manner ensuring that such standard is effective not later than January 1, 2014.

(c) EXPANSION OF ELECTRONIC TRANSACTIONS IN MEDICARE.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (23), by striking the “or” at the end;

(2) in paragraph (24), by striking the period at the end and inserting “under such part only if such plan consists of any of the following:

(a) a plan which receives active support of its employees or other means demonstrated by such plan in connection with plans in such class and payment of the prescribed fee under section 807(a).

(b) Certification of Self-Insured Association Health Plans.—The applicable authority may provide by regulation for continued certification of association health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 807(a).

(2) CLASS CERTIFICATION FOR FULLY INSURED PLANS.—The applicable authority shall establish a class certification procedure for association health plans under which all benefits consist of health insurance coverage. Under such procedure, the applicable authority shall provide for the granting of continued certification under this part to plans in each class of such association health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 807(a).

(3) Bylaw.-The applicable authority may provide in its regulation a procedure under which, subject to subsection (b), the applicable authority shall certify association health plans which apply for certification as meeting the requirements of this part.

(4) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—An association health plan which applies for certification under this part in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

(5) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide regulation for continued certification of association health plans under this part.

(6) CERTIFICATION OF FULLY INSURED PLANS.—The applicable authority shall establish a class certification procedure for association health plans under which all benefits consist of health insurance coverage. Under such procedure, the applicable authority shall provide for the granting of continued certification under this part to plans in each class of such association health plans upon appropriate filing under such procedure in connection with plans in such class and payment of the prescribed fee under section 807(a).

(7) REPORTS.—Not later than January 1, 2012, in a manner ensuring that such standard is effective not later than January 1, 2014, the applicable authority shall certify association health plans which are certified under this part only if such plan consists of any of the following:

(a) a plan which offers such coverage on the date of the enactment of the Small Business Health Fairness Act of 2010.

(b) a plan which offers such coverage on the date of the enactment of the Health Care Payment and Remittance Standards Act of 2010.

SECTION 802. CERTIFICATION OF ASSOCIATION HEALTH PLANS

(a) in General.—The applicable authority shall prescribe by regulation a procedure
with the date of the application for certification under this part.

"(b) BOARD OF TRUSTEES.—The requirements of this subsection are met with respect to an association health plan if the following requirements are met:

"(1) FISCAL CONTROL.—The plan is operated, maintained, and administered by a board of trustees which has complete fiscal control over the plan and which is responsible for all operations of the plan.

"(2) PLAN MANAGEMENT AND FINANCIAL CONTROLS.—The board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to ensure that all of the terms of the plan and to meet all requirements of this title applicable to the plan.

"(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.

  "(A) BOARD MEMBERSHIP.—
  "(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.
  "(ii) LIMITATION.—(I) GENERAL RULE.—Except as provided in subclauses (II) and (III), no such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the plan.
  "(II) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 10 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.
  "(III) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, subclause (I) shall not apply in the case of any service provider described in subclause (I) who is a provider of medical care under the plan.

"(c) TREATMENT OF FRANCHISE NETWORKS.—In the case of a group health plan which is established and maintained by a franchisor for a franchise network consisting of its franchisees—

"(1) the requirements of subsection (a) and section 804(a)(1) shall be deemed met if such requirements would otherwise be met if the franchiser were deemed to be the sponsor referred to in section 804(b); and

"(2) the requirements of section 804(a)(1) shall be deemed met

The Secretary may by regulation define for purposes of this subsection the terms "franchisor" and "franchisee".

SEC. 804. PARTICIPATION AND COVERAGE REQUIREMENTS.

(a) COVERED EMPLOYERS AND INDIVIDUALS.—In the case of an association health plan if, under the terms of the plan—

"(1) each participating employer must be—
  "(A) a member of the sponsor,
  "(B) the sponsor, or
  "(C) an affiliated member of the sponsor with respect to which the requirements of subsection (b) are met, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of the sponsor is an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or such an affiliated member of the sponsor, participating employers may also include such employer; and

"(2) all individuals commencing coverage under the plan after certification under this part must be—
  "(A) active or retired owners (including self-employed individuals), officers, directors, employer or employee of, or partners in, participating employers; or
  "(B) the beneficiaries of individuals described in subparagraph (A).

"(b) COVERAGE OF PREVIOUSLY UNINSURED EMPLOYEES.—In the case of an association health plan in existence on the date of the enactment of the Patient Protection and Affordable Care Act, an affiliated member of the sponsor of the plan may be offered coverage under the plan as a participating employer only if—

"(1) the affiliated member was an affiliated member on the date of certification under this part; or

"(2) during the 12-month period preceding the date of the offering of such coverage, the affiliated member has not maintained or contributed to a group health plan with respect to any of the individuals who would otherwise be eligible to participate in such association health plan.

"(c) INEDIUM MARKET UNAFFECTED.—The requirements of this subsection are met with respect to an association health plan if—

"(1) under the terms of the plan, no participating employer meeting the preceding requirements of this section of such plan is excluded on such basis, be eligible for coverage under the plan.

"(2) the applicable requirements of section 804(a)(1) and serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 316(A)); and

"(d) PREVENT DISCRIMINATORY.—The contribution rates for any participating small employer do not vary on the basis of any health status-related factor in relationship to employees of such employer or their beneficiaries and do not vary on the basis of the type of business or industry in which such employer is engaged.

"(e) Nothing in this title or any other provision of law shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from—

"(i) setting contribution rates based on the claims experience of the plan; or

"(ii) varying contribution rates for small employers in a State to the extent that such rates could vary using the same methodology employed in such State for regulating premium rates in the small group market with respect to health insurance coverage offered in connection with bona fide associations (within the meaning of section 303 of the Small Business Health Care Disparity Act) subject to the requirements of section 702(b) relating to contribution rates.

"(f) FLOOR FOR NUMBER OF COVERED INDIVIDUALS WITH RESPECT TO CERTAIN PLANS.—If any benefit option under a group health insurance policy which does not consist of health insurance coverage, the plan has as of the beginning of the plan year no fewer than 1,000 participants and beneficiaries.

"(g) MARKETING REQUIREMENTS.—

"(A) IN GENERAL.—If a benefit option which consists of health insurance coverage is offered under the plan, State-licensed insurance agents shall be used to distribute to small employers coverage which does not consist of health insurance coverage in a manner which is substantially similar to the manner in which such agents are used to distribute health insurance coverage.

"(h) STATE LICENSED INSURANCE AGENTS.—For purposes of subparagraph (A), the term 'State-licensed insurance agents' means one or more agents who are licensed in a State and are subject to the laws of such State relating to licensure, qualification, testing, examination, and continuing education of persons authorized to offer, sell, or solicit health insurance coverage in such State.

"(i) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority determines are necessary to carry out the provisions of this section.

"(j) ABILITY OF ASSOCIATION HEALTH PLANS TO PROVIDE COVERAGE THROUGH OTHER MEANS.—In the case of any association health plan, nothing in section 514(d), nothing in part or any provision of State law (as defined in section 514(c)(9)) shall be construed to preclude an association health plan, or a health insurance issuer offering health insurance coverage in connection with an association health plan, from exercising its sole discretion in selecting the specific items and services consisting of medical care to be included as benefits under such plan or coverage, except to the extent provided in section 885(a)(1) or to any law to the extent that it is not preempts under section 514(a)(1) with respect to such plan.
to matters governed by section 711, 712, or 713, or (2) any law of the State with which filing and approval of a policy type offered by the plan was initially obtained to the extent that filing and approval is an extension of a specific disease from such coverage.

SEC. 806. MAINTENANCE OF RESERVES AND PROVIDING FOR LOSS INQUIRIES FOR PLANS PROVIDING HEALTH BENEFITS IN ADDITION TO HEALTH INSURANCE COVERAGE.

(a) In General.—The requirements of this section are met with respect to an association health plan if—

(1) the benefits under the plan consist solely of health insurance coverage; or

(2) if the plan provides any additional benefit options which do not consist of health insurance, the plan—

(A) establishes and maintains reserves with respect to such additional benefit options, in amounts recommended by the qualified actuary, consisting—

(i) a reserve sufficient for unearned contributions;

(ii) a reserve sufficient for benefit liabilities which have been incurred, which have not been satisfied, and for which risk of loss has not yet been transferred, and for expected administrative costs with respect to such benefit liabilities;

(iii) a reserve sufficient for any other obligations of the plan; and

(iv) a reserve sufficient for a margin of error and other fluctuations, taking into account the specific circumstances of the plan; and

(B) establishes and maintains aggregate and specific excess/stop loss insurance and solvency indemnification, with respect to such additional benefit options for which risk of loss has not yet been transferred, as follows:

(1) The plan shall secure aggregate excess/stop loss insurance for the plan with an attachment point which is not greater than 125 percent of expected gross annual claims. The applicable authority may by regulation provide for upward adjustments in the amount of such percentage in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

(2) The plan shall secure specific excess/stop loss insurance for the plan with an attachment point which is at least equal to an amount recommended by the plan's qualified actuary. The applicable authority may by regulation provide for adjustments in the amount of such insurance in specified circumstances in which the plan specifically provides for and maintains reserves in excess of the amounts required under subparagraph (A).

(3) The plan shall secure indemnification insurance for any claim for which the plan is unable to satisfy by reason of a plan termination.

Any person issuing to a plan insurance described in subsection (a)(2), the applicable authority determines that, without such payments, claims would not be satisfied by reason of termination of such coverage. The Secretary shall, to the extent provided in advance in appropriation Acts, pay such amounts so determined to the insurer designated by the Secretary.

(b) Association Health Plan Fund.—

(A) In General.—There is established on the books of the Treasury a fund to be known as the ‘Association Health Plan Fund’. The Fund shall be credited with payments pursuant to paragraph (2). The Fund shall be available for making payments pursuant to paragraph (2) and for investments of amounts of the Fund under subparagraph (B).

(B) Investment.—Whenever the Secretary determines that the moneys of the fund are in excess of current needs, the Secretary may request the investment of such moneys. The Secretary may make such request by the Secretary of the Treasury in obligations issued or guaranteed by the United States.

(c) Excess/Stop Loss Insurance.—For purposes of this section—

(1) Aggregate Excess/Stop Loss Insurance.—The term ‘aggregate excess/stop loss insurance’ means, in connection with an association health plan, a contract—

(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation) provides for payment of indemnification insurance as the applicable authority may determine to be adequate to enable the plan to fully meet all its financial obligations on a timely basis and is otherwise no less protective of the interests of participants and beneficiaries than health insurance provided with respect to such plans or policies;

(B) which is guaranteed renewable; and

(C) which allows for payment of premiums by any third party on behalf of the insured plan.

(2) Specific Excess/Stop Loss Insurance.—The term ‘specific excess/stop loss insurance’ means, in connection with an association health plan, a contract—

(A) under which an insurer (meeting such minimum standards as the applicable authority may prescribe by regulation) provides for payment to the plan with respect to aggregate claims under the plan in excess of an amount or amounts specified in such contract;

(B) which is guaranteed renewable; and

(C) which allows for payment of premiums by any third party on behalf of the insured plan.

(d) Adjustments for Excess/Stop Loss Insurance and Indemnification Insurance Coverage for Certain Plans.—In any case in which the applicable authority determines that there is, or that there is reason to believe that there will be, (A) a failure to take necessary corrective actions under section 809(a) with respect to the association health plan described in subsection (a)(2); or (B) a termination of such a plan under section 809(b) or 810(b)(8) (and, if the applicable authority is not the Secretary, certification of the association to the Secretary), the Secretary shall determine the amounts necessary to make payments pursuant to paragraph (1)(A), penalties prescribed by subparagraph (B) which is guaranteed renewable; and

(2) which allows for payment of premiums by any third party on behalf of the insured plan.

(e) Alternative Means of Compliance.—The applicable authority may permit an association health plan described in subsection (a)(2) to substitute, for all or part of the requirements described in subsection (a)(2)(B)(iii), such security, guarantee, hold-harmless arrangement, or other financial arrangement as the applicable authority determines to be adequate to enable the plan to fully meet all its financial obligations on a timely basis and is otherwise no less protective of the interests of participants and beneficiaries than health insurance provided with respect to such plans or policies.

(f) Measures to Ensure Continued Payment of Benefits by Certain Plans in Distress.—

(1) Payments by Certain Plans to Association Health Plan Fund.—

(A) In General.—In the case of an association health plan described in subsection (a)(2), the requirements of this subsection are met if the plan makes payments into the Association Health Plan Fund under this subparagraph when they are due. Such payments shall consist of annual payments in the amount of $5,000, and, in addition to such annual payments, such supplemental payments as the Secretary may determine to be necessary under this paragraph. Payments under this subparagraph are payable to the Fund at the time determined by the Secretary. Initial payments are due in advance of certification under this part. Payments shall continue to accrue until a plan's assets are distributed pursuant to a termination procedure.

(B) Penalties for Failure to Make Payments.—If any payment is not made by a plan when it is due, a late payment charge of not more than 100 percent of the payment which should have been payable by the plan to the Fund.

(C) Continued Duty of the Secretary.—The Secretary shall not cease to carry out payments under this paragraph to the extent that the failure of a plan to pay any payment when due.

(2) Payments by Secretary to Continue Excess/Stop Loss Insurance Coverage and Indemnification Insurance Coverage for Certain Plans.—In any case in which the applicable authority determines that there is, or that there is reason to believe that there will be, (A) a failure to take necessary corrective actions under section 809(a) with respect to the association health plan described in subsection (a)(2); or (B) a termination of such a plan under section 809(b) or 810(b)(8) (and, if the applicable authority is not the Secretary, certification of the association to the Secretary), the Secretary shall determine the amounts necessary to make payments pursuant to paragraph (1)(A), penalties prescribed by subparagraph (B) which is guaranteed renewable; and

(2) which allows for payment of premiums by any third party on behalf of the insured plan.

(3) Association Health Plan Fund.—

(A) In General.—There is established on the books of the Treasury a fund to be known as the ‘Association Health Plan Fund’. The Fund shall be available for making payments pursuant to paragraph (2). The Fund shall be credited with payments received pursuant to paragraph (1)(A), penalties prescribed by subparagraph (B) which is guaranteed renewable; and

(2) which allows for payment of premiums by any third party on behalf of the insured plan.

(3) Association Health Plan Fund.—

(A) In General.—There is established on the books of the Treasury a fund to be known as the ‘Association Health Plan Fund’. The Fund shall be available for making payments pursuant to paragraph (2). The Fund shall be credited with payments received pursuant to paragraph (1)(A), penalties prescribed by subparagraph (B) which is guaranteed renewable; and

(2) which allows for payment of premiums by any third party on behalf of the insured plan.

(3) Association Health Plan Fund.—

(A) In General.—There is established on the books of the Treasury a fund to be known as the ‘Association Health Plan Fund’. The Fund shall be available for making payments pursuant to paragraph (2). The Fund shall be credited with payments received pursuant to paragraph (1)(A), penalties prescribed by subparagraph (B) which is guaranteed renewable; and

(2) which allows for payment of premiums by any third party on behalf of the insured plan.

(3) Association Health Plan Fund.—

(A) In General.—There is established on the books of the Treasury a fund to be known as the ‘Association Health Plan Fund’. The Fund shall be available for making payments pursuant to paragraph (2). The Fund shall be credited with payments received pursuant to paragraph (1)(A), penalties prescribed by subparagraph (B) which is guaranteed renewable; and

(2) which allows for payment of premiums by any third party on behalf of the insured plan.
pursuant to section 808(b) (relating to mandatory termination).

(2) which is guaranteed renewable and noncancelable for any reason (except as the applicable authority may prescribe by regulation); and

(3) which allows for payment of premiums by any third party on behalf of the insured plan.

(i) RESERVES.—For purposes of this section, the term ‘reserves’ means, in connection with an association health plan, plan assets set aside to meet the fiduciary standards under part 4 and such additional requirements regarding liquidity as the applicable authority may prescribe by regulation.

(2) SOLVENCY STANDARDS WORKING GROUP.—

(1) IN GENERAL.—Within 90 days after the date of the enactment of the Small Business Health Fairness Act of 2009, the applicable authority shall establish a Solvency Standards Working Group. In prescribing the initial regulations under this section, the applicable authority shall take into account the recommendations of such Working Group.

(2) MEMBERSHIP.—The Working Group shall consist of not more than 15 members appointed by the applicable authority. The applicable authority shall include among persons invited to membership on the Working Group at least one of each of the following:

(A) a representative of the National Association of Insurance Commissioners;

(B) a representative of the American Academy of Actuaries;

(C) a representative of the State governments, or their interests;

(D) a representative of existing self-insured plans; and

(E) a representative of associations of the type referred to in section 801(b)(1), or their interests; and

(F) a representative of multiemployer plans that are group health plans, or their interests.

SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

(a) FILING FEE.—Under the procedure prescribed pursuant to section 808(a), an association health plan shall pay to the applicable authority, at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent of amounts for administration, for the sole purpose of administering the certification procedures applicable with respect to association health plans.

(b) CERTIFICATION DOCUMENTS MAY BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:

(1) IDENTIFYING INFORMATION.—The names and addresses of—

(A) the sponsor; and

(B) the members of the board of trustees of the plan.

(2) STATES IN WHICH PLAN INTENDS TO DO BUSINESS.—The States in which participants and beneficiaries under the plan are to be located and the number of them expected to be located in each such State.

(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

(4) PLAN DOCUMENTS.—A copy of the document of the plan (including any by-laws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan and the administrators and other service providers.

(6) FUNDING REPORT.—In the case of association health plans providing benefits options that are not described in the plan as required by regulation prior to coverage, a report setting forth information with respect to such additional benefit options determined as of a date within the 120-day period preceding the date of the application, including the following:

(A) RESERVES.—A statement, certified by the board of trustees of the plan, and a statement of actuarial opinion signed by a qualified actuary, that all applicable requirements of section 806 are or will be met in accordance with regulations which the applicable authority shall prescribe.

(B) ADEQUACY OF CONTRIBUTION RATES.—A statement of actuarial opinion, signed by a qualified actuary, which sets forth a description of the extent to which contribution rates are adequate to provide for the payment of all obligations and the maintenance of required reserves under the plan for the 12-month period ending on the last day of the plan year.

(C) CURRENTLY PROJECTED VALUE OF ASSETS AND LIABILITIES.—A statement of actuarial opinion signed by a qualified actuary, which sets forth the current value of the assets and liabilities under the plan and a projection of the assets, liabilities, income, and expenses of the plan for the 12-month period referred to in subparagraph (B).

(D) COSTS OF COVERAGE TO BE CHARGED AND OTHER EXPENSES.—A statement of the costs of coverage to be charged, including an itemization of amounts for administration, reserves, and other expenses associated with the operation of the plan.

(E) OTHER INFORMATION.—Any other information as may be determined by the applicable authority, by regulation, as necessary to carry out this chapter.

(f) ENGAGEMENT OF QUALIFIED ACTUARY.—

(1) IN GENERAL.—Within 90 days after the date of the enactment of the Small Business Health Fairness Act of 2009, the applicable authority shall establish a Solvency Standards Working Group. In prescribing the initial regulations under this section, the applicable authority shall take into account the recommendations of such Working Group.

(2) MEMBERSHIP.—The Working Group shall consist of not more than 15 members appointed by the applicable authority. The applicable authority shall include among persons invited to membership on the Working Group at least one of each of the following:

(A) a representative of the National Association of Insurance Commissioners;

(B) a representative of the American Academy of Actuaries;

(C) a representative of the State governments, or their interests;

(D) a representative of existing self-insured plans; and

(E) a representative of associations of the type referred to in section 801(b)(1), or their interests; and

(F) a representative of multiemployer plans that are group health plans, or their interests.

SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

(a) ACTIONS TO AVOID DEPLETION OF RESERVES.—An association health plan which is certified under this part and which provides benefits other than health insurance coverage shall continue to meet the requirements of section 808, irrespective of whether such certification continues in effect. The board of trustees of such plan shall determine quarterly whether the requirements of section 808 are met. In any case in which the board determines that there is reason to believe that there is or will be a failure to meet such requirements, the applicable authority may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

(b) REPORTING REQUIREMENTS FOR CERTAIN ASSOCIATION HEALTH PLANS.—An association health plan which provides benefit options that may be exercised (including any by-law provisions) from the actuarial recommendations for corrective actions, the board shall notify the
applicable authority (in such form and manner as the applicable authority may prescribe by regulation) of such recommendations of the actuary for corrective action, together with a certification of the actuary (or any such other professional service personnel as may be necessary in connection with the applicable authority (in such form and manner as the applicable authority may prescribe by regulation) that the board has taken or plans to take in response to such recommendations.

The board shall thereafter report to the applicable authority, in such form and frequency as the applicable authority may specify to the board, regarding corrective action taken by the board until the requirements of section 806 have been satisfied.

(2) The applicable authority determines that the applicable authority has been notified under subsection (a) (or by an issuer of excess/stop loss insurance or indemnity insurance pursuant to section 806(a) of a failure of an association health plan which is or has been certified under this part and is described in section 806(a)(2) to meet the requirements of section 806 and has not been notified by the board of trustees of such plan that corrective action has restored compliance with such requirements; and

(3) the applicable authority determines that there is a reasonable expectation that the plan will continue to fail to meet the requirements of section 806.

The board of trustees of the plan shall, at the direction of the applicable authority, terminate the plan and, in the course of the termination, take such actions as the applicable authority may require, including satisfying any claims owed to an association health plan described in section 806(a)(2)(B)(iii) and recovering for the plan any liability under subsection (a)(2)(B)(iii) or (e) of section 806, as necessary to ensure that the applicable authority (in such form and manner as the applicable authority may prescribe by regulation or required by any order of the court; (8) to terminate the plan (or provide for its termination in accordance with section 809(b)) and liquidate the plan assets, to restore the plan to the responsibility of the sponsor, or to continue the trusteeship;

(9) to provide for the enrollment of plan participants and beneficiaries under appropriate coverage options; and

(10) to do such other acts as may be necessary to terminate the plan or any order of the court to protect the interests of plan participants and beneficiaries and providers of medical care.

(c) Notice of Appointment.—As soon as practicable after the Secretary’s appointment as trustee, the Secretary shall give notice of such appointment to:

(1) the sponsor and the plan administrator;

(2) each participant;

(3) each participating employer; and

(4) if applicable, each employee organization which, for purposes of collective bargaining, represents plan participants.

(d) Additional Duties.—Except to the extent inconsistent with the provisions of this title, or as otherwise provided by the court, the Secretary, upon appointment as trustee under this section, shall be subject to the same duties as those of a trustee under section 794 of title 11, United States Code, and shall have the duties of a fiduciary for purposes of this title.

(e) Other Proceedings.—An application by the Secretary for appointment under this subsection may be filed notwithstanding the pendency in the same or any other court of any bankruptcy, mortgage foreclosure, or equity receivership proceeding over, or to reorganize, conserve, or liquidate such plan or its property, or any proceeding to enforce a lien against property of the plan.

(f) Jurisdiction.—

(1) In General.—Upon the filing of an application for the appointment as trustee or the issuance of a decree under this section, the court to which the application is made shall have exclusive jurisdiction of the plan involved and its property wherever located with the powers, to the extent consistent with any provisions of this section, of a court of the United States having jurisdiction over cases under chapter 11 of title 11, United States Code. Pending an adjudication under this section such court shall stay, and upon appointment by it of the Secretary as trustee, such court shall continue the stay of any pending mortgage foreclosure, equity receivership, or other proceeding to reorganize, conserve, or liquidate the plan, the sponsor, or property of such plan or sponsor, and any other suit against any receiver, conservator, or trustee in bankruptcy of the plan, the sponsor, or property of the plan or sponsor. Pending such adjudication and upon the appointment by it of the Secretary as trustee, the court may stay any proceeding in any judicial or administrative forum to which the plan may be a party, or to which the Secretary may reasonably need in order to administer the plan.

(2) Venue.—An action under this section may be brought in the judicial district where the sponsor or the plan administrator resides or does business or where any asset of the plan is located.

(3) Proceedings.—In accordance with regulations which shall be prescribed by the Secretary, the applicable authority shall appoint, retain, and compensate accountants, actuaries, and other professional service personnel as may be necessary in connection with the Secretary’s service as trustee under this section.

*SEC. 811. STATE ASSESSMENT AUTHORITY.

(a) In General.—Notwithstanding section 514, a State may impose by law a contribution tax on an association health plan described in section 806(a)(2), if the plan commenced operations in such State after the date of the enactment of the Small Business Health Fairness Act of 2009.

(b) Contribution Tax.—For purposes of this section, the term ‘contribution tax’ imposed by a State on an association health plan means any tax imposed by such State if

(1) such tax is computed by applying a rate to the amount of premiums or contributions received by an association health plan under the plan who are residents of such State, which are received by the plan from participating employers located in such State from such plan;

(2) the rate of such tax does not exceed the rate of any tax imposed by such State on premiums or contributions received by insurers or health maintenance organizations for health insurance coverage offered in such State in connection with a group health plan;

(3) such tax is otherwise nondiscriminatory; and

(4) the amount of any such tax assessed on the plan is reduced by the amount of any tax or assessment otherwise imposed by the State on premiums, contributions, or both received by insurers or health maintenance organizations for health insurance coverage, aggregate excess/stop loss insurance (as defined in section 806(g)(1)), specific excess/stop loss insurance (as defined in section 806(g)(2)), other insurance related to the provision of medical care, or any combination thereof provided by such insurers or health maintenance organizations in such State in connection with such plan.

*SEC. 812. DEFINITIONS AND RULES OF CONSTRUCTION.

(a) Definitions.—For purposes of this part—

(1) GROUP HEALTH PLAN.—The term ‘group health plan’ has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

(2) MEDICAL CARE.—The term ‘medical care’ has the meaning provided in section 733(b)(2).

(3) HEALTH INSURANCE COVERAGE.—The term ‘health insurance coverage’ has the meaning provided in section 733(b)(2).

(4) HEALTH INSURANCE ISSUER.—The term ‘health insurance issuer’ has the meaning provided in section 733(b)(2).

(b) Applicable Authority.—The term ‘applicable authority’ means the Secretary, except that, in connection with any exercise of the Secretary’s authority regarding which the Secretary is required by section 506(d) to consult with a State, such term means the Secretary, in consultation with such State.

(6) HEALTH STATUS-RELATED FACTOR.—The term ‘health status-related factor’ has the meaning provided in section 733(d)(2).

(7) INDIVIDUAL MARKET.—
"(A) IN GENERAL.—The term ‘individual market’ means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(B) EXCEPTION.—Notwithstanding subsection (A), a plan, fund, or program which was established, with respect to health insurance issuers or health insurance coverage, to supersede or impair the law of any State—

(1) providing solvency standards or similar standards regarding the adequacy of insurer capital, surplus, reserves, or contributions, or

(2) relating to prompt payment of claims.

(4) For additional provisions relating to association health plans, see subsections (a)(2)(B) and (b) of section 805.

"(b) C ONFORMING AMENDMENTS TO PREEMP-
TOR RULES.—

(1) Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:

"(E) The preceding subparagraphs of this paragraph do not apply with respect to any State law in the case of an association health plan which is certified under part 8.

(2) Section 114 of such Act (29 U.S.C. 1144) is amended—

(A) in subsection (b)(4), by striking ‘‘Subsection (a)’’ and inserting ‘‘Subsections (a) and (d)’’;

(B) in subsection (b)(5), by striking ‘‘sub-
section (a)’’ in subparagraph (A) and inserting ‘‘subsection (a) of this section and subsection 805’’, and by striking ‘‘subsection (a)’’ in subparagraph (B) and inserting ‘‘subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805’’;

(C) by redesignating subsections (d) and (e) as subsections (e) and (f), respectively; and

(D) by inserting after subsection (c) the following new subsection:

‘‘(d)(1) Except as provided in subsection (b)(4), the provisions of this section shall supersede any and all State laws insular as they may now or hereafter exist with respect to health insurance issuers from offering health insurance coverage in connection with an association health plan which is certified under part 8.

‘‘(2) Except as provided in paragraphs (4) and (5) of subsection (b) of this section—

‘‘(A) in any case in which health insurance coverage of any policy type is offered under an association health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supercede all laws of such State insular as they may now or hereafter exist with respect to health insurance issuers from offering health insurance coverage of such type to any other employer, including any employers which are eligible for coverage under such association health plan, whether or not such other employers are participating employers in such plan,

‘‘(B) in any case in which health insurance coverage of any policy type is offered in a State under an association health plan cer-
tified under part 8, the provisions of such plan shall supercede any and all laws of such State insular as they may now or hereafter exist with respect to health insurance issuers from offering health insurance coverage of such type.

(2) PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYER HEALTH PLANS.—In the case of any plan, fund, or program which was established, with respect to health insurance issuers or health insurance coverage, to supersede or impair the law of any State—

(1) providing solvency standards or similar standards regarding the adequacy of insurer capital, surplus, reserves, or contributions, or

(2) relating to prompt payment of claims.

(4) For additional provisions relating to association health plans, see subsections (a)(2)(B) and (b) of section 805.

"(c) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence:

‘‘Such term also includes a person serving as an association health plan sponsor as defined in section 3(6)) shall include such individual.

(2) PLANS, FUNDS, AND PROGRAMS TREATED AS EMPLOYER HEALTH PLANS.—In the case of any plan, fund, or program which was established, with respect to health insurance issuers or health insurance coverage, to supersede or impair the law of any State—

(1) providing solvency standards or similar standards regarding the adequacy of insurer capital, surplus, reserves, or contributions, or

(2) relating to prompt payment of claims.

(4) For additional provisions relating to association health plans, see subsections (a)(2)(B) and (b) of section 805.

"(b) C ONFORMING AMENDMENTS TO PREEMP-
TOR RULES.—

(1) Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:

"(E) The preceding subparagraphs of this paragraph do not apply with respect to any State law in the case of an association health plan which is certified under part 8.

(2) Section 114 of such Act (29 U.S.C. 1144) is amended—

(A) in subsection (b)(4), by striking ‘‘Subsection (a)’’ and inserting ‘‘Subsections (a) and (d)’’;

(B) in subsection (b)(5), by striking ‘‘sub-
section (a)’’ in subparagraph (A) and inserting ‘‘subsection (a) of this section and subsection 805’’, and by striking ‘‘subsection (a)’’ in subparagraph (B) and inserting ‘‘subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805’’;

(C) by redesignating subsections (d) and (e) as subsections (e) and (f), respectively; and

(D) by inserting after subsection (c) the following new subsection:

‘‘(d)(1) Except as provided in subsection (b)(4), the provisions of this section shall supersede any and all State laws insular as they may now or hereafter exist with respect to health insurance issuers from offering health insurance coverage in connection with an association health plan which is certified under part 8.

‘‘(2) Except as provided in paragraphs (4) and (5) of subsection (b) of this section—

‘‘(A) in any case in which health insurance coverage of any policy type is offered under an association health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supercede all laws of such State insular as they may now or hereafter exist with respect to health insurance issuers from offering health insurance coverage of such type to any other employer, including any employers which are eligible for coverage under such association health plan, whether or not such other employers are participating employers in such plan,

‘‘(B) in any case in which health insurance coverage of any policy type is offered in a State under an association health plan cer-
tified under part 8, the provisions of such plan shall supercede any and all laws of such State insular as they may now or hereafter exist with respect to health insurance issuers from offering health insurance coverage of such type.
by inserting after the item relating to section 734 the following new items:  
"(a) Criminals and former employees of participating employers:  
(1) by inserting at the end the following new subsection:  
"(j) Any person who willfully falsifies, alters, or destroys any record, document, or other written communication concerning a participant or beneficiary, any employee, the Secretary, or any State, a plan or other arrangement established or maintained for the purpose of offering or providing any benefit described in section 3(1) to employees or their beneficiaries as—  
"(1) an association health plan which has been certified under part 8;  
"(2) having been established or maintained under or pursuant to one or more collective bargaining agreements which are reached pursuant to collective bargaining described in section 8(d) of the National Labor Relations Act (29 U.S.C. 158(d)) or paragraph Four of section 2 of the Railway Labor Act (45 U.S.C. 152, paragraph Fourth) or which are reached pursuant to labor-management negotiations under similar provisions of State public employee relations laws; or  
"(3) being a plan or arrangement described in section 3(30)(A)(i);  
shall, upon conviction, be imprisoned not more than 5 years, be fined under title 18, United States Code, or both;".  
(b) Cease activities orders:—  
Section 502 of such Act (29 U.S.C. 1132) is amended by adding at the end the following new subsection:  
"(c) Association health plan cease and desist orders:—  
(1) In general:—Subject to paragraph (2), upon the filing with the Secretary by a plan or arrangement of an application for certification under section 8 of such plan, the Secretary shall require the board of trustees or the named fiduciary of any such plan or arrangement if the plan or arrangement shows that—  
(A) the plan or arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of such plan or arrangement; and  
(B) in any other case, the Secretary shall certify such plan or arrangement as an association health plan under part 8 in accordance with regulations of the Secretary applicable to certification under part 8.  
(b) Association health plans:—  
The Secretary shall consult with the State recognized under paragraph (2) with respect to an association health plan regarding the exercise of—  
"(A) the Secretary’s authority under sections 502 and 504 to enforce the requirements for certification under part 8; and  
"(B) the Secretary’s authority to certify association health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8.  
(c) Recognition of primary domicile state:—  
In carrying out paragraph (1), the Secretary shall ensure that only one State will be recognized, with particular association health plan, as the State with which consultation is required. In carrying out this paragraph—  
"(A) in the case of a plan which provides health insurance coverage (as defined in section 812(a)(3)), such State shall be the State with which filing and approval of a policy type offered by the plan was initially obtained, and  
"(B) in any other case, the Secretary shall take into account the places of residence of the participating employers and beneficiaries under the plan and the State in which such trust is maintained.".
section 211. extending coverage of dependents through plan year that includes 25th birthday.

(b) EMPLOYER RETIREMENT INCOME SECURITY ACT OF 1974.—

(1) IN GENERAL.—Part 7 of subtitle B of title I of the Employee Retirement Income Security Act is amended by inserting after section 2714 the following new section:

"Sec. 715. extending coverage of dependents.—

"(a) in general.—In the case of a group health plan, or health insurance coverage offered in connection with a group health plan, that treats as a beneficiary under the plan an individual who is a dependent child of a participant or beneficiary under the plan, the plan or coverage shall continue to treat the individual as a dependent child without regard to the individual's age through at least the end of the plan year in which the individual turns an age specified in the plan, but not less than 25 years of age.

"(b) construction.—Nothing in this section shall be construed as requiring a group health plan to provide benefits for dependent children as beneficiaries under the plan or to require a participant to elect coverage of dependent children.

(2) Clerical amendment.—The table of sections in such chapter is amended by adding at the end the following new item:

"Sec. 715. Extending coverage of dependents through plan year that includes 25th birthday.

section 212. allowing auto-enrollment for employer sponsored coverage.

(a) in general.—No State shall establish a law that prevents an employer from instituting the automatic enrollment of a participant or beneficiary, including current employees, under a group health plan, or health insurance coverage offered in connection with such a plan, on or after such date.

(b) Effective date.—The amendments made by this section shall apply to group health plans for plan years beginning more than 3 months after the date of the enactment of this Act and shall apply to individual health insurance coverage offered in connection with such a plan, on or after such date.

section 213. interstate purchasing of health insurance.

(1) primary state.—The term 'primary State' means, with respect to individual health insurance coverage offered by a health insurance issuer, the State designated by the issuer as the State whose laws shall govern the health insurance issuer in the sale of such coverage under this part. An issuer, with respect to a particular policy that is issued in one State, may designate that State as its primary State with respect to such policy and shall be bound thereby.

(2) secondary state.—The term 'secondary State' means, with respect to individual health insurance coverage offered by a health insurance issuer, any State that is not the primary State. In the case of a health insurance issuer that is selling a policy or to a resident, a secondary State, the issuer is deemed to be doing business in that secondary State.

section 214. health insurance issuer.—The term 'health insurance issuer' has the meaning given such term in section 2791(b)(2), except that such an issuer must be licensed in the primary State and be qualified to sell individual health insurance coverage in that State.

section 215. individual health insurance coverage.
or order governing the use of care or cost management techniques, including any requirement related to provider contracting, network access or adequacy, health care data reporting, or guaranty or policy provisions relating to coverage at issue.

(8) STATE.—The term ‘State’ means the 50 States and includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

(9) UNFAIR CLAIMS SETTLEMENT PRACTICES.—The term ‘unfair claims settlement practices’ means only the following practices:

(A) Knowingly misrepresenting to claimants or insureds any relevant factor or policy provisions relating to coverage at issue.

(B) Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under policies.

(C) Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under policies.

(D) Failing to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear.

(2) Refusing to pay claims without conducting a reasonable investigation.

(F) Failing to affirm or deny coverage of claims within a reasonable period of time after having completed an investigation related to those claims.

(G) Any practice of compelling insured individuals or their beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them.

(H) A pattern or practice of attempting to settle or settling claims for less than the amount that a reasonable person would believe the insured individual or his or her beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application.

(I) Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured.

(J) Failing to provide forms necessary to present claims within 15 calendar days of a request with reasonable explanations regarding their use.

(K) Attempting to cancel a policy in less time than that prescribed in the policy or by the law of the State.

(10) FRAUD AND ABUSE.—The term ‘fraud and abuse’ means an act or omission committed by a person, knowingly and with intent to deceive, fraudulently, or recklessly, or a knowing or intentional misrepresentation, concealment, or omission of any material information concerning, one or more of the following:

(A) Presenting, causing to be presented or submitted to, or permitting, any false, fictitious, or fraudulent information, statement, or entry in any application for an insurance policy or reinsurance contract.

(B) Submitting to an examination of its financial condition by the State insurance commissioner as its agent solely for the purpose of receiving service of legal documents or process.

(C) To submit to an examination of its financial condition by the State insurance commissioner in any State in which the issuer is doing business to determine the issuer’s financial condition, if—

(i) the State insurance commissioner of the primary State has not done an examination within the period recommended by the National Association of Insurance Commissioners; and

(ii) any such examination is conducted in accordance with the National Association of Insurance Commissioners and is coordinated to avoid unjustified duplication and unjustified repetition.

(D) Failing to comply with a lawful order issued—

(i) in a delinquency proceeding commenced by the State insurance commissioner if there has been a finding of financial impairment; or

(ii) in a voluntary dissolution proceeding;

(E) Failing to comply with an injunction issued by a court of competent jurisdiction, upon a petition of the State insurance commissioner alleging that the insurer is in hazardous financial condition;

(F) To participate, on a nondiscriminatory basis, in any insurance insolvency guaranty association or similar association to which a health insurance issuer in the State is required or entitled;

(G) To comply with any State law regarding fraud and abuse (as defined in section 2795(10)); or

(H) Failing to comply with any State law regarding unfair claims settlement practices (as defined in section 2796(9)); or

(i) to comply with the applicable requirements of an independent examiner; or

(j) otherwise discriminate against the issuer issuing insurance in both the primary State and in any secondary State.

(C) CLEAR AND CONSPICUOUS DISCLOSURE.—A health insurance issuer shall provide the following notice, in 12-point bold type, in an insurance coverage offering in any secondary State under this part by such a health insurance issuer and at renewal of the policy, with the 5 blank spaces therein being replaced with the name of the health insurance issuer, the name of primary State, the name of the secondary State, the name of the secondary State, and the name of the secondary State, respectively, for the coverage concerned:

THIS POLICY IS ISSUED BY . AND IS GOVERNED BY THE LAWS AND REGULATIONS OF THE STATE OF , AND IT HEADS ALL THE LAWS OF THAT STATE AS DETERMINED BY THAT STATE’S DEPARTMENT OF INSURANCE. THIS POLICY MAY BE LESS EXPENSIVE THAN OTHERS BECAUSE IT IS NOT SUBJECT TO ALL OF THE INSURANCE LAWS AND REGULATIONS OF THE STATE OF , INCLUDING COVERAGE OF SOME SERVICES OR BENEFITS MANDATED BY THE LAW OF THE STATE OF . ADDITIONALLY, THIS POLICY IS NOT SUBJECT TO ALL OF THE CONSUMER PROTECTION LAWS OR REGULATIONS ON RATING AND CLASSIFICATIONS OF THE STATE OF AS WITH ALL INSURANCE PRODUCTS. BEFORE PURCHASING THIS POLICY, YOU SHOULD CAREFULLY REVIEW THE POLICY AND DETERMINE WHAT HEALTH CARE SERVICES THE POLICY COVERS AND WHAT BENEFITS IT PROVIDES, INCLUDING ANY EXCLUSIONS, LIMITATIONS, OR CONDITIONS FOR SUCH SERVICES OR BENEFITS.

(4) PROHIBITION ON CERTAIN RECLASSIFICATIONS AND PREMIUM INCREASES.—

(A) In general.—For purposes of this section, if a health insurance issuer provides individual health insurance coverage to an individual under this part in a primary or secondary State may not upon renewal—

(i) increase the premiums assessed the individual insures under the health insurance coverage from the class such individual is in at the time of issue of the contract based on the health-status related factors of the individual; or

(ii) increase the premiums assessed the individual for such coverage based on a health status-related factor or change of a health status-related factor or the past or prospective claim experience of the insured individual.

(B) Interpretation.—Nothing in paragraph (1) shall be construed to prohibit a health insurance issuer—
“(A) from terminating or discontinuing coverage or a class of coverage in accordance with subsections (b) and (c) of section 2742;

“(B) from raising premium rates for all policies writers within a class based on claims experience;

“(C) from changing premiums or offering discounted premiums to individuals who engage in wellness activities at the request of the issuer, if such premium changes or incentives—

“(i) are disclosed to the consumer in the insurance contract; and

“(ii) are based on specific wellness activities that are not applicable to all individuals;

“(D) from reinstating lapsed coverage; or

“(E) from retroactively adjusting the rates charged an insured individual if the initial rates were set based on material misrepresentation by the individual at the time of issue.

“(f) PRIOR OFFERING OF POLICY IN PRIMARY STATE.—A health insurance issuer may not offer for sale individual health insurance coverage in a secondary State unless that coverage is currently offered for sale in the primary State.

“(f)(1) LICENSING OF AGENTS OR BROKERS FOR HEALTH INSURANCE ISSUERS.—Any State may require that a person acting, or offering to act, as an agent or broker for a health insurance issuer with respect to the offering of individual health insurance coverage obtain a license from that State, with commissions or other compensation subject to the provisions of the laws of that State, except that a State may not impose any qualification or requirement which discriminates against a nonresident agent or broker.

“(f)(2) REQUIREMENT TO SUBMIT TO STATE INSURANCE COMMISSIONER.—Each health insurance issuer issuing individual health insurance coverage in both primary and secondary States shall submit—

“(i) to the insurance commissioner of each State in which it intends to offer such coverage, before it may offer individual health insurance coverage in such State—

“(A) a copy of the plan of operation or feasibility study or any similar statement of the policy being offered and its coverage (which shall include the name of its primary State and its principal place of business);

“(B) written notice of any change in its designation of its primary State; and

“(ii) to the insurance commissioner of the State of incorporation of the issuer of the insurer’s compliance with all the laws of the primary State; and

“(3) to the insurance commissioner of each secondary State in which it offers individual health insurance coverage, a copy of the insurer’s quarterly financial statement submitted to the primary State, which statement shall not be subject to public disclosure, and a statement of opinion on loss and loss adjustment expense reserves made by a qualified actuary of the American Academy of Actuaries; or

“(B) a qualified loss reserve specialist.

“(g) POWER OF COURTS TO ENJOIN CONDUCT.—Nothing in this section shall be construed to affect the authority of any Federal or State court to enjoin—

“(1) the solicitation or sale of individual health insurance coverage by a health insurance issuer to any person or group who is not eligible for such insurance; or

“(2) the solicitation or sale of individual health insurance coverage that violates the requirements of the law of a secondary State which are described in subparagraphs (A) through (G) of section 2796b(b)(1).

“(h) POWER OF SECONDARY STATES TO TAKE ADMINISTRATIVE ACTION.—Nothing in this section shall be construed to affect the authority of any State to enjoin conduct in violation of that State’s laws described in section 2796b(b)(1).

“(i) STATE POWERS TO ENFORCE STATE LAWS.—

“(1) IN GENERAL.—Subject to the provisions of subsections (b) and (c) of paragraph (2), nothing in this section shall be construed to affect the authority of any State to make use of any of its laws or powers empowering such State with respect to which a health insurance issuer is not exempt under subsection (b).

“(2) COURTS OF COMPETENT JURISDICTION.—If a State determines, after a hearing and review of the conduct described in paragraphs (1) and (2) of subsection (b), such injunction must be obtained from a Federal or State court of competent jurisdiction.

“(j) STATES’ AUTHORITY TO SUE.—Nothing in this section shall affect the authority of any State to bring action in any Federal or State court.

“(k) GENERALLY APPLICABLE LAWS.—Nothing in this section shall be construed to affect the applicability of State laws generally applicable to persons or corporations.

“(l) GUARANTEED AVAILABILITY OF COVERAGE TO HIPAA ELIGIBLE INDIVIDUALS.—To the extent that a health insurance issuer is offering coverage in a primary State that does not accommodate residents of secondary States, the issuer shall—

“(1) as permitted by law of that State, provide a working mechanism for residents of a secondary State, and the issuer is offering coverage under this part in such secondary State which has not adopted a qualified high risk pool as its acceptable alternative mechanism (as defined in section 2744(c)(2)), the issuer shall, with respect to any individual health insurance coverage in a secondary State under this part, comply with the guaranteed availability requirements for eligible individuals in the qualified high risk pool.

“SEC. 2797. PRIMARY STATE MUST MINT FEDERAL FLOOR BEFORE INSURER MAY SELL INTO SECONDARY STATES.

“A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State if the State insurance commissioner does not use a risk-based capital formula for the determination of capital and surplus requirements for all health insurance issuers.

“SEC. 2798. RIGHTS TO EXTERNAL APPEALS PROCEDURES.

“(a) RIGHT TO EXTERNAL APPEAL.—A health insurance issuer may not offer, sell, or issue individual health insurance coverage in a secondary State unless that State’s authority and the insurance commission for such State have—

“(1) adopted a qualified high risk pool as its acceptable alternative mechanism (as defined in section 2744(c)(2));

“(2) the solicitation or sale of individual health insurance coverage that violates the requirements of the law of a secondary State which are described in subparagraphs (A) through (G) of section 2796b(b)(1).

“(4) PRACTICING HEALTH CARE PROFESSIONAL IN SAME FIELD.—

“(A) IN GENERAL.—In a case involving treatment, or the provision of items or services—

“(i) by a physician, a reviewer shall be a practicing physician (allopathic or osteopathic) of the same or similar specialty, as a physician who, acting within the appropriate scope of practice within the State in which the services are to be provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review; or

“(ii) by a non-physician health care professional, the reviewer shall be a practicing physician (allopathic or osteopathic) of the same or similar specialty, as a physician who, acting within the appropriate scope of practice
within the State in which the service is provided or rendered, typically treats the condition, makes the diagnosis, or provides the type of treatment under review.

(5) PEDIATRIC EXPERTISE.—In the case of an external review relating to a child, a reviewer shall have expertise under paragraph (2) in pediatrics.

(6) LIMITATIONS ON REVIEWER COMPENSATION.—(A) The provider or issuer is not prohibited by law from referring a case to an independent medical reviewer in connection with a review under this section if—

(A) not exceed a reasonable level; and

(B) not be contingent on the decision rendered by the reviewer.

(7) RELATED PARTY DEFINED.—For purposes of this section, the term ‘related party’ means, with respect to a denial under a coverage relating to an enrollee, any of the following:

(A) the enrollee (or authorized representative);

(B) The manufacturer of any drug or other item that is included in the items or services (or treatment) involved in the denial.

(8) Any other party determined under any regulations to have a substantial interest in the denial involved.

(9) Definitions.—For purposes of this subsection:

(A) 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.

(B) Health Care Professional.—The term ‘health care professional’ means an individual who is licensed, accredited, or certified under State law to provide specified health services and who is operating within the scope of such licensure, accreditation, or certification.

SEC. 2799. ENFORCEMENT.

(a) IN GENERAL.—Subject to subsection (b), with respect to specific individual health insurance coverage offered by a health insurance issuer, an individual enrolled with the issuer to receive such coverage.

(b) SECONDARY STATE’S AUTHORITY.—Nothing in subsection (a) shall be construed to affect the authority of a secondary State to enforce its laws as set forth in the exception specified in section 2796(b)(1).

(c) NOTICE OF COMPLIANCE FAILURE.—In reviewing action initiated by the applicable secondary State authority, the court of competent jurisdiction shall apply the covered laws of the primary State.

(d) NOTICE OF COMPLIANCE FAILURE.—In the case of individual health insurance coverage offered in a secondary State that fails to comply with the covered laws of the primary State, the applicable State authority of the secondary State may notify the applicable State authority of the primary State.

(e) EFFECTIVE DATE.—The amendments made by this subsection shall apply to insurance policies offered in different States; and

(f) The availability and cost of health insurance policies generally.

SEC. 231. SAVERS’ CREDIT FOR CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS.

(a) ALLOWANCE OF CREDIT.—Subsection (a) of section 223(d)(1) of the Internal Revenue Code of 1986 is amended by inserting “aggregate qualified HSA contributions and” after “so much of the.”

(b) QUALIFIED HSA CONTRIBUTIONS.—Subsection (d) of section 223 of such Code is amended by redesignating paragraph (2) as paragraph (3) and by inserting after paragraph (1) the following new paragraph:

(2) QUALIFIED HSA CONTRIBUTIONS.—The term ‘qualified HSA contribution’ means, with respect to any taxable year, a contribution of the enrollee to a health savings account (as defined in section 223(d)(1)) for which a deduction is allowable under section 22(a) for such taxable year.

(c) CONFORMING AMENDMENT.—The first sentence of section 25B(d)(3)(A) of such Code is amended by redesignating subsection (b) as subsection (c), redesignating subsection (c) as subsection (b), and inserting after subsection (b) the following:

The aggregate contributions received by the individual during the testing period from any entity of a type to which contributions under paragraph (2) (as the case may be) may be made.”

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to contributions made after December 31, 2009.

SEC. 232. HSA FUNDS FOR PREMIUMS FOR HIGH DEDUCTIBLE HEALTH PLANS.

(a) IN GENERAL.—Subparagraph (C) of section 223(d)(2) of the Internal Revenue Code of 1986 is amended by striking ‘‘or’’ at the end of clause (iii), by inserting ‘‘and’’ after ‘‘in the case of’’ and by striking the period at the end of clause (iv) and inserting ‘‘.’’.

(b) EFFECTIVE DATE.—The amendments made by this subsection shall apply to insurance policies offered in different States; and

(c) GAO ONGOING STUDY AND REPORTS.—(1) STUDY.—The Comptroller General of the United States shall conduct an ongoing study concerning the effect of the amendment made by subsection (a) on—

(A) the number of uninsured and under-insured;

(B) the availability and cost of health insurance policies offered in different States; and

(C) the availability and cost of health insurance policies generally.

(2) ANNUAL REPORTS.—The Comptroller General shall submit to Congress an annual report, after the end of each of the 5 years following the effective date of the amendment made by subsection (a), on the ongoing study conducted under paragraph (1).

TITLE IV—IMPROVING HEALTH SAVINGS ACCOUNTS

SEC. 302. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTIONS BY A MINOR.—Subsection (c) of section 219 of the Civil Rights Act of 1964 is amended by inserting ‘‘a minor’’ after ‘‘the injury,’’ and by striking the period at the end of subparagraph (A) and inserting ‘‘, the injury, whichever occurs first.’’

(b) EFFECTIVE DATE.—The amendment made by this subsection shall apply to insurance policies offered in different States; and

(c) GAO ONGOING STUDY AND REPORTS.—(1) STUDY.—The Comptroller General of the United States shall conduct an ongoing study concerning the effect of the amendment made by subsection (a) on premiums for a high deductible health plan for periods beginning after December 31, 2009.

SEC. 303. ENHANCED MEASURES TO ENSURE ACCESS TO HEALTH SAVINGS ACCOUNTS.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTIONS BY A MINOR.—Subsection (b) of section 219 of the Civil Rights Act of 1964 is amended by striking ‘‘the injury’’ and the period at the end of subparagraph (D) and inserting ‘‘the injury, whichever occurs first.’’

(b) EFFECTIVE DATE.—The amendment made by this subsection shall apply to insurance policies offered in different States; and

(c) GAO ONGOING STUDY AND REPORTS.—(1) STUDY.—The Comptroller General of the United States shall conduct an ongoing study concerning the effect of the amendment made by subsection (a) on premium rates for a high deductible health plan for periods beginning after December 31, 2009.

SEC. 304. INCREASING THE DEDUCTIBLE FOR CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT.

(a) IN GENERAL.—Subsection (a) of section 223 of the Internal Revenue Code of 1986 is amended by redesignating paragraph (4) as paragraph (5) and by inserting after paragraph (4) the following new paragraph:

4) CERTAIN MEDICAL EXPENSES INCURRED BEFORE ESTABLISHMENT OF ACCOUNT TREATED AS QUALIFIED.—

(b) EFFECTIVE DATE.—The amendment made by this subsection shall apply with respect to insurance purchased after the date of the enactment of this Act in taxable years beginning after such date.

DIVISION C—ENACTING REAL MEDICAL LIABILITY REFORM

SEC. 301. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury unless tolled for any of the following:

(1) upon proof of fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person’s system.

Actions by a minor shall be commenced within 3 years of the date of manifestation of injury except that actions by a minor under the full age of 6 years shall be commenced within 3 years of manifestation of injury or prior to the minor’s 8th birthday, whichever provides a longer period.

The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury unless tolled for any of the following:

(1) upon proof of fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person’s system.

The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury unless tolled for any of the following:

(1) upon proof of fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person’s system.

The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury unless tolled for any of the following:

(1) upon proof of fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person’s system.

The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury unless tolled for any of the following:

(1) upon proof of fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person’s system.

The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury unless tolled for any of the following:

(1) upon proof of fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person’s system.

The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury unless tolled for any of the following:

(1) upon proof of fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person’s system.
in this title shall limit a claimant’s recovery of the full amount of the available economic damages, notwithstanding the limitation in subsection (b).

(2) ADDITIONAL NONECONOMIC DAMAGES.—In any health care lawsuit, the amount of non-economic damages, if available, may be as much as $250,000, regardless of the number of parties to the action or the action or actions brought with respect to the same injury.

(c) No Discount of Award for Non-economic Damages.—For purposes of applying the limitation in subsection (b), future noneconomic damages shall not be discounted to present value. The jury shall not be instructed of the maximum award for noneconomic damages. An award for non-economic damages in excess of $250,000 shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law. If separate awards are rendered for past and future noneconomic damages and the combined awards exceed $250,000, the future noneconomic damages shall be reduced.

(d) Fair Share Rule.—In any health care lawsuit, each party shall be liable for that party’s share of any damages only and not for the share of any other party. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party’s percentage of fault. Whenever a settlement of liability is rendered as to any party, a separate judgment shall be rendered against each such party for the amount allocated to such party by the settlement.

SECTION 306. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) In General.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter an order of judgment that such future damages be paid by periodic payments. In any health care lawsuit, the court may be guided by the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) Application.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this title.

SECTION 307. DEFINITIONS.

In this title:

(1) Alternative Dispute Resolution System; ADR.—The term “alternative dispute resolution system” or “ADR” means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) Claimant.—The term “claimant” means any person who brings a health care lawsuit, including a person who asserts or claims a legal right to money damages as a result of the conduct of another, whether as a plaintiff, defendant, or opposing party.

(3) Collateral Source Benefits.—The term “collateral source benefits” means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers’ compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits for a health care liability claim or action, and any group, organization, partnership, or corporation, or any State or Federal health care program, that provides health benefits for a health care liability claim or action;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the claimant for medical, hospital, dental, or income-disability benefits; and

(D) any other publicly or privately funded program.

(4) Compensatory Damages.—The term “compensatory damages” means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, lost earnings, employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), loss of enjoyment of future earnings, loss of services of the deceased, and all other nonpecuniary losses of any kind or nature. The term “compensatory damages” includes economic damages and non-economic damages, as qualified terms defined in this section.

(5) Contingent Fee.—The term “contingent fee” includes all compensation to any person who has a financial stake in the outcome of any health care lawsuit only if it is proven that such person knew the claimant was substantially certain to suffer harm in the future or on behalf of the claimant.

(6) Court Supervision of Share of Damages Actually Paid to Claimants.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants. In particular, in any health care lawsuit, the claimant’s attorney for the claimant who claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant’s share of damages to such attorney for the claimant, and to redirect such damages to the claimant or receive any lien or credit against the claimant’s recovery or be equitably or legally subrogated to the right of the claimant to receive any lien or credit against the claimant’s recovery or be equitably or legally subrogated.

(7) Economic Damages.—The term “economic damages,” as such terms are defined in this title, includes economic damages and non-economic damages, as qualified terms defined in this section.

(8) Economic Damages, Noneconomic Damages.—In any health care lawsuit involving injury or wrongful death, any party may introduce evidence of collateral source benefits. If a party elects to introduce such evidence, any opposing party may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the opposing party to secure the right to such collateral source benefits. No provider of collateral source benefits is liable for any punitive damages against the claimant or receive any lien or credit against the claimant’s recovery or be equitably or legally subrogated to the right of the claimant to receive any lien or credit against the claimant’s recovery or be equitably or legally subrogated.

(9) Economic Damages, Noneconomic Damages.—In any health care lawsuit where no judgment for compensatory damages is entered by the court, and no punitive damages are awarded, the claimant is entitled to receive any lien or credit against the claimant’s recovery or be equitably or legally subrogated to the right of the claimant to receive any lien or credit against the claimant’s recovery or be equitably or legally subrogated.

(10) Economic Damages, Noneconomic Damages.—In any health care lawsuit where no judgment for compensatory damages is entered by the court, and no punitive damages are awarded, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants. In particular, in any health care lawsuit, the claimant’s attorney for the claimant who claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant’s share of damages to such attorney for the claimant, and to redirect such damages to the claimant based on the interests of justice and principles of equity. In no event shall the total contingent fee for the representation of all claimants in a health care lawsuit exceed the following limits:

(A) 40 percent of the first $50,000 recovered by the claimant(s);

(B) 33 percent of the next $50,000 recovered by the claimant(s);

(C) 25 percent of the next $500,000 recovered by the claimant(s); and

(D) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $500,000.

(b) Applicability.—The limitations in this section shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution. In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve such fees, if less than the maximum permitted under this section. The requirement for court supervision in the first two sentences of subsection (a) applies only in civil actions.

SECTION 304. ADDITIONAL HEALTH BENEFITS.

In any health care lawsuit involving injury or wrongful death, any party may introduce evidence of collateral source benefits. If a party elects to introduce such evidence, any opposing party may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the opposing party to secure the right to such collateral source benefits. No provider of collateral source benefits is liable for any punitive damages against the claimant or receive any lien or credit against the claimant’s recovery or be equitably or legally subrogated.

SECTION 305. PUNITIVE DAMAGES.

(a) In General.—Punitive damages may, if otherwise permitted by applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer. In any health care lawsuit where no judgment for compensatory damages is entered by the court, punitive damages may be awarded with respect to the claim in such lawsuit. No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that punitive damages will prevail on the claim for punitive damages. At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(1) whether punitive damages are to be awarded and the amount of such award; and

(2) the amount of punitive damages following the proceedings for estoppeling the opposing party from introducing evidence of collateral source benefits. If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be in any proceeding to determine whether compensatory damages are to be awarded.

(b) Determining Amount of Punitive Damages.—

(1) Factors Considered.—In determining the amount of punitive damages, if awarded, in a health care lawsuit, the trier of fact shall consider the following—

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of the conduct;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) Maximum Award.—The amount of punitive damages, if awarded, in a health care lawsuit may be as much as $250,000 or as much as $500,000, whichever is greater. The jury shall not be informed of this limitation.

(3) Punitive Damage Limitation.—The amount of punitive damages shall not be subject to reduction by settlement, or any other form of alternative dispute resolution, by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution. In any health care lawsuit, no punitive damages may be awarded against any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(4) Punitive Damages May Be Awarded Against Any Person.—In any health care lawsuit involving injury or wrongful death, any party may introduce evidence of collateral source benefits. If a party elects to introduce such evidence, any opposing party may introduce evidence of collateral source benefits. If a party elects to introduce such evidence, any opposing party may introduce evidence of collateral source benefits.
(6) Economic damages.—The term “economic damages” means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining another product or service, loss of time, loss of business or employment opportunities.

(7) Health care lawsuit.—The term “health care lawsuit” means any health care liability claim concerning the provision of health care goods or services or any medical product affecting interstate commerce, or any action claiming a violation of any such provision of health care goods or services or any medical product affecting interstate commerce, or any cause of action under any other provision of Federal law, or any action against a State court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim. Such term does not include any action which is based on criminal liability; which seeks civil fines or penalties paid to Federal, State, or local government; or which is grounded in antitrust.

(8) Health care liability action.—The term “health care liability action” means a civil action brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider, a health care organization, or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(9) Health care liability claim.—The term “health care liability claim” means a demand by any person, whether or not pursuing to ADR, against a health care provider, health care organization, the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, including, but not limited to, third-party payers, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(10) Health care organization.—The term “health care organization” means any person or entity which is obligated to provide or pay for health care services under any health plan, including any person or entity acting under a contract or arrangement with a health care organization to provide or administer any health benefit.

(11) Health care provider.—The term “health care provider” means any person or entity, whether or not pursuant to ADR, against a health care provider, health care organization, the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, or any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person or entity. Punitive damages are neither economic nor noneconomic damages.

(12) Health care services or products.—The term “health care services or products” means any goods or services provided by a health care organization, or the manufacturer, distributor, supplier, marketer, or vendor working under the supervision of a health care provider, that relates to the diagnosis, prevention, or treatment of any human disease or impairment, or the assessment or care of the health of human beings.

(13) Malicious intent to injure.—The term “malicious intent to injure” means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) Medical product.—The term “medical product” means a drug, device, or biological product intended for humans, and the terms “drug”, “device”, and “biological product” have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321(g)(1) and (h)) and section 351(a) of the Public Health Service Act (42 U.S.C. 262(a)), respectively, including any component or raw material used therein, but excluding health care services.

(15) Noneconomic damages.—The term “noneconomic damages” means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(16) Punitive damages.—The term “punitive damages” means damages awarded, for a purpose, or in any other proceeding (or failure to provide, use, or pay for) health care services or medical products, regardless of whether such monetary amount is greater or lesser than is provided for under this title, notwithstanding section 302(a); or any defense available to a party in a health care lawsuit brought in a Federal or State court, or pursuant to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring prior to the date of the enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

DIVISION D—PROTECTING THE DOCTOR-PATIENT RELATIONSHIP

SEC. 401. RULE OF CONSTRUCTION.

Nothing in this Act shall be construed to interfere with the doctor-patient relationship or the practice of medicine.

SEC. 402. RULE OF GENERAL APPLICABILITY.

This title shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring prior to the date of the enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

DIVISION E—INCENTIVIZING WELLNESS AND QUALITY IMPROVEMENTS

SEC. 501. INCENTIVIZING WELLNESS AND QUALITY IMPROVEMENTS.

subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this title. The provisions governing health care lawsuits shall supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a particular amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of the periodic payment of damage claims, than provided in this title; or

(2) prohibits the introduction of evidence regarding collateral source benefits, or mandates separate subrogation or a lien on collateral source benefits.

(b) Protection of States’ Rights and Other Laws.—(1) Any issue that is not governed by any provision of law established by or under this title (including State standards of negligence) shall be governed by otherwise applicable State or Federal law.

(2) This title shall not preemp....
SEC. 601. PROVIDE FULL FUNDING TO HIS OIG AND HCFA.

(a) HCFAC FINANCING.—Section 1817(k)(3)(A) of the Social Security Act (42 U.S.C. 1395i(k)(3)(A)) is amended—

(1) in clause (i)—

(A) in subclause (IV), by striking “2009, and” and inserting “and 2009”;

(B) by amending subclause (V) to read as follows:

“(V) for each fiscal year after fiscal year 2009, $300,000,000.”; and

(2) in clause (ii)—

(A) in subclause (IX), by striking “2009, and” and inserting “and 2009”;

(B) in subclause (X), by striking “2010” and inserting “2009” and inserting before the period at the end the following:

“; plus the amount, if any, of such amount made available under clause (i)(V) for fiscal year 2010 exceeds the amount made available under clause (i)(IV) for 2009.”.

SEC. 601A. NO GOVERNMENT DISCRIMINATION AGAINST CERTAIN HEALTH CARE ENTITIES.

(1) IN GENERAL.—No funds authorized or appropriated by federal law may be made available to a Federal agency or program, or to a State or local government, if such agency, program, or government subjects any institutional or individual health care entity to discrimination on the basis that the health care entity does not provide, pay for, or otherwise participate in the provision of services that are such services.

(2) HEALTH CARE ENTITY DEFINED.—For purposes of this section, the term ‘health care entity’ includes a physician or hospital, or other entity providing health services, or a provider-sponsored organization, a health maintenance organization, a health insurance plan, or any other kind of health care facility, organization, or plan.”.

SEC. 603. IMPROVED ENFORCEMENT OF THE MEDICARE AND MEDICAID SECONDARY PAYER PROVISIONS.

(a) MEDICARE.—

(1) IN GENERAL.—The Secretary, in coordination with the Inspector General of the Department of Health and Human Services, shall provide through the Coordination of Benefits Contractor for the identification of payments where the secondary payer should be, but is not, acting as a secondary payer to an individual’s private health benefits coverage under section 1862(b) of the Social Security Act (42 U.S.C. 1395j).

(2) UPDATING PROCEDURES.—The Secretary shall update procedures for identifying and resolving credit balance situations which arise under the Medicare program under such title and from other health benefit plans exceed the providers’ charges or the allowed amount.

(3) REPORT ON IMPROVED ENFORCEMENT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit a report to Congress on progress made in improved enforcement of the Medicare secondary payer provisions, including recoupment of credit balances.

(b) MEDICAID.—Section 1903 of the Social Security Act (42 U.S.C. 1396p) is amended by adding at the end the following new subsection:

“(w) ENFORCEMENT OF PAYOR OF LAST RESORT PROVISIONS.—

“(1) Submission of State plan amendment.—Each State shall submit, not later than 1 year after the date of the enactment of this Act, a State plan amendment that details how the State will become fully compliant with the requirements of section 1903(w).

“(2) Bonus for compliance.—If a State submits a timely State plan amendment under paragraph (1) that the Secretary determines provides for full compliance of the State with the requirements of section 1902(a)(25), the Secretary shall provide for an additional payment to the State of $1,000,000. If a State certifies, to the Secretary’s satisfaction, that it is already fully compliant with such requirements, such amount shall be increased to $2,000,000.

“(3) Reversion for noncompliance.—If a State does not submit such an amendment, the Secretary shall reduce the Federal medical assistance percentage otherwise applicable to payments to the State under section 1902(a)(25), disregarding the status of the State’s submission of a State plan amendment under this subsection or previous determinations of compliance such compliance the Secretary shall reduce the Federal medical assistance percentage otherwise applicable under this title for the State by 1 percentage point during the period of noncompliance as determined by the Secretary.”.

SEC. 604. STRENGTHEN MEDICARE PROVIDER ENROLLMENT STANDARDS AND SAFEGUARDS.

(a) PROTECTING AGAINST THE FRAUDULENT USE OF MEDICARE PROVIDER NUMBERS.—Subject to subsection (b), for the first time for a provider number under the Medicare program and before granting billing privileges under such title, the Secretary shall screen the provider or supplier for a criminal background or other financial or operational irregularities
(2) Application Fees.—The Secretary shall impose an application charge on such a provider in order to cover the Secretary’s costs in performing the screening required under paragraph (1) and that is revenue neutral to the Federal government.

(3) Imposition of Moratoria.—During the initial, provisional period (specified by the Secretary) in which such a provider or supplier has been issued such a number, the Secretary shall impose a moratorium on approval of provider and supplier numbers under the Medicare program, or may impose a civil money penalty (in the amount described in sections 1128 and 1128A, respectively, of the Act) on any provider or supplier under the Medicare program, such as through prepayment review and payment limitations.

(4) Penalties for False Statements.—In the case of a provider or supplier that makes a false statement in an application for such a number, the Secretary may exclude the provider or supplier from participation under the Medicare program, or may impose a civil money penalty (in the amount described in section 1128A(a)(4) of the Social Security Act), in the same manner as the Secretary may impose such an exclusion or penalty under sections 1128 and 1128A, respectively, of such title, or knowledge of presentation of a false claim described in section 1128A(a)(1)(A) of such Act.

(5) Disclosure Requirements.—With respect to approval of such an application, the Secretary—

(A) shall require applicants to disclose previous affiliation with enrolled entities that have uncollected debt related to the Medicare or Medicaid programs;

(B) may deny approval if the Secretary determines that these affiliations pose undue risk to the Medicare or Medicaid programs, subject to an appeals process for the applicant as determined by the Secretary; and

(C) may implement enhanced safeguards (such as surety bonds).

(b) Moratorium.—The Secretary may impose moratoria on approval of provider and supplier numbers under the Medicare program for new providers of services and suppliers as determined necessary to prevent or combat fraud a period of delay for any one applicant cannot exceed 30 days unless cause is shown by the Secretary.

(c) Funding.—

(1) In General.—There are authorized to be appropriated to carry out this section such sums as may be necessary.

(2) Condition.—The provisions of paragraphs (1) and (2) of subsection (a) shall not apply unless and until funds are appropriated to carry out such provisions.

SEC. 605. TRACKING BANNED PROVIDERS ACROSS STATE LINES.

(a) Greater Coordination.—The Secretary of Health and Human Services shall provide for increased coordination between the Administrator of the Centers for Medicare & Medicaid Services (in this section referred to as “CMS”) and other Federal, State, and local offices to ensure that providers of services and suppliers that have operated in one State and are excluded from participation in the Medicare program are unable to begin operation and participation in the Medicare program in another State.

(b) Improved Information Systems.—

(1) In General.—The Secretary shall improve information systems to allow greater integration between databases under the Medicare program so that—

(i) managed care organizations, their contractors, fiscal intermediaries, and carriers have immediate access to information identifying providers and suppliers excluded from participation in the Medicare and Medicaid programs and other Federal health care programs; and

(ii) such information can be shared across Federal health care programs and agencies, including between the Departments of Health and Human Services, the Social Security Administration, the Department of Veterans Affairs, the Department of Defense, the Department of Justice, and the Office of Personnel Management.

(c) Medicare/Medicaid “One PI” Database.—The Secretary shall implement a database that includes claims and payment data for all components of the Medicare program and the Medicaid program.

(d) Authorizing Expanded Data Matching.—Notwithstanding any provision of the Computer Matching and Privacy Protection Act of 1988 to the contrary—

(1) the Secretary and the Inspector General in the Department and Human Services may perform data matching of data from the Medicare program with data from the Medicaid program; and

(2) the Commissioner of Social Security and the Secretary may perform data matching of data of the Social Security Administration with data from the Medicare and Medicaid programs.

(e) Consolidation of Data Bases.—The Secretary shall consolidate and expand into a centralized database individuals and entities that have been excluded from Federal health care programs, the Healthcare Integrity and Protection Data Bank, the National Practitioner Data Bank, the List of Excluded Individuals/Entities, and a national patient identifier database, and such other information as the Secretary determines to be necessary.

(f) Comprehensive Provider Database.—

(1) Establishment.—The Secretary shall establish a comprehensive database that includes information on providers of services, suppliers, and entities participating in the Medicare program, the Medicaid program, or both. Such database shall include, information on ownership and business relationships, history of adverse actions, results of site visits or other monitoring by any program.

(2) Use.—Prior to issuing a provider or supplier number for an entity under the Medicare program, the Secretary shall obtain information from such database to assure that the entity meets the requirements for the issuance of such a number.

(g) Comprehensive Sanctions Database.—The Secretary shall establish a comprehensive sanctions database on sanctions imposed on providers of services and related entities. Such database shall be overseen by the Inspector General of the Department of Health and Human Services and shall be linked to related databases maintained by State licensure boards and by Federal or State law enforcement agencies.

(h) Access to Claims and Payment Databases.—The Secretary shall ensure that the Inspector General of the Department of Health and Human Services and Federal law enforcement agencies have direct access to all claims and payment databases of the Secretary under the Medicare or Medicaid programs.

(i) Civil Money Penalties for Submission of Erroneous Information.—In the case of a provider of services, supplier, or other entity that submits an application, or a supplement to an application submitted under this subsection—

(I) the biological product is biosimilar to a reference product based upon data from the product meeting the standards described in section 351(a)(2)(A) of this title, by inserting "the Commissioner of Social Security Administration, the Office of Personnel Management, the Department of Defense, and the Department of Veterans Affairs, the Department of Justice, and the Office of Personnel Management.

(II) the Secretary may determine, in the Secretary’s discretion, that an element described in clause (I)(i) is unnecessary in an application submitted under this subsection.

(III) Additional Information.—An application submitted under this subsection—

(i) shall include publicly available information regarding the Secretary’s previous determination that the reference product is safe, pure, and potent; and

(ii) may include any additional information in support of the application, including publicly available information with respect to the reference product or another biological product.

(IV) Interchangeability.—An application (or a supplement to an application) submitted under this subsection may include information demonstrating that the biological product meets the standards described in paragraph (3).

(V) Evaluation by Secretary.—Upon review of an application (or a supplement to an application) submitted under this subsection, the Secretary shall—

(1) determine the requirements and standards necessary to determine interchangeability of the biological product with the reference product in the United States; and

(2) grant a license if the Secretary determines that the biological product is interchangeable with the reference product.

SEC. 701. LICENSURE PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) License of Biological Products as Biosimilar or Interchangeable.—Section 351 of the Public Health Service Act (42 U.S.C. 262) is amended—

(1) in subsection (a)(1)(A), by inserting "the Commissioner of Social Security Administration, the Office of Personnel Management, the Department of Defense, and the Department of Veterans Affairs, the Department of Justice, and the Office of Personnel Management.

(2) by adding at the end the following:

(k) Licensure of Biological Products as Biosimilar or Interchangeable.—

(i) In General.—Any person may submit an application for licensure of a biological product under this subsection.

(II) Required Information.—An application submitted under this subsection shall include information demonstrating that—

(I) the biological product is biosimilar to a reference product based upon data from the product meeting the standards described in section 351(a)(2)(A) of this title, and

(II) the biological product and reference product utilize the same mechanism or mechanisms of action for the condition or conditions of use prescribed, recommended, or suggested in the proposed labeling, but only to the extent the mechanism or mechanisms of action are known for the reference product.

(III) the condition or conditions of use prescribed, recommended, or suggested in the labeling proposed for the biological product are the same as those of the reference product; and

(l) the facility in which the biological product is manufactured, processed, packed, held meets standards designed to ensure that the biological product continues to be safe, pure, and potent.

(m) Determination by Secretary.—The Secretary may determine, in the Secretary’s discretion, that an element described in subsection (a)(1)(i) is unnecessary in an application submitted under this subsection.

(n) Additional Information.—An application submitted under this subsection—

(I) shall include publicly available information regarding the Secretary’s previous determination that the reference product is safe, pure, and potent; and

(II) may include any additional information in support of the application, including publicly available information with respect to the reference product or another biological product.

(o) Commercialization of Biosimilar or Interchangeable Biological Products.—The Secretary shall—

(1) register the biological product in the Federal Register; and

(2) provide written notice to the Commissioner of Social Security Administration, the Office of Personnel Management, the Department of Defense, and the Department of Veterans Affairs, the Department of Justice, and the Office of Personnel Management.

DIVISION G—PATHWAY FOR BIOSIMILAR BIOLOGICAL PRODUCTS.
application) submitted under this subsection, the Secretary shall license the biological product under this subsection if—

(A) the Secretary determines that the information submitted in the application (or the supplement) is sufficient to show that the biological product—

(i) is bioisimilar to the reference product; or

(ii) meets the standards described in paragraph (4), and therefore is interchangeable with the reference product; and

(B) the applicant (or other appropriate person) consents to the inspection of the facility that is the subject of the application, in accordance with subsection (c).

(4) STANDARDS FOR DETERMINING INTERCHANGEABILITY.—Upon review of an application submitted under this subsection or any supplement to such application, the Secretary shall determine the biological product to be interchangeable with the reference product if the Secretary determines that the information submitted in the application (or a supplement to such application) is sufficient to show that—

(A) the biological product—

(i) is bioisimilar to the reference product; and

(ii) can be expected to produce the same clinical result as the reference product in any given patient; and

(B) the biological product that is administered more than once to an individual, the risk in terms of safety or diminished efficacy of alternating or switching between use of the biological product and the reference product is not greater than the risk of using the reference product without such alternation or switch.

(5) PHARMACEUTICAL RULES.

(A) ONE REFERENCE PRODUCT PER APPLICATION.—A biological product, in an application submitted under this subsection, may not be evaluated against more than 1 reference product.

(B) REVIEW.—An application submitted under this subsection shall be reviewed by the division within the Food and Drug Administration that is responsible for the review and approval of the application under which the reference product is licensed.

(C) EVALUATION AND MITIGATION STRATEGIES.—The authority of the Secretary with respect to risk evaluation and mitigation strategies under section 505A of the Federal Food, Drug, and Cosmetic Act shall apply to biological products licensed under this subsection in the same manner as such authority applies to biological products licensed under sections 505A and 505A(d)(3).

(D) RESTRICTIONS ON BIOLOGICAL PRODUCTS CONTAINING DANGEROUS INGREDIENTS.—If information in an application submitted under this subsection, in a supplement to such an application, or otherwise available to the Secretary shows that a biological product—

(i) is, bears, or contains a select agent or toxin listed in section 73.3 or 73.4 of title 42, section 121.3 or 121.4 of title 9, or section 331.3 of title 7, Code of Federal Regulations (or any successor regulations); or

(ii) is, bears, or contains a controlled substance in schedule I or II of section 202 of the Controlled Substances Act, as listed in part 1308 of title 21, Code of Federal Regulations (or any successor regulations); the Secretary shall not license the biological product under this subsection unless the Secretary determines, after consultation with appropriate national security and drug enforcement agencies, that there would be no increased risk to the security or health of the public from licensing such biological product under this subsection.

(6) EXCLUSIVITY FOR FIRST INTERCHANGEABLE BIOLOGICAL PRODUCT.—Upon review of an application submitted under this subsection relying on the same reference product for which a prior biological product has received a determination of interchangeability under paragraph (4), the Secretary shall not make a determination under paragraph (4) that the second or subsequent biological product is interchangeable for any condition of use of the first biological product unless—

(A) 1 year after the first commercial marketing of the first interchangeable bio-

similar biological product to be approved as interchangeable for that reference product; or

(B) 18 months after—

(i) a final court decision on all patents in suit in an action instituted under subsection (l)(5) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

(ii) the dismissal with or without prejudice of an action instituted under subsection (l)(5) against the applicant that submitted the application for the first approved interchangeable biosimilar biological product; or

(C)(i) 42 months after approval of the first interchangeable biosimilar biological product if the applicant that submitted such application has been sued under subsection (l)(5) and such litigation is still ongoing within such 42-month period; or

(ii) 18 months after approval of the first interchangeable biosimilar biological product if such application has been sued under subsection (l)(5) and such litigation is still ongoing within such 42-month period; or

For purposes of this paragraph, the term ‘final court decision’ means a final decision of a court from which no appeal (other than a petition to the United States Supreme Court for a writ of certiorari) has been or can be taken.

(7) EXCLUSIVITY FOR REFERENCE PRODUCT.—

(A) EFFECTIVE DATE OF BIOISIMILAR APPLICATION.—If a supplement to an application under this subsection may not be submitted to the Secretary unless the application agrees to the request, such study shall commence not later than 3 years after the date on which the reference product was first licensed under subsection (a).

(B) FILING PERIOD.—An application under this subsection may not be submitted to the Secretary unless the application is filed not later than 3 years after the date which the reference product was first licensed under subsection (a).

(C) FIRST LICENSURE.—Subparagraphs (A) and (B) shall not apply to a license for or approval of—

(i) a supplement for the biological product that is the reference product; or

(ii) a supplement filed by the same sponsor or manufacturer of the biological product that is the reference product (or a licensor, predecessor in interest, or other related entity) for—

(I) a change (not including a modification to the structure of the biological product) that results in a new indication, route of administration, dosage form, delivery system, delivery device, or strength; or

(II) a modification or reversal .—The Secretary will use to determine whether a bio-

logical product is highly similar to a reference product in such biological product class (not including any recombinant protein, antibody, or cell product). The Secretary may issue a subsequent guidance document under clause (ii) if the determination in such class (not including any recombinant protein, antibody, or cell product) does not allow approval of an application for a license as provided under this section for such product or product class.

(D) MODIFICATION OR REVERSAL.—The Secretary may issue a subsequent guidance document under subsection (a) to modify or reverse a guidance document under clause (i).

(II) MODIFICATION OR REVERSAL.—The Secretary may issue a subsequent guidance document under subsection (a) to modify or reverse a guidance document under clause (i).

(III) NO EFFECT ON ABILITY TO DENY LICENSE.—Clause (i) shall not be construed to require the Secretary to approve a product with respect to which the Secretary has not included a guidance document that the Secretary issued or approved, as described in clause (i), does not allow approval of such an application.
‘(10) NAMING.—The Secretary shall ensure that the labeling and packaging of each biological product licensed under this subsection bears a name that uniquely identifies the biological product and distinguishes it from the reference product and any other biological products licensed under this subsection following evaluation against such reference product.

‘(i) PATIENT NOTICES; RELATIONSHIP TO FINAL APPROVAL.—

‘(A) ‘biosimilar product’ means the biological product that is the subject of the application pursuant to subsection (k);

‘(B) ‘relevant patent’ means a patent that—

(i) expires after the date specified in subsection (A) that applies to the reference product; and

(ii) could reasonably be asserted against the applicant due to the unauthorized making, using, or selling of the product or sale within the United States, or the importation into the United States, of the biosimilar product, or due to a use of the biosimilar product, or due to a use of the biosimilar product in a method of treatment that is indicated in the application.

‘(C) ‘reference product sponsor’ means the holder of an approved application or license for the reference product; and

‘(D) ‘interested third party’ means a person owning a relevant patent, that owns a relevant patent, or has the right to commence or participate in an action for infringement of a relevant patent.

‘(1) HANDLING OF CONFIDENTIAL INFORMATION.—Any entity receiving confidential information pursuant to this subsection shall designate one or more individuals to receive such information. Each individual so designated shall execute an agreement in accordance with regulations promulgated by the Secretary. The regulations shall require each such individual to take reasonable steps to maintain the confidentiality of information received pursuant to this subsection and use the information solely for purposes authorized by this subsection. The obligations imposed on an individual who has received confidential information pursuant to this subsection shall continue until such individual returns or destroys the confidential information, a court imposes a protective order that governs the use or handling of the confidential information, or the party providing the confidential information agrees to other terms or conditions regarding the handling or use of the confidential information.

‘(2) PUBLIC NOTICE BY SECRETARY.—Within 30 days of acceptance by the Secretary of an application filed under subsection (k), the Secretary shall publish a notice identifying—

(A) the reference product identified in the application; and

(B) the name and address of an agent designated by the applicant to receive notices pursuant to paragraph (4)(B).

‘(3) EXCHANGES CONCERNING PATENTS.—

(A) EXCHANGES WITH REFERENCE PRODUCT SPONSOR.—

(i) Within 30 days of the date of acceptance of the application by the Secretary, the applicant shall provide the reference product sponsor with a copy of the application and information concerning the biosimilar product and its production. This information shall include a detailed description of the biosimilar product, its method of manufacture, and the materials used in the manufacture of the product.

(ii) Within 60 days of the date of receipt of the application, the reference product sponsor shall provide to the applicant a list of relevant patents owned by the reference product sponsor, or in respect of which the reference product sponsor has the right to commence an action of infringement or otherwise to enforce such patent as such patent concerns the biosimilar product.

‘(ii) If the reference product sponsor is issued or acquires an interest in a relevant patent, or is notified by the application that the reference product sponsor has the right to commence an action of infringement concerning a relevant patent, the reference product sponsor shall identify that patent to the applicant within 10 business days after the date of acquisition of the interest in the patent, as applicable.

(B) EXCHANGES WITH INTERESTED THIRD PARTIES.—

(i) At any time after the date on which the Secretary publishes a notice for an application under paragraph (3), any interested third party may provide notice to the designated agent of the applicant that the interested third party owns or has rights under 1 or more patents that may be relevant patents. The notice shall identify at least 1 patent and shall designate an individual who has executed an agreement in accordance with paragraph (2) to receive confidential information from the applicant.

(ii) Within 30 days of the date of receiving notice pursuant to clause (i), the applicant shall send to the individual designated by the interested third party the information specified in subparagraph (A). The interested third party agrees to allow the applicant and interested third party otherwise agree.

(iii) Within 90 days of the date of receiving information pursuant to clause (ii), the interested third party shall provide to the applicant a list of relevant patents which the interested third party owns, or in respect of which the interested third party has the right to commence or participate in an action for infringement.

(iv) If the interested third party is issued or acquires an interest in a relevant patent after the date on which the interested third party provides the list required by clause (iii), the interested third party shall identify that patent within 30 days of the date of issue of the patent, or the date of acquisition of the interest in the patent, as applicable.

‘(A) REQUIREMENTS.—

(i) At any time after the date on which the Secretary publishes a notice for an application under paragraph (3), the interested third party shall—

(A) if a relevant patent is identified under clause (ii) or (iii) of subparagraph (A)(i), the interested third party shall provide to the applicant a list of relevant patents which the interested third party owns, or in respect of which the interested third party has the right to commence or participate in an action for infringement;

(B) if an interested third party enters into an agreement described in subparagraph (B)(ii) of paragraph (4)(B), the interested third party may provide notice to the designated agent of the applicant that the interested third party has entered into an agreement described in subparagraph (B)(ii) of paragraph (4) for agreements described in paragraph (4)(B), the interested third party shall specify the number and date of the relevant patents owned by the reference product sponsor that the interested third party has entered into an agreement to infringe.

(ii) At any time after the date of the first commercial marketing of, for agreements described in subparagraph (A)(ii), the interested third party shall—

(A) if a relevant patent is identified under clause (ii) or (iii) of paragraph (4)(B), the interested third party shall provide to the applicant a list of relevant patents which the interested third party owns, or in respect of which the interested third party has the right to commence or participate in an action for infringement;

(B) if an interested third party enters into an agreement described in subparagraph (B)(ii) of paragraph (4)(B), the interested third party shall specify the number and date of the relevant patents owned by the reference product sponsor that the interested third party has entered into an agreement to infringe.

‘(B) EXCHANGES WITH INTERESTED THIRD PARTIES.—

(i) At any time after the date of the first commercial marketing of, for agreements described in subparagraph (A)(ii), the interested third party shall—

(A) if a relevant patent is identified under clause (ii) or (iii) of paragraph (4)(B), the interested third party shall provide to the applicant a list of relevant patents which the interested third party owns, or in respect of which the interested third party has the right to commence or participate in an action for infringement;

(B) if an interested third party enters into an agreement described in subparagraph (B)(ii) of paragraph (4)(B), the interested third party shall provide to the applicant the list of relevant patents which the interested third party owns, or in respect of which the interested third party has the right to commence or participate in an action for infringement.

‘(C) FILING.—

‘(i) IN GENERAL.—The text of an agreement required to be filed by subparagraph (A) shall be filed with the Assistant Attorney General and the Federal Trade Commission not later than 10 business days after the date on which the agreement is executed; and

(ii) PRIOR TO THE DATE OF THE FIRST COMMERCIAL MARKETING OF, FOR AGREEMENTS DESCRIBED IN SUBPARAGRAPH (A)(II), THE INTERESTED THIRD PARTY SHALL PROVIDE TO THE APPLICANT A LIST OF RELEVANT PATENTS WHICH THE INTERESTED THIRD PARTY OWNS, OR IN RESPECT OF WHICH THE INTERESTED THIRD PARTY HAS THE RIGHT TO COMMENCE OR PARTICIPATE IN AN ACTION FOR INFRINGEMENT AND SETTING FORTH THE REASONS WHY THE APPLICANT BELIEVES THE AGREEMENT SHALL NOT RESULT IN INFRINGEMENT.

‘(D) CERTIFICATION BY APPLICANT CONCERNING IDENTIFIED RELEVANT PATENTS.—Not later than 90 days after the date on which a relevant patent is identified under clause (ii) or (iii) of subparagraph (A) or under clause (ii) or (iii) of subparagraph (B), the applicant shall certify to the Secretary that the applicant certifies that the identified relevant patent is the subject of a single patent, or a number of patents held by the same patentee, that the same patentee has the right to commence an action of infringement concerning a relevant patent.

‘(E) INTERESTED THIRD PARTY APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor enter into an agreement described in subparagraph (B)(ii) of paragraph (4)(B), the applicant and sponsor shall each file the agreement in accordance with subparagraph (C).

‘(F) ACTION FOR INFRINGEMENT INVOLVING AGREEMENTS.—Any action for infringement involving one or more agreements described in subparagraph (B)(ii) of paragraph (4)(B), brought by an interested third party under clause (i) or (ii) of paragraph (4)(B), is brought within 60 days of the date of receipt of notice pursuant to paragraph (4)(D)(ii), and the court in which such action has been commenced determines that the patent is infringed prior to the date applicable under clause (A)(i) or (ii) of paragraph (4)(D)(ii), the Secretary shall make approval of the application effective on the day after the date of expiration of the patent that has been found to be infringed. If more than one such patent is found to be infringed by the court, the approval of the application shall be made effective on the day after the date that the last such patent expires.

‘(G) NOTIFICATION OF AGREEMENTS.—

‘(A) REQUIREMENTS.—

(i) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANT AND REFERENCE PRODUCT SPONSOR.—If a biosimilar product applicant under subsection (k) and the reference product sponsor or one or more biosimilar product applicants under subsection (k) that is continuous with the biosimilar product for which an application was submitted or currently pending, is engaged in the manufacture, marketing, or sale of the biosimilar product (or biosimilar products) for which an application was submitted or currently pending, or otherwise relates to an agreement described in clause (i) and (ii), the biosimilar product applicant and the reference product sponsor shall—

(A) notify the Secretary of the existence of the agreement; and

(B) provide a detailed written explanation of the agreement.

(ii) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANTS.—If 2 or more biosimilar product applicants submit an application under subsection (k) for biosimilar products for the same reference product and enter into an agreement described in subparagraph (B), the applicants shall each file the agreement in accordance with subparagraph (C).

‘(H) AGREEMENT BETWEEN BIOSIMILAR PRODUCT APPLICANTS.—An agreement described in this subparagraph—

(i) is an agreement between the biosimilar product applicant under subsection (k) and the reference product sponsor or between 2 or more biosimilar product applicants under subsection (k) regarding the manufacture, marketing, or sale of the biosimilar product (or biosimilar products) for which an application was submitted or currently pending; or

(ii) is an agreement between the biosimilar product applicant under subsection (k) and the reference product sponsor or between 2 or more biosimilar product applicants under subsection (k) that is continuous upon, provides a contingent condition for, or otherwise relates to an agreement described in clause (i) and (ii).

(iii) excludes any agreement that solely concerns—

(A) purchase orders for raw material supplies;

(B) equipment and facility contracts;

(C) employment or consulting contracts; or

(D) packaging and labeling contracts.

‘(I) FILING.—

‘(i) IN GENERAL.—The text of an agreement required to be filed by subparagraph (A) shall be filed with the Assistant Attorney General and the Federal Trade Commission not later than 10 business days after the date on which the agreement is executed; and

(ii) PRIOR TO THE DATE OF THE FIRST COMMERCIAL MARKETING OF, FOR AGREEMENTS DESCRIBED IN SUBPARAGRAPH (A)(II), THE INTERESTED THIRD PARTY SHALL PROVIDE TO THE APPLICANT A LIST OF RELEVANT PATENTS WHICH THE INTERESTED THIRD PARTY OWNS, OR IN RESPECT OF WHICH THE INTERESTED THIRD PARTY HAS THE RIGHT TO COMMENCE OR PARTICIPATE IN AN ACTION FOR INFRINGEMENT AND SETTING FORTH THE REASONS WHY THE APPLICANT BELIEVES THE AGREEMENT SHALL NOT RESULT IN INFRINGEMENT.
subject of an application described in such subparagraph.

(ii) If agreement not reduced to text.—If an agreement required to be filed by subparagraph (A) has not been reduced to text, the persons required to file the agreement shall each file written descriptions of the agreement that are sufficient to disclose all the terms of the agreement.

(iii) Certification.—The chief executive officer or the company official responsible for negotiating any agreement required to be filed by subparagraph (A) shall include in any filing under this paragraph a certification as follows: 'I declare under penalty of perjury that the foregoing is true and correct: The materials filed with the Federal Trade Commission and the Department of Justice under section 351(1)(6) of the Public Health Service Act with respect to the agreement referenced in this certification: (1) represent the complete, final, and exclusive agreement between the parties; (2) include any ancillary agreements that are contingent upon, provide a contingent condition for, or are otherwise related to, the referenced agreement; and (3) include written descriptions of the representations, commitments, or promises between the parties that are responsive to such section and have not been reduced to writing.'

(D) Disclosure Exemption.—Any information or documentary material filed with the Assistant Attorney General or the Federal Trade Commission pursuant to this paragraph shall be exempt from disclosure under section 552 of title 5, United States Code, and no such information or documentary material may be made public, except as may be relevant to any administrative or judicial action or proceeding. Nothing in this subparagraph shall bar any disclosure of information or documentary material to either body of the Congress or to any duly authorized committee or subcommittee of the Congress.

(E) Enforcement.

(1) Civil penalty.—Any person that violates a provision of this paragraph shall be liable for a civil penalty of not more than $11,000 for each day on which the violation occurs. Such penalty may be recovered in a civil action.

(2) brought by the United States; or

(3) brought by the Federal Trade Commission in accordance with the procedures established in section 16(a)(1) of the Federal Trade Commission Act.

(4) in the matter following subparagraph (B), by adding ''or'' after ''paragraph (a)'' and inserting in the matter following subparagraph (C) as added by paragraph (3), by inserting before the period the following: ':, or if the statement described in subparagraph (C) is contained in an application to obtain a license to engage in the commercial manufacture, use, or sale of a biological product claimed in a patent or the use of such method as claimed in a patent before the expiration of such patent''.

(II) brought by the United States; or

(c) Products Previously Approved Under Section 505.—

(1) Requirement to follow section 351.—Except as provided in paragraph (2), an application for a biological product shall be submitted under section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act).

(2) Exception.—An application for a biological product may be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if—

(A) such biological product is for a product class for which a biological product in such product class is the subject of an application approved under such section 505 not later than the date of enactment of this Act; and

(B) such application—

(i) has been submitted to the Secretary of Health and Human Services (referred to in this Act as the 'Secretary') before the date of enactment of this Act; or

(ii) is submitted to the Secretary not later than the date that is 10 years after the date of enactment of this Act.

(3) Limitation.—Notwithstanding paragraph (2), an application for a biological product may not be submitted under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) if there is another biological product approved under subsection (a) of section 351 of the Public Health Service Act that could be a reference product for such application with respect to such application (within the meaning of such section 351) if such application were submitted under subsection (k) of such section 351.

(d) Deemed Approved Under Section 351.—An approved application for a biological product under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) shall be deemed to be a license for the biological product under such section 351 on the date that is 10 years after the date of enactment of this Act.

(b) Section 271(e)(2) of title 35, United States Code is amended by striking ''in paragraph (2)'' in both places it appears and inserting ''in paragraph (2)(A) or (2)(B)''.

The SPEAKER pro tempore. Pursuant to House Resolution 903, the gentleman from Ohio (Mr. BOEHNER) and a Member opposed each will control 30 minutes.

The Chair recognizes the gentleman from Ohio.

Mr. BOEHNER. Mr. Speaker, all of us know that our health care delivery system needs help. There could be broad bipartisan agreement on the kinds of steps that we need to take in order to lower the cost of health care in America and expand access. The bill before us, in my view, is a big government takeover of our health care system that will replace the current health care that Americans get.

Republicans have offered better solutions all year on the major bills that have come to this floor. I think we had a much better solution on the stimulus bill that would have created twice the jobs at half the cost. I think our better solution on the budget clearly had less spending, less debt and lower deficits.

I think our all-of-the-above American energy plan was a much better solution to the national energy tax, the so-called cap-and-trade bill, that was on this floor in June. I believe that what we have before us, as a Republican substitute, is a commonsense plan that takes steps towards reducing the cost of health care and expanding access. Simple things, like allowing people to buy insurance across State lines, allowing groups of...
individuals or small businesses to group together for the purposes of buying health insurance like big businesses and unions can today. How about getting rid of junk lawsuits that drive up the cost of health care in America and the defensive medicine that doctors have to practice as a result.

I think what we have before us and the bill that we are offering is a commonsense approach that does take major steps in the right direction to bring down the cost of health care and to expand access.

I reserve the balance of my time.

Mr. WAXMAN. Mr. Speaker, I seek to control the time in opposition, and I ask unanimous consent that the time for opposition speakers on the substitute amendment be divided such that the first 10 minutes is controlled by Chairman MILLER of the Committee on Education and Labor; the second 10 minutes is controlled by Chairman RAX, of the Committee on Ways and Means; and the final 10 minutes is controlled by Chairman WAXMAN of the Committee on Energy and Commerce.

The SPEAKER pro tempore. The gentleman from California (Mr. WAXMAN) is recognized to control the time in opposition.

Without objection, that time will be divided, subject to the Chair's discretion as to the order of recognition.

There was no objection.

The SPEAKER pro tempore. The Chair recognizes the gentleman from California (Mr. MILLER).

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 2 minutes to the gentleman from New York (Mr. TONKO).

Mr. TONKO. Mr. Speaker, I am here to speak in support of the Affordable Health Care for America Act, one of the most important pieces of legislation this body has considered since the passage of Medicare in 1965 and Social Security in 1935.

Mr. Speaker, every Member of this body has been listening to her or his constituents, and they are saying that they are ready for health insurance reform. They need health insurance reform.

We listened when seniors said they wanted better care from their doctors, and the doughnut hole eliminated. This bill does that. We listened when young adults told us they were having trouble finding insurance and wanted to stay on their parents' insurance until age 27. This bill does that. We listened when the uninsured told us heart-breaking stories about going without needed health care and asked us to give them affordable, quality health care insurance. This bill does that. We listened when the insured told us they were paying too much for insurance and they needed more protections for their health insurance. This bill does that.

Our colleagues on the other side of the aisle have not listened. They are offering a substitute bill that would not accomplish any of the things our constituents have asked for. Instead, they are offering a bill that does not end the discrimination based on pre-existing conditions; does not reduce the number of uninsured Americans; does not offer assistance to those struggling to afford health insurance; does not put in place the anti-trust exemption for health insurers; and does not stop price gouging by insurance companies. Our bill does all these things and more.

Mr. Speaker, the Affordable Health Care for America Act not only brings quality health care within reach of tens of millions of Americans, it enhances the care that those with insurance and Medicare already receive. This bill is as much about the insured as it is about the uninsured. It is a monumental bill. I urge defeat of the Republican substitute and, indeed, encourage passage of H.R. 3962.

The SPEAKER pro tempore, Without objection, the gentleman from Michigan will control the time on the proponent's side.

There was no objection.

Mr. CAMP. Mr. Speaker, I yield myself 4 minutes.

Mr. Speaker, the American people deserve and demand a commonsense approach to health care reform that, one, makes health care more affordable; two, that guarantees all Americans, regardless of preexisting condition, have access to affordable health care; and, three, does so without raising taxes, without increasing the deficit and without the Federal Government making health care decisions that should be made by patients and doctors.

The Common Sense Health Care Reform and Affordability Act, the House Republican health care bill, does that. The plan offered today by the Speaker does not.

Just some of the highlights of the Republicans' Common Sense Health Care Reform and Affordability Act include:

- Lowering health care premiums: The Republican plan will lower health care premiums for American families and small businesses, addressing Americans' number-one priority for health care reform.

According to the Congressional Budget Office, the Republican health care reforms would reduce premiums by up to 3 percent for Americans who get insurance through their workplace, up to 6 percent for Americans who get employer-sponsored insurance, and up to 10 percent for those working for a small business. CBO has not made a claim that the Democrats' bill would lower premiums at all.

What do these numbers mean? It means families who do not have health insurance in 2016 through their job could buy health insurance that is $5,000 less expensive than the cheapest plan the Republicans have.

The Republican plan guarantees access to affordable health care for those with preexisting conditions. Republicans create universal access programs that expand and reform high-risk pools and reinsurance programs to guarantee that all Americans, regardless of pre-existing conditions or past illnesses, have access to affordable care, while lowering costs for all Americans.

The Republican plan reduces the number of junk lawsuits, which saves taxpayers' money and lowers premiums, by enacting medical liability reforms modeled after the successful State laws of California and Texas.

The Republican plan prevents insurers from wrongly canceling a policy unless a person commits fraud.

The Republican plan encourages Small Business Health Plans so these employers can pool together and offer health care at lower prices, just as large corporations and labor unions do today.

The Republican plan encourages innovative programs by rewarding States that reduce premiums and the number of uninsured. In comparison, the Democrat plan takes away funds from States and creates programs that States cannot afford with their over $400 billion expansion of Medicaid.

The Republican plan allows Americans to buy insurance across State lines and find the health care plan that best meets their needs at a cost they can afford.

The Republican plan promotes prevention and wellness by more than doubling the financial incentives employers may reward employees who adopt healthier lifestyles.

Republicans enhance health savings accounts by allowing Americans to use HSA funds to pay premiums for high deductible health insurance.

And the Republican plan allows dependents to remain on their parents' policies up to the age of 25.

The health insurance reforms in the Republican bill will significantly reduce health care premiums, insure millions of Americans, guarantee those with preexisting conditions have access to quality, affordable care.

We do all of this without raising taxes, without spending $1 trillion we don't have, without cutting Medicare and without putting some new health care in between doctors and patients, which is what the Democrat majority does in their government takeover bill.

Clearly the bill offered by the Speaker is not what the American people want. Americans are clamoring for lower cost health care and that is what the Republican plan offers.

I urge my colleagues to reject the Democrats' government takeover of health care and vote 'yes' on the Republican substitute that will lower health care premiums.

I reserve the balance of my time.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair would remind Members not to traffic the well when another Member is under recognition.

Mr. GEORGE MILLER of California. Mr. Speaker, I yield 2½ minutes to the gentleman from Massachusetts (Mr. TIERNEN), a member of the committee.
Mr. TIERNEY. I thank the gentleman.

Since 1995, when our Republican colleagues held the majority in the House of Representatives, until 2007 when they relinquished that and the voters threw them out, they had done exactly nothing, nothing, with respect to the health care crisis in this country.

Now they want to come in and they want to do something. They want to have a race for getting less. This is their great plan.

The one thing they tried to do in 2003 would put pharmaceutical prescription drugs in Medicare which they did by giving seniors a so-called doughnut hole they had to pay for and costing us $900 billion on our current debt.

My friends, the only ones they made happy then were the pharmaceutical companies, and the only ones they want to make happy now are the private insurance companies. They want to try to kill reform. If they can’t kill reform, they want to give them this gift of a Republican substitute.

While they sat idle since 1985, family health policies rose from 7 percent of median income to 17 percent. Sixty percent of families reporting bankruptcies did so in part because of health care costs. Forty-six million Americans went uninsured, 85 percent of them working families.

Small business premiums went up 129 percent. Twenty-eight million of our uninsured are small business owners, employees or their families. Small businesses are projected to lose $52.1 billion going forward in the next decade if we continue on the Republican path of do nothing.

The question is, who is on our side? Who is on the side of the consumers, the individuals, the small businesses and the families, and that is the bill that the Democrats have put forward on this floor. It is affordable; it is health care for every American.

If you compare the two bills, you will see the Budget Office says the Republicans may—may—save you from 0 to 3 percent on 80 percent of the private premiums.

The Democratic bill saves you 12 percent. The Democratic bill covers 96 percent of Americans. The Republicans in 2019 will leave you exactly where you are today, covering only 83 percent of the people, leaving by that time 52 million uninsured.

We will end the discrimination against people with preexisting conditions. They will study it.

We will have an exchange for small businesses and employees so they get better prices comparable to what large companies have been able to get. They will do nothing of the kind except let you shop for a place, but to get your insurance it might cost you less because you get less, because you will have a race to the bottom, where insurance companies will be able to avoid cost containment of States and practice fraud almost indiscriminately. There will be no way of cutting it back. You pay less because you get less.

Mr. CAMP. Mr. Speaker, I yield myself 15 seconds.

When Republicans were in the majority, we passed a children’s health initiative; a prescription drug plan for seniors; we put wellness into Medicare; we established portability so people could change jobs and keep their health care; and we established health savings accounts. Our record on health care is strong. What we need is this continuation of this step-by-step approach to comprehensive health care reform.

I would now yield 5 minutes to the distinguished gentleman from Indiana (Mr. PENCE).

(Mr. PENCE asked and was given permission to revise and extend his remarks.)

Mr. PENCE. Mr. Speaker, I rise in support of the Republican substitute.

After months of overwhelming public opposition to a government takeover of health care, liberal Democrats here in Washington ignored the clear voice of the American people, bringing forth a freight train of runaway Federal spending, bloated bureaucracy, mandates and higher taxes.

And even a few courageous Democrats have stood up to speak out. In opposing the bill, the distinguished Democrat chairman of the Armed Services Committee, IKE SKELETON, a man who knew President Truman, said that he, quote, had serious concerns for Missourians who have private insurance plans they like.

And my Democrat colleague, DAN BOREN of Oklahoma, said, and I quote, the worst thing we could do in a recession is raise taxes, and this bill does just that.

As these Democrat colleagues attest, if the Pelosi health care bill passes today, you probably will lose your health insurance, and you might just lose your job. The Pelosi health care plan targets us when we are most vulnerable. Illness, our own, or, more importantly, the illness of a parent, spouse or a child, has the capacity to suspend our priorities. What was important before the crisis grows dim in the harsh light of disease affecting a loved one. The result, little by little, in the midst of a family crisis we yield our freedoms and our resources to the ever-growing appetite of the Federal Government.

But if liberal Democrats think this is what our Nation wants, they don’t know the America that I know.

Mike Schwaller is my cousin. He is an extraordinary young man. He has been struggling with cancer, but throughout has maintained his faith in Christ and his courage. He has been an inspiration to us all.

Mike wrote me an email the other day, and he gave me permission to share it with you. Mike has limited treatment options, he is awaiting insurance approval for experimental treatment. He seems like just the kind of American that my Democrat colleagues keep telling us want government-run insurance. But they don’t know Mike.

As he wrote about his coverage recently, he said, If this was a government-run program, I have faith that it would be processed in a timely manner, and even then, if it would be approved. The idea of a public health care option, he wrote, as a chronic cancer patient scares the living hell out of me. I feel that at this moment in time you are betting for his life. Please, please, don’t give up or give in. Michael, we won’t.

The truth is, this debate is not just about health care. It is about who we are as a nation. As President Reagan said, it is about whether we abandon the American revolution and confess that a little intellectual elite in a far distant capital can plan our lives better for us than we can plan them for ourselves.

You know, earlier today I greeted about 50 Hoosiers, mostly in wheelchairs, unit caps and uniforms, down at the World War II Memorial. These heroes were gathered for their first and maybe their only visit to that monument built in their honor.

As I made my way back to the Capitol, I thought about those brave men and what sustained them in those days where the survival of democracy hung in the balance. I believe it must have been because they were fighting for a cause more important than their health or even their lives, and that cause was freedom.

In the coming hours, we are going to take a vote of incalculable significance to the American people, and we will see what our so-called Blue Dog Democrat colleagues are made of. We will see whether Democrats who profess to believe in limited government will take a stand, or whether they will fold under the weight of the Democratic majority in the White House.

Look, I know from personal experience, it is no easy thing to take on your President or your party on a major piece of legislation. But let me assure my colleagues, decent Americans all, if you will take this stand for freedom, for the right to live and work and care for a family without the unnecessary intrusion of the government, I believe with all my heart that you will know for the rest of your lives just what those men in wheelchairs have known every day since they came home, that when freedom hung in the balance, you did freedom’s work, and the American people will never forget it.

Mr. GEORGE MILLER of California. I yield 1½ minutes to the gentleman from Virginia (Mr. SCOTT), a member of the committee.

(Mr. SCOTT of Virginia asked and was given permission to revise and extend his remarks.)

Mr. SCOTT of Virginia. Mr. Speaker, all afternoon we have heard about the freedom to be uninsured. Seniors in my
Mr. CAMP. Mr. Speaker, I yield 3 minutes to the distinguished gentleman from Texas (Mr. BARTON), the ranking member of the Energy and Commerce Committee.

Mr. BARTON of Texas. Mr. Speaker, I asked to go after the distinguished chairman of the Education and Labor Committee because what we have here is a failure to communicate, or perhaps a difference in philosophy.

The Democrats have decided that the bottom line is coverage. By golly, coverage. That is the matter. So they are saying: you want to be covered or not, you are going to be. We are going to have an employer mandate. We are going to have an employee mandate and an individual mandate. We are going to have a premium mandate.

We are going to have how you cover the insurance, a “comparative research council,” to dictate the practice of medicine. We are going to raise Medicaid to 150 percent of poverty, and add health care of unhealthy individual in this country who is unmarried, whether they want to be or not.

We are going to tell every young American who has decided that they don’t want to pay those premiums, they want to save up to get married or to buy a home, that, by golly, they are going to have to take insurance, and they are going to pay three to four times what they would under the current system because there is only a two-to-one ratio. So they are going to get their coverage, at a cost of $1.2 trillion.

Now, we have a different philosophy. We think you need to control costs, but we also agree that you have to provide access to the private insurance market. If you can’t get it today and you want it.

Congressman MILLER talks about the 40 to 50 million Americans that are not insured, and he is right. But of those 40 to 50 million, 15 to 20 million are in this country illegally. Ten or 15 million are young Americans who don’t want insurance.
When you really boil it down, there are 5 to 10 million Americans who have a preexisting condition or work where insurance is not provided and they can't afford it.

Our plan covers them. It gives them the opportunity. That doesn't give them the money, but it gives them the opportunity. So we have a difference in a philosophy.

We don't believe in mandates and make no apology about it, but we do believe in the individual opportunity. We believe in individual choice. We believe in the American system of free enterprise. We believe in lowered taxes, and we believe in a plan that's going to lower premiums an average of $5,000 per person per year for the next 10 years. That's what CBO says. That's not me. That's the CBO.

So there is a choice. Bigger government, more mandates, more control, less freedom, or lower costs, more opportunity, more freedom, more choice. I vote for more freedom.

Vote "no" on the Big Government plan. Vote "yes" on the individual opportunity plan.

Mr. RANGEL. Mr. Speaker, I yield 2 minutes to the gentleman from California (Mr. STARK), the chairman of the Ways and Means Subcommittee on Health.

I would like to take this time to thank him for the great work he's done over the years, not just for our committee, but for this Congress, and I would like to thank him publicly.

Mr. STARK. I thank the chairman for yielding.

Mr. Speaker, the Republican substitute is not a substitute on health reform. It substitutes gifts to the wealthy insurance companies for morality and dignity. Their bill spends $61 billion over the next decade, and what would the American public get for that investment? It would get 5 million more uninsured people than we have in America today. That's not a conservative solution. It's no solution at all.

Our legislation expands coverage to 36 million more Americans, reforms the insurance market to end abusive practices, provides financial assistance to lower-income and middle-income families, creates a public health insurance option that will make health insurance more affordable, and protects our children's futures by not adding one dime to the deficit.

A vote for the Republican substitute is nothing more than a vote for transferring money to wealthy insurance companies. Vote "no" on the Republican substitute and "yes" to provide affordable, quality health care for all Americans.

Mr. CAMP. At this time, I yield 1 minute to the gentleman from South Carolina (Mr. BROWN).

Mr. BROWN of South Carolina. Mr. Speaker, I rise in strong support of the Republican amendment and true health care reform. Our plan makes the cost-saving changes so sorely needed in our health care system without forcing our children and grandchildren into unending debt.

This amendment will allow insurance to be bought directly. People canangle to drive down costs and allow small businesses to band together in order to negotiate fair and affordable coverage. Furthermore, this amendment improves quality, putting you and your doctor in charge of your care by removing the powers of insurance companies and trial lawyers.

Finally, this amendment ensures that the taxpayer dollars my constituents in South Carolina's First Congressional District pay into the Federal Treasury never find their way into abortion clinics.

Mr. Speaker, Republicans have a better plan. I urge all of my colleagues to support this amendment and urge them to vote "no" on this Big Government plan.

Mr. RANGEL. Mr. Speaker, I yield 2 minutes to the gentleman from Washington, Dr. McDermott, who worked his whole career down here to improve the quality of health care for all Americans.

[Mr. McDermott asked and was given permission to revise and extend his remarks.]

Mr. McDermott. Mr. Speaker, the Republican health plan and proposal has been in effect since 1995. A friend of mine, who came to New York, had some problems, got on the phone to call a doctor, and the first question that is always asked is what kind of insurance do you have. When he said he didn't have any, they said, Well, we can't take care of you unless you come to the office with $250 in cash. We'll see you if you do that. He said, I don't have that kind of money. They said, Then go to the emergency room. That's where 50 million people in this country are today. Go to the emergency room if you can't come with the cash to hand it to the doctor.

My office phone today has been ringing off the hook with people demanding that we have health care now. The Republican alternative doesn't help anyone, except protects the insurance companies. The bankruptcy of this plan is pretty clear to everybody. Health analysts, the media, The New York Times, the CBO all agree that the Republican plan would leave 42 million people with nothing.

Now, the Republican plan does nothing to help the seniors. It really isn't a plan. It's just a bunch of stuff they scrambled up off the floor that they had laying around for 12 years and did nothing.

Now, why don't they put forward a plan? Well, I will tell you. I've cracked the code. This plan they brought out here, they either haven't read their own bill because you couldn't keep a straight face and you couldn't figure out here and say it was a plan—or they would rather spend more time hating government than helping people.

Mr. Speaker, Republicans have a better plan. I urge all of my colleagues to support this amendment and urge them to vote "no" on this Big Government plan.

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Mr. Speaker, Republicans have a better plan. I urge all of my colleagues to support this amendment and urge them to vote "no" on this Big Government plan.

Mr. RANGEL. Mr. Speaker, I yield 2 minutes to the gentleman from Washington, Dr. McDermott, who worked his whole career down here to improve the quality of health care for all Americans.
Our Democratic plan is a lifesaver for 12 times as many Americans, and it’s a dollar savior, responsibly reducing the national debt by $36 billion more than this phony Republican scheme.

Now is the time for a truly historic choice. The Republicans have chosen to side against the uninsured. We choose to strengthen Medicare. We chose to stand up for the millions of struggling families who have been denied health care access for too long.

Mr. RANGEL. Could I ask how much time I have remaining, Mr. Speaker?

The SPEAKER pro tempore. The gentleman from New York has 5 minutes remaining.

Mr. RANGEL. I yield 2 minutes of that time to the gentleman from Oregon (Mr. BLUMENAUER) and ask him to share the great contribution he has made and the loopholes we find in the Republican substitute.

Mr. BLUMENAUER. I appreciate the gentleman’s question. I hope every American examines the plan that has been offered to us by the Republicans.

Our citizens are outraged by practices of taking away insurance when you buy pre-existing coverage for preexisting conditions. Our bill fixes it. You won’t find it in the Republican bill. Republicans strip out provisions so important to Oregon and other low-cost, high-quality States. Republicans do not deal with those vast regional disparities.

They ignore the extra costs faced by seniors caught in the prescription drug doughnut hole while Democrats provide financial relief within the next 2 years. If Republicans have their way, there will be more uninsured Americans in 10 years than there are today. Weaker protections ignore the needs of the most vulnerable, yet the CBO says the Republican plan will increase the deficit by $36 billion more than the Democratic plan.

Mr. Speaker, this is a colossal failure of imagination. The Republicans could have passed this package any time during the 6 years they and George Bush have passed this package any time during their imagination. The Republicans could increase the national deficit by $36 billion more than the Democratic package as the best they could do, the Republican substitute.

Mr. BLUNT. Mr. Speaker, I thank the gentleman. I yield 3 minutes to the gentleman from Missouri (Mr. BLUNT).

Mr. BLUNT. Mr. Speaker, I thank the gentleman for yielding.

I do not deal with those vast regional disparities.

In the Republican Congresses did send important parts of this plan, the House, to the other body. We sent lawsuit abuse reform seven times. We sent associated health plans at least a half dozen by $36 billion. They didn’t get to the floor. We continue to send the elements of this plan that save every taxpayer money and also save every insured American money. This is the only plan that reduces the cost of insurance for every group of insured Americans.

One of the goals that the President set for health care reform was to reduce the cost of premiums. This is the only plan that does that. It does it for individuals. It does it for small businesses. It does it for large groups.

This is a plan where we could provide access to coverage for everyone regardless of preexisting conditions. Now, we don’t spend $1.3 trillion to do that. We spend about $23 billion to make the risk pool and ensure access for everybody. We’re for access for everybody to coverage; we’re just not for spending $1 trillion to create that access.

This plan lowers premiums. It prohibits insurance companies from canceling policies. It prohibits insurance companies from capping the lifetime expenditures that those policies might incur.

One of the reasons that there were more people uninsured at the end of the 10 years under this plan is, when our friends on the other side insisted on the children’s health insurance plan, they put everybody that goes on that plan in the first 5 years back into no insurance in the last 5 years. Look at the numbers. That’s where those numbers go up. You could pretend that our plan puts the numbers up. We’re not the one that said we’re going to insure all children for 5 years and in the second 5 years they’re back to where they are today. Check the numbers. Look at what this does for premiums. Look at what this does for families.

This is a plan that truly does keep what works and fixes what’s broken. The President repeatedly has said, Everyone, if you like what you have, you should be able to keep it. This is the only plan that would allow that pledge to be made and be kept.

Mr. Speaker, I encourage my colleagues to support this plan. Let’s take these first steps that work without bankrupting the American people.

I urge support of this plan.

The SPEAKER pro tempore. The gentleman from New York has 3½ minutes remaining.

Mr. RANGEL. Mr. Speaker, I yield 2 minutes to the gentleman from Wisconsin, RON KIND, and thank him for the great contributions he has made to looking at health care the way it should be, and that is value and not volume.

(Mr. KIND asked and was given permission to revise and extend his remarks.)

Mr. KIND. I ask my colleagues to support true health care reform and provide all Americans with access to affordable and quality care that they all deserve.

Mr. RANGEL. Mr. Speaker, I yield myself the balance of my time.

I’m not going to be as difficult with the Republicans as some of my colleagues because I’m glad at the end of the day they finally understood the problem. And even though it was only Tuesday that they actually put something together for us to look at, at least we know that some of them are going in the right direction.

It’s going to be tragic to explain this to the American people not only now but in the future as to when they had a great opportunity. They lost it on Social Security. They said government doesn’t work. They lost it on Medicaid. They said we have too much money. They should have freedom instead of health care. And they certainly lost it in

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Medicare where they made it appear as though it was going to be a Big Government takeover.

And now it just seems to me that they’ve proven how well government can do in these programs. And the fact that in lieu of just plain freedom, in lieu of that they can get insurance if they’re at risk, the whole idea that they’re proud of people who cannot afford to do this at least to have the opportunity to do it.

So, Mr. Speaker, I just hope that some of those on the other side might allow morality to go beyond just party loyalty.

At this time it gives me pleasure to present to this body Chairman Waxman, who has done so much to make this a reality.

Mr. CAMP. Mr. Speaker, I reserve the balance of my time.

Mr. WAXMAN. Mr. Speaker, I’m pleased to yield 1 minute to the gentleman from Vermont (Mr. Welch).

Mr. WELCH. Mr. Speaker, tonight the question before Congress is neither new nor complicated: Will we do what it takes to make health care affordable and available to all Americans?

Our predecessors in Congress faced similar challenges and they extended voting rights to all Americans, established Social Security and Medicare for all seniors. Mr. Speaker, Congress faced those challenges and we are the better for it. We did so without conflict and controversy but with some bipartisan support.

Tonight is different. Unique. Our Republican friends have assured us that not a single member of their caucus will vote for health care reform. Every single person will vote ‘no.’

The Republicans’ alternative says to Americans with a preexisting condition, you are on your own. To the 47 million Americans without insurance, you’re on your own. To the millions of Americans who can’t afford the coverage that they have, you’re on your own.

Our health care bill has a different philosophy, the one that prevailed when Democrats, and some Republicans, passed Social Security, voting rights, and Medicare: We are in it together.

Mr. CAMP. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. Mica).

Mr. MICA. Mr. Speaker, this is a sad day for Americans who lack health care coverage. While Democrat efforts to resolve health care problems may be well intended, in fact they totally miss the mark. People want lower premiums, increased access, less cost, and less red tape. They want choice and quality health care.

Instead, the Democrat health care plan dramatically expands government, cuts Medicare, and imposes significant new taxes. The creation of 118 new Federal programs, agencies, and czars adds bureaucracy and red tape rather than providing a cure to bring health care costs down and accessibility up. The $729 billion in new taxes on Americans and small businesses will result in a loss of 5.5 million more jobs at a time when our country can least afford it and unemployment has topped a record 10.2 percent.

I oppose the cuts of nearly a half trillion dollars in Medicare. This is the wrong solution at the wrong time.

Mr. WAXMAN. Mr. Speaker, I’m pleased at this time to yield 1 minute to the gentleman from Texas (Mr. Gonzalez).

Mr. GONZALEZ. Mr. Speaker, I rise in strong opposition to the substitute. This substitute includes medical liability reforms that draw on the Texas model. I’m from Texas. Let me tell you about our Texas experience.

We were promised that medical malpractice reform in Texas would result in attracting doctors to underserved areas. Today, Texas ranks 43rd out of the 50 States in the number of doctors per capita.

We were promised that it would rein in health costs. Health care costs in Texas with Medicare alone rose 24 percent in the 3 years after Texas tort reform.

We were told that it would reduce the cost of health care insurance for Texans. Premiums actually increased 86.8 percent from the years 2000 to 2007. The average insurance policy for a family in Texas went from $6,638 to $12,403.

Instead, the Democrat health insurance plans make health insurance plans more readily available for Texans. Today, Texas has the highest rate of uninsured adults and the highest rate of uninsured children.

If ever there was a time not to mess with Texas, it is tonight. Vote ‘no’ on the substitute.

Mr. WAXMAN. Mr. Speaker, I’m pleased at this time to yield 2 minutes to the gentleman from New York (Mr. Weiner), an important member of our committee and a leader in health care reform.

Mr. WAXER. You know, there are honorable people on both sides of this debate; but there are moments that come along, and they come along about every generation or so, that make it clear why this side of the aisle are Republicans and why we’re Democrats.

In 1935 when there was the Social Security Act and we decided we weren’t going to allow 30 percent of seniors to slip into poverty. Democrats proposed. Democrats passed; Republicans opposed Social Security.

In 1965 when Medicare was passed, Democrats proposed, Democrats supported; Republicans opposed, and now Medicare is a fact of life. And the very same arguments that were made against Medicare then are being made tonight.

I hear this talk about the single-payer plan that’s going to creep over. I can tell you I wanted a single-payer plan. I would like it to be there, but it’s not. But you opposed it then, and now you claim to support it.

There’s been a lot of talk about how big the bill is, but here’s what it’s all about: this is what Members of Congress get. This is a guidebook with affordable health care plans, many choices, deep discounts because we pool people together, minimum standards for each plan. This is what Members of Congress get, but they don’t want you, the American people, to get it.

This is what it’s about: they say they want to protect Medicare, but it was
they who wanted to eliminate it. They say they want to protect Social Security. It was they who wanted to privatize it. Now they say we don’t want to cover those who are uninsured because you shouldn’t care. Well, I say to my colleagues, who pay those bills? The bill fairy? Who pays those bills are you, the taxpayer. They say they want you to pay those, too.

When you look at how big the bills are, remember this document. Eight million Americans who work for the Federal Government, including my colleagues, get this document in the mail. They get good health care. We want it for you. They’re going to get Medicare at 65. They don’t say we don’t want Medicare because we don’t believe in single-payer. They want it because they want to take and take and take, but they don’t want it for you.

The Democrats want this for you and the Republican Party just wants it for themselves.

The plan cuts Medicare benefits to seniors. Ours retains them. Their proposal blows a hole in the deficit. Ours actually saves money. Their bill imposes penalties and mandates on our small businesses that cost jobs. Ours don’t.

Specifically, Mr. Speaker, our bill will help you access health care if you lose or change your job. And it will ensure that you have access to medical care if you have a preexisting condition. And we also, Mr. Speaker, deliver on something that the majority refuses to even talk about, and that’s real, meaningful medical liability reform.

And most importantly, Mr. Speaker, we produce cost savings for workers, families, and small businesses. The Congressional Budget Office says that the Democrats’ new government-run system won’t reduce costs. CBO says our legislation lowers health care costs. In fact, CBO says that the Republican plan cuts premiums by up to 10 percent for those covered by small businesses, up to 8 percent for those not covered by employers, and up to 3 percent for employees covered by large businesses.

Mr. Speaker, in the face of 10.2 percent unemployment, Americans want jobs. They want less government spending and more economic security. The majority’s bill shows they have not listened. Ours shows we have.

Interestingly, Mr. Speaker, the only bipartisan majority on Capitol Hill today will be in opposition to Speaker Pelosi’s trillion-dollar-plus government overhaul of America’s health care system.

With that, Mr. Speaker, I urge passage of this substitute.

Mr. WAXMAN. Mr. Speaker, I ask unanimous consent that the 2 minutes that has been reserved for the Education and Labor Committee debate time in opposition to the Republican substitute be transferred to the Energy and Commerce Committee’s time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

Mr. WAXMAN. Mr. Speaker, at this time I yield 1 minute to the gentlewoman from the District of Columbia (Ms. NORTON).

Ms. NORTON. Mr. Speaker, I thank the gentleman for yielding and for the extraordinary work that he and others have done on this bill.

The extraordinary diversity of our Democratic Caucus, Mr. Speaker, from right to left, has ensured that this bill represents a cross-section of our country—urban, suburban, and rural. The incredible diversity of our Democratic Caucus, representing Republicans, right-leaning, moderate, and progressive areas meant that we could come to this floor today only with a bill that sensitivity put all of America together into one convincing bill. That is why we have produced a bill that satisfies deficit hawks, who are more wary of increasing deficits than of most other issues, as well as single-payer advocates who believe that only Medicare for all can markedly reduce costs while providing adequate health care for the middle class and the uninsured.

Thus, there can be no doubt this evening that the Affordable Health Care for America Act is a balanced bill and the best bill for the citizens of the United States of America.

The extraordinary diversity of our Democratic Caucus—from right to left has ensured that this bill represents a cross-section of the our country—urban, suburban, and rural. The incredible diversity of our Democratic Caucus, representing Republican, right-leaning, moderate, and progressive areas, meant that we could come to this floor today only with a bill that sensitively put all of America together into one convincing bill. That is why we have produced a bill that satisfies deficit hawks, who are more wary of increasing deficits than of most other issues, as well as single-payer advocates who believe that only Medicare for all can markedly reduce costs while providing adequate health care for the middle class and the uninsured. Thus, there can be no doubt that the Affordable Health Care for America Act is the best bill for the citizens of the United States of America.

The bill’s greatest achievements are that it would reduce the deficit over the next 10 years and into the future while covering 96 percent of the American people; would end discrimination by insurers who dropped or refused to renew or sell coverage because of health status and would ensure that coverage is affordable by providing subsidies for people in employer-based health care or through an insurance exchange of private insurers and a consumer option to drive down the cost of health care while operating on a level playing field with other insurers.

The SPEAKER pro tempore. The gentlemen will state his parliamentary inquiry.

Mr. GOHMERT. Parliamentary inquiry.

The SPEAKER pro tempore. The gentleman will state his parliamentary inquiry.

Mr. GOHMERT. Mr. Speaker, my understanding of the rules is that there is required to be a copy of the bill, and some have a manager’s amendment, that is supposed to be somewhere. A number of us have been trying to find a copy of the manager’s amendment since we are going to be voting on it. I hear some aahs, but isn’t there supposed to be a copy, and if so, where would that copy be, since we are about to do this to the American people?

The SPEAKER pro tempore. The official papers are at the desk.

Mr. GOHMERT. It was just at the desk, Mr. Speaker, so parliamentary inquiry: If you could direct me to that place on the desk where the 200 pages are, it would be very helpful.

The SPEAKER pro tempore. The Clerk has the official papers. Additional copies are in the lobby and Members have been carrying them around all day.

Mr. GOHMERT. Parliamentary inquiry. Does the Speaker know where a copy, as the rule requires, is at the desk so that we can come up and see it at the desk as a requirement of the rules?
Mr. WAXMAN. We are ready to close, Mr. Speaker.

The SPEAKER pro tempore. The gentleman from Michigan, Mr. GOHMER, has 4 minutes remaining, and the gentleman from California has the right to close.

Mr. CAMP. We will reserve our time.

Mr. WAXMAN. We are ready to close, so use your time. Use it or lose it.

Mr. CAMP. At this time, Mr. Speaker, I yield the customary 1 minute to the distinguished minority leader, the gentleman from Ohio (Mr. BOEHNER).

Mr. BOEHNER. Let me thank my colleague for yielding, and thank him and our ranking members for the job they have done putting our substitute together.

Ladies and gentlemen, before I came here, I ran a small business. While I was running my small business, it became pretty clear to me that government was growing in my view out of control. More regulations, more taxes, more compliance costs, both for my suppliers, for my customers, and for my own little small business. It seemed to me that government was choking the goose that was laying the golden egg.

You know, we were all lucky enough to be raised in America, most of us born in America, the greatest country in the world. That is a great country because Americans have had the freedom, the freedom to succeed, the freedom of opportunity. But I think all of us can understand that the bigger government gets, the more that it takes from the American people, the more money that individuals have to spend to comply with all of these regulations, is less money that is left in American families’ pockets, small business’s pockets, and as a result the opportunities available for our citizens get diminished.

We live in a great country. But it can only be great if we are willing to allow the freedom that Americans have had to succeed to remain. That freedom has been dimming. The bright lights of freedom have been dimming for decades because government continues to grow. One only has to look at what has happened this year to wonder why we are here tonight doing this. We all know we have had a difficult economic shock in our country over the last year.

So we see a stimulus bill that came to this floor with a promise that we were going to create jobs, jobs, jobs. And unemployment wasn’t going to exceed 8 percent. Now we have unemployment rates at 10.2 percent and over 3 million Americans have lost their jobs. So all of a sudden we have a budget on the floor, a trillion-and-a-half-dollar deficit this year, and trillion-dollar deficits on average for as far as the eye can see are not sustainable and will ruin their future.

But, no, it wasn’t enough. All of a sudden we have to have this national energy tax on the floor in June. It is called cap-and-trade because no one in America really knows what that means, but it is a giant energy tax. And it would tax anybody who drives a car, anybody who works at a place that uses electricity. Anyone who would have the audacity to flip on a light switch is going to pay a higher tax.

Not only are we going to pay higher taxes and have less energy and higher energy costs in America, it will ship millions of American jobs overseas at a time when Americans are asking, Where are the jobs? And the policies that have been coming down the pike all year have more than diminished the possibility that we will be creating the jobs that Americans so desperately want. That still wasn’t enough.

Now we are going to bring this 2,000-page bill to the floor of the House. It’s got $1.3 trillion and will kill millions more American jobs.

The American people want us to focus on getting our economy moving again because they are looking for work. They want to make sure that those who have their job can keep it.

What has happened here all year is we’re moving policies that are going to destroy the ability of the private sector to create those jobs. But I don’t think there is anything that will diminish the job prospect in America more than what has happened this year, than this health care bill.

Now, you just think about this bill that we have in front of us. It is going to raise taxes. It is going to raise insurance premiums for those who have insurance. It’s full of mandates. And as if that’s not enough, we are going to cut Medicare.

Now, the President said that if you like the health insurance you have, you can keep it. And I know the President was sincere in that, but that is not what this bill represents and there’s not a Member in this Chamber that doesn’t understand that. Because if you’re a Medicare Advantage enrollee, like 27,000 of my constituents, the Congressional Budget Office says that 80 percent of them are going to lose their Medicare Advantage.

If you look at this bill and you look at the employer mandate in this bill, you will find out that if employers don’t provide health insurance, there is a tax. And for many employers, the tax will be cheaper than the actual cost of health insurance. A lot of employers in America are going to look up and say, Listen, I’d rather pay the tax, and my employees are going to have to go fend for themselves and end up in the government plan.

But it doesn’t stop there. This bill also has provisions that cap plan that is offered today has to be approved once again by the Department of Labor and the health choices czar; big compliance cost there. Some employers are going to say, Listen, this isn’t worth it. Because it’s not just going to push this plan; it’s approved again. It is going to go through the health choices czar so that the health choices czar can determine whether your plan is adequate according to some Federal bureaucrat. And so a lot of employers, they’re just going to get out of it. They’re not going to do it. And what is going to happen to those employees who like the coverage they have today? They are going to end up in the government plan.

But no, it doesn’t stop there. We have an individual mandate. The bill in front of us that says every American is going to buy health insurance whether you want it or not. And if you don’t want it, you’re going to pay a tax. And if you don’t pay the tax—listen to this. If you don’t pay the tax, you’re going to be subject to a fine of up to $250,000 and imprisonment up to 5 years. Now, this is the most unconstitutional thing I’ve ever seen in my life. The idea that we can tell Americans, force Americans by some law they have to buy health insurance or we’re going to fine you and send you to jail.

But there has been all this focus on the employer mandate and on the individual mandate, on the government option, but let me tell you where there hasn’t been much attention, and that is the giant bureaucracy that is being built here in Washington in the Federal Government to take control of Americans’ health care system and force you out of the insurance you have and into some government-run plan.

I know most of my colleagues, they might think this is hyperbole or it might sound political. Let me tell you, it isn’t. Well, just listen to this. Most of my colleagues on the left have been down here today. They are for this because it does in fact set up this big infrastructure for the government to eventually take control of all of our health care and just go to a single-payer system.

Now, it starts with the exchange that’s in this bill. Once it takes effect, the health exchange, you can’t buy private insurance on your own. You can’t go out and buy insurance. You have to go to the exchange, and the exchange will decide for you which plans are offered to you. So, if you change your job or you don’t like what you have, guess what? You get to go to the government’s health exchange to get your insurance.

It’s just not the government option that I’m talking about. When you look at this infrastructure that’s there, it is going to require tens of thousands decades.
of new Federal employees. The American people want two things from health care reform: They want lower cost and they want more choices. I think the underlying bill here tonight does exactly the opposite. It raises the cost of health insurance and confines choices. This is not the kind of agency that make health care decisions that should be left to doctors and their patients.

So let's talk about this bureaucracy for a moment. If you go to page 131, section 241 provides for an unelected ‘Health Choices Commissioner’ who would run a ‘Health Choices Administration,’ an independent agency of the executive branch.

Now, here are some of the examples of the powers of this new health choices commissioner—let's just call him the health czar. On page 167 through 172, in section 303, the health czar will decide which treatments patients could receive and at what cost. Or you can go to page 132, section 242, the health choices czar would only allow a ‘premium rating area’ before they would allow to participate in the exchange.

Then you go to page 127, section 234. This new health czar will regulate all insurance plans both in and out of the exchange.

Then you go to page 162 to 165, section 302, the health choices czar will determine which employers are going to be allowed to participate in the exchange.

Then you go to page 174 to 178, section 304(b), the health choices czar will decide which physicians and hospitals get to participate in the government-run plan.

Then you go to page 197 to 202, section 306, the health choices czar can override State laws regarding covered health benefits. It's in the bill. Go read it.

Page 133, section 242(a)(2). This person will determine how trillions of taxpayer and employer dollars would be spent within the exchange.

And page 133, section 242, “commit random complaint audits.” The person still has more powers here.

Page 183, section 305, automatically enroll as you go into the exchange if they don't have coverage, including potentially forcing these individuals into the government-run plan. Now, this is referred to as “random assignment.”

This commissioner is charged with establishing “waiting lists” and defining such terms as “dependent,” “service area,” “premium rating area,” “employee,” “part-time employee,” and “full-time employee.” Let's all be honest, this is the czar to end all czars.

But it doesn't stop there. When you look at this expanding bureaucracy created in the Federal Government, on page 1322, section 2401, it creates a new Center for Quality Improvement to prioritize areas for identification, development, evaluation, and implementation of best practices for quality improvement of best practices for the delivery of health care services. We've already got Centers for Quality Improvement, but we've got new Centers for Quality Improvement. We've got Centers for Quality Improvement who will decide which treatments are most effective. But the bill does not establish a Center for Medicare and Medicaid Innovation within the Centers for Medicare and Medicaid Services to legislate innovation as part of a bill that cuts. I think, the most innovative Medicare program we've ever had—Medicare Advantage. But we still have more.

Page 25, section 101 authorizes the Secretary of Health and Human Services to reduce benefits, increase premiums, and establish waiting lists to make up for funding in the shortfalls of high-risk pools. That's right there in the bill, “establish waiting lists.” Pages 734, 738, and 1162, sections 1401 and 1802 create the Center for Comparative Effectiveness Research and the Comparative Effectiveness Research Commission and the Comparative Effectiveness Research Trust Fund. These are bureaucracies that will decide which treatments are most effective. But the bill does not provide any protection to doctors and patients that they all get to decide what's in their own best interest.

Then we get into a lot more duplicative Federal programs. Page 1452, section 2552, the bill creates ‘incentive payments to States that enact new medical liability laws, but only if such laws do “not limit attorneys’ fees or impose caps on damages.” So we're telling States to solve the problems, but also telling them not to use the tools that work most effectively in the States that are using them.

Page 1624, section 2589 creates a new Personal Care Attendant Workforce Advisory Panel. That's again, a Personal Care Attendant Workforce Advisory Panel made up in part by personal care workers, including their union representatives, to study working conditions and salaries of these workers. Does this have to do with lowering health care costs?

Page 1968, section 3103 establishes a “Committee for the Establishment of the Native American Health and Wellness Foundation.” So we're going to set up a committee whose job it is is to set up a foundation, and we're going to take half a million dollars of American money to do this.
We can do that. What we don't need to do is to create this giant bureaucracy, spend all of this tax money, and imprison our children's future by passing this 2,000-page bill.

So, I think we do have a better solution, a commonsense solution that American families need—how proud I am of the discussion that has taken place today. I want to thank the chairman of our committee, Mr. WAXMAN, and for the bill reported by three committees after long and hard work.

Interestingly enough, under the Republican amendment, individuals would pay up to $2,821 more, and families would pay up to $8,188 more under the Republican amendment compared with H.R. 3962. It's not in the public interest that we should do that. Having said that, this is historic legislation. It addresses two of the most terrifying problems we have in this country.

The first is what was the problem when my dad introduced the first legislation in 1943, that there are now some 47 million Americans without health insurance. It can't have been canceled by your insurance; it can't have been canceled by your insurer. It's going to be visited on us in 2080 when the costs of health care will equal the gross domestic product of the United States. That will bring us to a fine economic mess if we permit that to happen. Health care and GDP costs will be equal.

Now, the bill carries out the President's suggestions: deficit neutral. It provides coverage for 96 percent of Americans. It offers everyone, regardless of income, age, or health status, the peace of mind that comes from knowing they will have real access to quality, affordable health insurance when they need it; that pre-existing conditions will not bar them from insurance; that loss of job or dropping of coverage by employer will not deny insurance.

Additionally, this bill will ensure choice and honest competition; bring security to our seniors; and will reduce the out-of-control health care costs that are crushing American businesses.

Now is the time for health care reform. We can't afford to wait. We must offer big solutions for the big problems that face the American people. We must succeed.

Mr. Speaker, I have heard from a number of my colleagues, and I appreciate the fact the vote before us today is a tough vote. We will understand there are numerous compelling issues confronting the American people—the economy, jobs, financial system overhaul. That was so in 1935 when we enacted Social Security.

History and the American people will ask what we did here this day when presented with a real opportunity to ease the strain of rising health care costs and provide quality, affordable health coverage for all Americans.

Mr. Speaker, I urge my Republican colleagues to tell the House—all Members—how proud I am of the discussion that has taken place today. I want to commend the three committees and their chairmen, including my good friend, the chairman of our committee, Mr. WAXMAN, for the work they have done.

You, Madam Speaker and the leadership, we thank you for the extraordinary leadership which you have given us in bringing this to the point where we are tonight. Thank you.

I want to begin by spending much time on the bill offered by my Republican colleagues. It is really no substitute for H.R. 3962. According to The New York Times—and I think this sufficiently disposes of the matter—the Republican amendment does “almost nothing to reduce the scandalously high number of Americans who have no insurance, and it makes only a token stab at slowing the relentlessly rising costs of medical care.”

Today, this may be a tough vote, but it is not in the public interest that we should do that. Having said that, this is historic legislation. It addresses two of the most terrifying problems we have in this country.

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Now is the time for health care reform. We can't afford to wait. We must offer big solutions for the big problems that face the American people. We must succeed.
My vote today is for American businesses—big and small. They are confronted with the real burden of providing quality health care for their workers or fall victim to their foreign competitors.

My vote today is for the federal government, and states and local governments throughout the country which are being stretched to make room for larger and larger health bills.

Mr. Speaker, my vote today is also personal.

It is a vote to fulfill the legacy left by a little, skinny, broken nose and a mustache who served as a proud Member of this distinguished body.

My father, John D. Dingell, Sr., was a part of the original New Dealers—a brand of big thinking Democrats—who believed that health care is a right, not a privilege and government had a responsibility to protect it; provide for their basic rights; and ensure opportunity for all.

So, it is in that tradition that I urge my colleagues to act today to pass this bill.

Join with the AARP, the Consumers Union, the American Cancer Society, the different medical specialist groups, the Nurses and others who support this bill.

Mr. Speaker, we have an opportunity today, to do something meaningful for the American people and for American businesses.

We can take advantage of this opportunity or we can shirk our responsibilities and allow the calamitous situation that faces our people to continue to grow out of hand, overwhelm the federal budget, force more and more families into bankruptcy, and shift more jobs overseas. Reform is neither easy nor cheap, but the cost of inaction is far greater—in terms of lost lives, quality of life and dollars. If we don’t reduce costs we face certain economic disaster.

So, today, we must overcome the naysayers, the loyal opposition, the lies about our plan, the fear that causes us to think the status quo is the safe thing to do.

We must overcome all of these things and we must act boldly, with conviction, and deliberately—not because of our own righteousness—but because there is no other acceptable alternative.

I urge my colleagues to vote “yes” on H.R. 3962 and give the American people the relief they so desperately need.

Ms. RICHARDSON. Mr. Speaker, I rise today to oppose the Boehner amendment and in strong support of H.R. 3962, the Affordable Health Care for America Act of 2009, because this bill is good for seniors, good for women, good for small businesses, and good for all Americans.

President Theodore Roosevelt proposed national health insurance in 1908. Forty years later in 1948, President Truman proposed it again. Under the leadership of Lyndon B. Johnson and a Democratic Congress, Medicare was enacted in 1965 which provided health care for senior citizens.

Today, we write another great chapter in the remarkable history of this country. Today, we extend to tens of millions of our fellow citizens the security that comes from knowing that they will have health care that is there when they need it and won’t bankrupt their families.

The health care system we have now is not working for working class families, not working for businesses trying to compete in a global economy, not working for taxpayers or for the uninsured.

There are 54 million Americans who are uninsured who need us to reform this broken system. One in five Californians are uninsured or underinsured. These numbers are staggering and if we do nothing, they will only grow worse.

H.R. 3962, the Affordable Health Care for Americans Act is the answer to the broken health care system. This bill provides American families with stability and peace of mind. Never again will they have to choose between their health and their livelihood.

This bill provides American families with higher quality health care. It leaves important health decisions up to patients and doctors, not to insurance companies.

Finally, this bill lowers costs for American families. It eliminates medical malpractice lawsuits, so preventive care while putting an annual cap on out-of-pocket expenses for American families.

Now, we need to stop playing politics and focus on actually improving people’s lives. H.R. 3962 will reform the health care system so that it provides quality, affordable coverage that cannot be taken away. It eliminates discrimination based on gender and preexisting conditions. It eliminates the prescription drug donut hole for seniors. It ends the era of no and begins the era of yes for millions of Americans seeking coverage.

The hour is late, and the need is great. I urge my colleagues to vote “no” on the Boehner Amendment and “yes” on H.R. 3962.

Mr. GALLEGLY. Mr. Speaker, I rise in support of the amendment offered by Mr. BOEHNER. I have long supported changes to current health care system which reduce health care costs through increased efficiency and provide affordable insurance for people with preexisting conditions. But, at the same time, any changes to our current system should ensure doctors and patients are allowed to make health care decisions—not government bureaucrats.

Therefore, I support real health insurance reform and support the version offered by the Minority Leader, which would:

Lower health care premiums for working families,

Allow small businesses to join together in order to buy reasonably priced health insurance,

Reduce medical costs by limiting frivolous medical malpractice lawsuits,

Prevent insurers from unjustly cancelling health insurance policies, and Establish universal access programs that provide affordable insurance for people with preexisting conditions.

Mr. Speaker, we should not consider changes of this magnitude without a complete report from the Congressional Budget Office. CBO. The preliminary estimate from the CBO puts the cost of H.R. 3962 at more than $1.05 trillion, but many independent experts believe this bill will actually increase Federal expenditures by more than $1.3 trillion.

In addition, this bill would impose $730 billion in new taxes and mandates on individuals and small businesses. Most economists, including CBO experts, have concluded that these requirements could increase unemployment by discouraging businesses from hiring low-wage workers. It could also lead to wages stagnation as payroll is diverted to comply with new Federal mandates on health care coverage.

I am also concerned about the impact of this proposal on Medicare beneficiaries. H.R. 3962 would cut $400 billion from Medicare over 10 years, including a $170 billion reduction to Medicare Advantage plans, which provides insurance coverage for many seniors.

This amendment addresses the problem of frivolous malpractice lawsuits in a meaningful way. These suits lead to the practice of expensive, defensive medicine and raise the health care expenses of all patients.

I urge my colleagues to reject H.R. 3962 and support the amendment offered by Mr. BOEHNER.

Mr. SAM JOHNSON of Texas. Mr. Speaker, today, I want to add my support for the Republican substitute amendment, the Commonsense Health Care Reform and Affordability Act. This amendment is a patient centered solution to healthcare reform that our country can afford and that members on both sides of the aisle can support. It also addresses the number one concern on the mind of all Americans in this country: the high cost of health care.

The Congressional Budget Office has estimated that this Republican substitute amendment would reduce health insurance premiums by up to 8 percent for those families who currently do not have access to employer-provided coverage. My constituents have told me that over against the cost of healthcare is too high. They need healthcare that is more affordable, accessible and available and the Commonsense Health Care Reform and Affordability Act provides just that.

Included in the Republican substitute amendment is a new bill, H.R. 2607, the Small Business Health Fairness Act. This legislation allows small businesses to band together to purchase health insurance so they can enjoy the same bargaining power large corporations and labor unions have at the purchasing table. In all parts of our economy we know that buying in bulk reduces the price tag, and healthcare is no different. Government-forced healthcare is not the way to solve our health care problem. We can and have to do better.

With almost 60 percent of the uninsured population tied to a small business, this provision in the Commonsense Health Care Reform and Affordability Act, helps bring access to affordable healthcare to those that currently don’t have it. Clearly, there are better ways to make healthcare more accessible for American families—and this Republican substitute is it.

Real healthcare reform should protect doctors and hospitals from frivolous lawsuits, so they can stop practicing defensive medicine and instead focus on practicing patient-focused care. This amendment extends medical liability reform that has been successful in several States to the rest of the Nation, saving lives and saving money.

Another provision in the Republican substitute amendment I am proud to support is the State Innovations Program. This amendment provides incentives to States who adopt reforms that reduce the cost of health insurance and expand coverage to the citizens of their States.

This provision allows States the freedom to solve their health problems in their own way. Speaker PELOSI’s health-care bill focuses on the Federal Government trying to fix what is broken with our health care. But in my great State of Texas, I believe those that are best...
equipped to solve our healthcare problems are
Tennessee. It is time for real reform that works
and not the same old answers of more money
and more government.
Finally, this amendment protects American
innovation while ensuring patients will have
more cutting-edge treatment options in the
area of "follow-on biologics." The Commonsense
Health Care Reform and Affordable
Act contains a provision that will create
a pathway for new, life saving products while
maintaining the proper incentives for compa-

ties to research and strive to discover them.
Most importantly, this provision will ensure
that many of the jobs created in this industry
will stay in the United States.
The Commonsense Health Care Reform
and Affordability Act is exactly the solution
the American public has asked Congress to pass.
It saves money, lowers the cost of health care,
protects the patient-doctor relationship and
keeps the government out of personal
healthcare decisions. I ask my colleagues to
join me in supporting this amendment today.
Mr. CAMP. Mr. Speaker, I yield back the
balance of my time.
Mr. WAXMAN. Mr. Speaker, I yield back the
balance of my time.
Mr. Speaker pro tempore. The question
is on the amendment offered by the gentleman
from Ohio (Mr. BOEHNER).
The question was taken; and the
Speaker pro tempore announced that the
noes appeared to have it.
Mr. CAMP. Mr. Speaker, on that I de-
mand the yeas and nays.
The yeas and nays were ordered.
The Speaker pro tempore. Pursuant
to section 2 of House Resolution
903, further proceedings on this
question will be postponed.
ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE
The Speaker pro tempore. The
amendment offered by the gentleman
from Texas (Mr. JOHNSON)
was agreed to without a recorded
vote.
The Speaker pro tempore. Pursuant
to section 2 of House Resolution
903, proceedings will now resume on the
amendments printed in parts C and D of
House Report 111-330 on which further
proceedings were postponed, in the
following order:
Amendment printed in part C by Mr.
STUPAK of Michigan.
Amendment printed in part D by Mr.
BOEHNER of Ohio.
The Chair will reduce to 5 minutes
the time for any electronic vote after
the first vote in this series.
AMENDMENT OFFERED BY MR. STUPAK
The Speaker pro tempore. The
un-
finished business is the vote on the
amendment offered by the gentleman
from Michigan (Mr. STUPAK) on which
the yeas and nays were ordered.
The Clerk will redesignate the
amendment.
The Clerk redesignated the amend-
ment.
Mr. COHEN and Ms. JACKSON-LEE
of Texas changed their vote from "yea"

to "nay.
Messrs. SPRATT and LEWIS of Cal-
ifornia changed their vote from "nay"
to "yea.
So the amendment was agreed to.
The result of the vote was announced
as above recorded.
A motion to reconsider was laid on the
table.
AMENDMENT OFFERED BY MR. BOEHNER
The Speaker pro tempore. The un-
finished business is the vote on the
amendment offered by the gentleman
from Ohio (Mr. BOEHNER) on which
the yeas and nays were ordered.
The Clerk will redesignate the
amendment.
The Clerk redesignated the amend-
ment.
The Speaker pro tempore. The question
is on the amendment.
This is a 5-minute vote.
The vote was taken by electronic
device, and there were—yeas 258, nays
194, answered "present" 1, not voting
0, as follows:

[Roll No. 885]
YEAS—176

Aderholt
Adler
Akin
Alexander
Altmire
Anderholt
Arnold
Baird
Baldwin
Becerra
Berkeley
Berman
Bishop (NY)
Blumenauer
Boehlert
Boehner
Boehm
Boehm
Boehm
Boehm
Bosco
Bradley
Breece

NAYS—194

Abercrombie
Ackerman
Adler (NJ)
Andrews
Arcuri
Baird
Baldwin
Becerra
Berkeley
Berman
Bishop (NY)
Blumenauer
Boehlert
Boehner
Boehm
Boehm
Boehm
Boehm
Bosco
Bradley
Breece

Brown, Corrine
Brown, Dan
Brown, Jim
Brown, Mark
Brown, Ray
Brown, Ray (KY)
Brown, Tom
Brown, Tom (OH)
Brown, Tom (NY)
Brown, Tom (RI)
Brown, Tom (NJ)
Brown, Tom (CA)
Brown, Corrine
Brown, Dan
Brown, Jim
Brown, Mark
Brown, Ray
Brown, Ray (KY)
Brown, Tom
Brown, Tom (OH)
Brown, Tom (NY)
Brown, Tom (RI)
Brown, Tom (NJ)
Brown, Tom (CA)
Brown, Corrine
Brown, Dan
Brown, Jim
Brown, Mark
Brown, Ray
Brown, Ray (KY)
Brown, Tom
Brown, Tom (OH)
Brown, Tom (NY)
Brown, Tom (RI)
Brown, Tom (NJ)
Brown, Tom (CA)
Brown, Corrine
Brown, Dan
Brown, Jim
Brown, Mark
Brown, Ray
Brown, Ray (KY)
Brown, Tom
Brown, Tom (OH)
Brown, Tom (NY)
Brown, Tom (RI)
Brown, Tom (NJ)
Brown, Tom (CA)
The SPEAKER pro tempore. Is the motion to reconsider at the desk?

Mr. CANTOR. Mr. Speaker, I have a motion to reconsider at the desk.

The SPEAKER pro tempore. Is the motion to reconsider as ordered on the bill, as amended?

The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMEND

Mr. CANTOR. Mr. Speaker, I have a motion to recommence the bill.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. CANTOR. Yes, Mr. Speaker, in its current form.

The SPEAKER pro tempore. Pursuant to House Resolution 903, the motion is considered as read.

The text of the motion is as follows:

Mr. Cantor moves to recommence the bill, H.R. 3962, to the Committee on Energy and Commerce with instructions to report the same to the House forthwith with the following amendments:

Page 1209, after line 15, insert the following new title and reform the table of contents of title B of division B, and the table of divisions, titles and subtitles in section 1(b), accordingly:

**TITLE X—SENIORS PROTECTION AND MEDICARE REGIONAL PAYMENT EQUITY FUND**

SEC. 1191. FINDINGS.

Congress finds the following:

(1) When analyzing the Medicare cuts contained in division B, OACT predicts that of the Centers for Medicare and Medicaid Services noted that the "additional demand for health services could be difficult to meet initially with existing health care providers and resources and led to price increases, cost-shifting, and changes in providers' willingness to treat patients with low-reimbursement health coverage."

(2) When analyzing the Medicare cuts contained in division B, OACT predicts that, "Over time, a substantial reduction in payment updates, based on productivity expectations that are difficult to attain, would cause Medicare payment rates to grow more slowly than, and in a way that was unrelated to, the provider's costs of furnishing services to beneficiaries. Thus, providers for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and might end their participation in the program (possibly jeopardizing access to care for beneficiaries)."

(3) The Medicare Payment Advisory Commission (MedPAC) found that 28 percent of seniors currently have difficulty finding a new physician to treat them.

(4) Medicare geographic payment inequities are well documented and have been extensively studied.

(5) The Congressional Budget Office stated that per capita health care spending varies widely across the United States.

(6) Low-cost, high-quality States are setting the national standard for Medicare yet they are penalized by the current Medicare reimbursement formula.

(7) Geographic payment inequities must be resolved for health care reform to be successful and for Medicare to achieve long-term sustainability.

(8) Rural counties face unique challenges in delivering health care.

(9) MedPAC finds that every senior currently has the ability to enroll in a Medicare Advantage plan instead of the traditional fee-for-service program.

(10) OACT predicts that because of Medicare cuts contained in division B, 1 in 5 seniors will no longer have this choice and be forced to receive their Medicare benefits from the traditional program.

(11) MedPAC estimates that, on average, Medicare physician reimbursements are 20 percent lower than the reimbursements physicians receive from private health plans.

(12) MedPAC predicts that, on average, Medicare hospital reimbursements will be 6.9 percent below the cost of providing care in 2009.

SEC. 1192. SENIORS PROTECTION AND MEDICARE REGIONAL PAYMENT EQUITY FUND. (a) ESTABLISHMENT.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish under this title a Seniors Protection and Medicare Regional Payment Equity Fund (in this section referred to as the "Fund") which shall be available to the Secretary to provide for improvements (described in subsections (b)(1) and (b)(2)) under the Medicare program under title XVIII of the Social Security Act.

(b) IMPROVEMENTS MADE BY FUND.—

(1) IN GENERAL.—The improvements described in this paragraph are the following:

(A) CORRECTING PAYMENT INEQUITIES.—In order to correct inequities in Medicare payment policies that punish high-quality, low-cost counties as defined in paragraph (2) and to promote high quality, cost effective patient care, by providing additional funding to Medicare providers located in such counties.

(B) PRESERVING SENIORS' CHOICE.—In order to protect the choice of the seniors for the Medicare health benefits that best meet their needs, by providing additional funding...
to ensure that every Medicare beneficiary continues to have access to at least 1 Medicare Advantage plan under part C of the Medicare program.

(C) Of implementation or peripherally necessary care and treatment.—By providing such additional funding as may be necessary to ensure access by Medicare beneficiaries to medically necessary treatment, including care and treatment furnished by physicians, hospitals, and other health care providers under the Medicare program, without wait times or coverage determinations based solely on the basis of cost.

(2) High quality. Low-cost county defined.—In this subsection, the term 'high quality' means having a county (or equivalent area) in which, as determined by the Secretary—

(A) the quality of care exceeds the national average; and

(B) the per beneficiary fee-for-service Medicare costs are substantially lower than the national average.

(c) Purnin.—There shall be available to the Fund—

(A) $15,500,000,000 for expenditures from the Fund during 5-year period beginning from 2010 and

(B) $40,500,000,000 for expenditures from the Fund during the 5-year period beginning with 2015.

Such amounts reflect savings in Federal expenditures and increases in Federal revenues estimated to result from the provisions of division E.

(2) Funding limitation.—Amounts in the Fund shall be available in advance of appropriations but only if the total amount obligated for expenditures from the Fund under paragraph (1) The Secretary may obligate funds from the Fund only if the Secretary determines that the Commonwealth of the Arts & Humanities is likely to be a contributor to the arts and humanities.

DIVISION E—ENACTING REAL MEDICAL LIABILITY REFORM

TABLE OF CONTENTS OF DIVISION

Sec. 4101. Encouraging speedy resolution of claims

Sec. 4102. Compensating patient injury

Sec. 4103. Maximizing patient recovery

Sec. 4104. Additional health benefits

Sec. 4105. Punitive damages.

Sec. 4106. Authorization of payment of future damages to claimants in health care lawsuits.

Sec. 4107. Definitions.

Sec. 4108. Effect on other laws.

Sec. 4109. State flexibility and protection of state rights.

Sec. 4110. Applicability; effective date.

SEC. 4101. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

The time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first. In no event shall the time for commencement of a health care lawsuit exceed 3 years after the date of manifestation of injury unless toll for any of the following—

(i) Upon proof of fraud;

(ii) Intentional concealment; or

(iii) Failure of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

Actions by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury unless actions by a minor under the full age of 6 years shall be commenced within 3 years from the date of manifestation or prior to the minor's 8th birthday, whichever provides a longer period. Such time periods shall be tolled for minor parents for any period during which a parent or guardian and a health care provider or health care organization have committed fraud or collusion to bring an action on behalf of the injured minor.

SEC. 4102. COMPENSATING PATIENT INJURY.

(a) Unlimited Amount of Damages for Actual Economic Losses in Health Care Law Suits.—In any health care lawsuit, nothing in this division shall limit a claimant's recovery of the full amount of the available economic damages, notwithstanding the limitation in subsection (b).

(b) Additional Non-Economic Damages.—In any health care lawsuit, the amount of non-economic damages, if available, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same injury.

(c) No Discount of Award for Non-Economic Damages.—In any health care lawsuit, nothing in this division shall disallow non-economic damages. An award for non-economic damages in excess of $250,000 shall be reduced either before the entry of judgment by a percentage of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law.

(d) Fair Share Rule.—In any health care lawsuit, each party shall be liable for that party's share of any damages only and not for the damages suffered by any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. Whenever a judgment of liability is rendered as to any party, a separate judgment shall be rendered against each such party to which allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. 4103. MAXIMIZING PATIENT RECOVERY.

(a) Court Supervision of Share of Damages Actually Paid to Claimants.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages actually paid to claimants. In particular, in any health care lawsuit in which the attorney for a party claims to have earned the income by reason of a contingent fee, the court shall have the power to restrict the payment of a claimant's damages to such attorney, and to damages to the claimant based upon the interests of justice and principles of equity. In no event shall the total of all contingent fees for representing a claimant exceed 25 percent of the total damages awarded for any claimant except that in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(i) whether punitive damages are to be awarded and the amount of any award, and

(ii) the amount of punitive damages following a determination of punitive liability. If a separate proceeding is requested, evidence relevant only to the claim for punitive damages as determined by the court shall be admissible in any proceeding to determine whether compensatory damages are to be awarded.

(b) Determining Amount of Punitive Damages.—

(i) Factors Considered.—In determining the amount of punitive damages, if awarded, in a health care lawsuit, the trier of fact shall consider only the following—

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the probability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the
case may be, by such party, of the kind causing
the harm complained of by the claimant;
(E) any criminal penalties imposed on such
party, as a result of the conduct complained of
by the claimant; and
(F) the amount of any civil fines assessed
against such party as a result of the conduct
complained of by the claimant.

(2) REMEDIES.—The amount of punitive
damages, if awarded, in a health care lawsuit
may be as much as $250,000 or as much as
two times the amount of economic
damages, if awarded, in a health care
lawsuit.

SEC. 4106. AUTHORIZATION OF PAYMENT OF FU-
TURE DAMAGES TO CLAIMANTS IN ALTERNATIVE DISPUT-
E RESOLUTION SYSTEMS

(a) IN GENERAL.—In any health care law-
suit, if an award of future damages, without
reduction to present value, equaling or ex-
ceeding $50,000 is made against a party with
sufficient insurance or other assets to fund
a periodic payment of such a judgment,
the court shall, at the request of any party,
enter a judgment ordering that the future
damages be paid by periodic payments. In
any health care lawsuit, the court may be
guided by the Uniform Periodic Payment of
Judgments Act promulgated by the National
Conference of Commissioners on Uniform
State Laws.

(b) APPLICABILITY.—This section applies
only to actions which have not been first set
for trial or retrial before the effective date of
this division.

SEC. 4107. DEFINITIONS.

In this division:
(1) ALTERNATIVE DISPUTE RESOLUTION SYS-
TEM; ADR.—The term “alternative dispute
resolution system” or “ADR” means a sys-
tem that provides a resolution of health care
lawsuits in a manner other than
judicial proceedings.

(2) CLAIMANT.—The term “claimant”
means any person who brings a health care
lawsuit, including a person who asserts or
claims a right to legal or equitable contribu-
tion, indemnity, or subrogation, arising out
of a health care liability claim or action, and
any person on whose behalf such a claim is
asserted or such an action is brought, wheth-
er deceased, or a minor under the age of
(3) COLLATERAL SOURCE BENEFITS.—The
term “collateral source benefits” means any
amount paid or reasonably likely to be paid
in reimbursement of the claimant’s damages,
or any service, product, or other benefit pro-
vided or reasonably likely to be provided in the
future to or on behalf of the claimant, as a
result of the injury or wrongful death, pursu-
ant to:
(A) any State or Federal health, sickness,
income-disability, accident, or workers’
compensation law;
(B) any health, sickness, income-disability,
or accident insurance that provides health
benefits or income-disability coverage;
(C) any agreement, or any group, organiza-
tion, partnership, or corporation
or association to provide, pay for, or reimburse the cost of medical, hospital, dental, or income-
disability benefits; and
(D) any other publicly or privately funded
program.

(4) COMPENSATORY DAMAGES.—The term
“compensatory damages” means objectively
verifiable monetary losses incurred as a re-
sult of the provision of, use of, or payment for
(or failure to provide, use, or pay for)
health care services or medical products,
such as past and future medical expenses,
loss of past and future earnings, cost of ob-
taining domestic services, loss of employ-
ment, and cost of loss of domestic services,
loss of past and future earnings, cost of ob-
taining domestic services, loss of employ-
manship, or income-disability coverage;
and

(5) CONTINGENT FEE.—The term “conting-
ent fee” includes all compensation to any
person or persons which is payable only if
recovery is effected on behalf of one or more
claimants.

(6) ECONOMIC DAMAGES.—The term “eco-
nomic damages” means any person or
persons which is payable only if
recovery is effected on behalf of one or more
claimants.

(7) HEALTH CARE LAWSUIT.—The term
“health care lawsuit” means any health care
liability claim concerning the provision of,
use of, or payment for (or the failure to pro-
vide, use, or pay for) health care services or
medical products affecting interstate commerce, or
any health care liability action concerning
the provision of, use of, or payment for
health care services or any medical product affecting interstate commerce, brought in a State or Federal
court or pursuant to an alternative dispute
resolution system, against a health care pro-
vider, a health care organization, or the
manufacturer, distributor, supplier, mar-
keter, promoter, or seller of a medical prod-
uct, regardless of the theory of liability
upon which the claim is based, or the number
of claimants, plaintiffs, defendants, or other
parties, or the number of claims or causes of
action in which the claimant alleges a health care liability claim. Such term does not
include a claim or action which is based
on criminal liability; which seeks civil fines
or penalties paid to Federal, State, or local
government; or which is grounded in anti-
trust.

(8) HEALTH CARE LIABILITY ACTION.—The
term “health care liability action” means
a civil action brought in a State or Federal
court or pursuant to an alternative dispute
resolution system, against a health care pro-
vider, a health care organization, or the
manufacturer, distributor, supplier, mar-
keter, promoter, or seller of a medical prod-
uct, regardless of the theory of liability
upon which the claim is based, or the number
of claimants, plaintiffs, defendants, or other
parties, or the number of claims or causes of
action in which the claimant alleges a health care liability claim.

(9) HEALTH CARE LIABILITY CLAIM.—The
term “health care liability claim” means a
demand by any person, whether or not pursu-
ant to a health care liability action, for
compensation, in the form of money damages,
whether such money damages are neither
economic nor non-economic damages.

(10) HEALTH CARE ORGANIZATION.—The
term “health care organization” means any
person or entity which is obligated to provid-
emotional pain, suffering, inconvenience,
physical impairment, mental anguish, dis-
figurement, loss of enjoyment of life, loss
of society and companionship, loss of consor-
tium (other than loss of domestic service),
and all other noneconomic losses of any kind or
nature. The term “compensatory damages”
includes economic damages and non-
economic damages, as such terms are defined
in this section.

(11) HEALTH CARE PROVIDER.—The
term “health care provider” means any person or
entity which is obligated to provide, pay for, or reimbursement the cost of medical, hospital, dental, or income-
disability coverage; and

(12) NONCOMPENSATIVE DAMAGES.—The
term “noncompensative damages” means damages
which are neither economic nor
non-economic damages.

(13) PATIENT.—The term “patient” means
any person or entity which is

(14) MEDICAL PRODUCT.—The term
“medical product” means a drug, device, or
biological product intended for humans, and the
terms “drug”, “device”, or “biological product”
have the meanings given such terms in
sections 201(g)(1) and 201(h) of the Federal Food,
Drug and Cosmetic Act (21 U.S.C. 321(g)(1)
and (h)) and section 351(a) of the Public
Health Service Act (42 U.S.C. 262(a)), respec-
tively, including any component or raw
material used therein, but excluding health care
goods or services.

(15) NONSEXECUTIVE DAMAGES.—The term
“nonservice” means damages for
physical and emotional pain, suffering, in-
convenience, physical impairment, mental
anguish, disfigurement, loss of enjoyment
of life, loss of society and companionship, loss
of consortium (other than loss of domestic
service), hedonic damages, injury to reputa-
tion, and all other noneconomic losses of
any kind or nature.

(16) PUNITIVE DAMAGES.—The term “puni-
tive damages” means damages awarded,
for the purpose of punishment or deterrence,
and not solely for compensatory purposes,
against a health care provider, health care
organization, or a manufacturer, distributor,
or supplier of a medical product. Punitive
damages are neither economic nor non-
economic damages.

(17) RECOVERY.—The term “recovery”
means the net sum recovered after deducting
any disbursements or costs incurred in con-
nection with prosecution or settlement of
the claim, including all costs paid or ad-
vanced by any person. Costs of health care
services which are provided by the claimants’
office overhead costs or charges for legal
services are not deductible disbursements or
 costs for such purpose.

(18) STATE.—The term “State” means each
of the several States, the District of Colum-
bia, the Commonwealth of Puerto Rico,
the Virgin Islands, Guam, American Samoa,
the Northern Mariana Islands, the Trust
Territory of the Pacific Islands, and any other
territory or possession of the United States,
or any political subdivision thereof.

SEC. 4108. EFFECT ON OTHER LAWS.

(a) VACCINE INJURY.—(1) To the extent that

(2) If there is an aspect of a civil action
brought for a vaccine-related injury or death—

(A) this division does not affect the appli-
cation of the rule of law to such an action; and

(B) any rule of law prescribed by this divi-
sion in conflict with a rule of law of such
time shall not apply.

(3) To the extent that a health care organ-
ization, or a manufacturer, distributor,

(4) To the extent that the State of Rhode
Island or the District of Columbia
enacted or promulgated any law or regula-
tion that would require such health care
organization, or a manufacturer, distributor,

(5) If there is an aspect of a civil action
brought for a vaccine-related injury or death—

(A) this division does not affect the appli-
cation of the rule of law to such an action; and

(B) any rule of law prescribed by this divi-
sion in conflict with a rule of law of such
time shall not apply.

(6) To the extent that a health care organ-
ization, or a manufacturer, distributor,

(7) If there is an aspect of a civil action
brought for a vaccine-related injury or death—

(A) this division does not affect the appli-
cation of the rule of law to such an action; and

(B) any rule of law prescribed by this divi-
sion in conflict with a rule of law of such
time shall not apply.

(8) To the extent that a health care organ-
ization, or a manufacturer, distributor,

(9) If there is an aspect of a civil action
brought for a vaccine-related injury or death—

(A) this division does not affect the appli-
cation of the rule of law to such an action; and

(B) any rule of law prescribed by this divi-
sion in conflict with a rule of law of such
time shall not apply.

(10) To the extent that a health care organ-
ization, or a manufacturer, distributor,

(11) If there is an aspect of a civil action
brought for a vaccine-related injury or death—

(A) this division does not affect the appli-
cation of the rule of law to such an action; and

(B) any rule of law prescribed by this divi-
sion in conflict with a rule of law of such
time shall not apply.

(12) To the extent that a health care organ-
ization, or a manufacturer, distributor,

(13) If there is an aspect of a civil action
brought for a vaccine-related injury or death—

(A) this division does not affect the appli-
cation of the rule of law to such an action; and

(B) any rule of law prescribed by this divi-
sion in conflict with a rule of law of such
time shall not apply.
to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this division or otherwise applicable law (as determined under this division) will apply to such aspect of such action.

(b) **Other Federal Law.**—Except as provided in this section, nothing in this division shall be deemed to affect any defense available to a defendant in a health care lawsuit or action under any other provision of Federal law.

**SEC. 4109. STATE FLEXIBILITY AND PROTECTION OF STATES RIGHTS.**

(a) **Health Care Suits.**—The provisions governing health care lawsuits set forth in this division preempt, submerge in, or supersede chapter 171 of title 28, United States Code, to the extent that such chapter 171 of title 28, United States Code, to the extent that such chapter 171 does not otherwise apply, the provisions governing health care lawsuits set forth in this division.

(b) **State Law.**—State law to the extent that State law prevents the application of any provisions of law established by or under this division. The provisions governing health care lawsuits set forth in this division supersede section 171 of title 28, United States Code, to the extent that such section 171 of title 28, United States Code, to the extent that such section 171 does not otherwise apply, the provisions governing health care lawsuits set forth in this division.

(c) **State Flexibility.**—No provision of this division shall be construed to preempt—

(1) any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages or (the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this division, notwithstanding section 171 of title 28, United States Code; or

(2) any defense available to a party in a health care lawsuit under any other provision of State or Federal law.

**SEC. 4110. APPLICABILITY; EFFECTIVE DATE.**

This division shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring prior to the date of the enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Virginia is recognized for 5 minutes in support of the motion.

□ 2230

Mr. CANTOR. Mr. Speaker, any physician in America will tell you that the simplest way to reduce health care costs is to enact real medical liability reform. The fear of being sued by opportunistic trial lawyers is pervasive in the practice of medicine. Our system wastes billions on defensive medicine that should be going to patient care. That’s why real medical liability reform is needed. In fact, CBO estimates that as much as $54 billion can be saved by the Federal government alone. It is simply totally unacceptable that this money is being spent in the courtroom instead of the operating room.

At the same time, the majority has promised that no patient that needs their health care bill will see costs rise, yet the bill before us today. Mr. Speaker, contains no medical liability reforms. And why not? The truth comes from one of the Democrats’ own, no less than former DNC Chair and presidential hopeful Howard Dean, who said last August. The reason that tort reform is not in the bill is because the people that wrote it did not want to take on the trial lawyers in addition to everybody else they were taking on, and that is the truth.

Mr. Speaker, the Republican motion to recommit adds real meaningful medical liability reform and uses its $54 billion in savings to create a fund that will protect seniors, especially those in rural areas, from the steep cuts to Medicare in the Democrats’ reform package. It gives Members the chance to prioritize the health of our Nation’s seniors instead of lining the bank accounts of trial lawyers. It’s time to choose the doctors and nurses who care for the patients in the operating rooms and leave patient care to the people trained to handle it best—our doctors.

Mr. Speaker, to talk about this further, I now yield to the gentlewoman from Florida, Congresswoman Brown-Waite.

Ms. GINNY BROWN-WAITE of Florida. Betty, a constituent of mine, recently told me that if it weren’t for Medicare Advantage, she would have been dead. You see, Medicare Advantage plans are the only way that seniors can choose their doctors, and it’s the only way that seniors can choose the preventive treatment they need.

This motion is about choice. It’s about living in a free country. It’s about having freedom. Mr. Speaker, the commonsense motion will protect seniors’ health care, lower health care costs, and preserve freedom.

Mr. HOYER. Mr. Speaker, I rise in opposition to the motion to recommit.

The SPEAKER pro tempore. The gentleman from Maryland is recognized for 5 minutes.

Mr. HOYER. Mr. Speaker, I yield to the gentleman from Iowa (Mr. BRALEY).

Mr. BRALEY of Iowa. Mr. Speaker, during this entire health care debate, we’ve heard a lot from our friends on the other side of the aisle about something called medical liability reform, but all day as they’ve been talking about this point, you have not heard one word about patient safety. If you want to talk about real meaningful health care reform, it’s important to talk about the most critical aspect of true, meaningful health care reform—standing up for patients. Who will speak for the patients?

Mr. Speaker, who will speak for the patients? We have the reports from the highly respected nonpartisan Institute of Medicine on patient safety. The first one is on patient safety. Achieving a New Standard for Care. The second one is Preventing Medication Errors, and the third one, Safer Health System. Building a Safer Health System.

What did the Institute of Medicine tell us about the state of patient safety? They told us that the most significant way to reduce the costs of medical malpractice is to emphasize patient safety by reducing the number of preventable medical errors. They also told us that’s the only way we’re going to our seniors. AARP put their profits ahead of our seniors.

With this motion, you have a chance to restore some of our cuts. No excuses about this amendment killing the bill can be made. No word games can get you out of this. This has to be a vote for all seniors of America. Please remember your constituents will be watching.

Mr. CANTOR. Mr. Speaker, I now yield to the gentleman from Washington (Mr. REICHERT).

Mr. REICHERT. Thank you. This motion was and will protect seniors from drastic cuts to Medicare and stop expensive lawsuits that increase the costs of health care for every American. We’ve heard, if you like it, you can keep it, but the bill before us is a direct assault on America’s seniors, cutting $500 billion from Medicare.

Under this bill, one out of every five seniors will lose the health care plan they chose. Because of regional payment disparities in many parts of this country, Medicare Advantage plans are the only way seniors can receive needed care. It’s the only way that seniors can choose their doctors, and the only way that seniors can choose the preventive treatment they need.
bring about meaningful health care reform. They also told us that medical errors kill as many as 98,000 Americans every year; and that, if it were ranked by the Centers for Disease Controls, would be the sixth leading cause of deaths in America.

They also told us that every year there are 15 million incidents of medical liability in this country and that patient safety is indistinguishable from the delivery of medical care. That’s why they aren’t telling you about what the Institutes of Medicine reported the party fiduciary of medical errors is in this country.

They reported in their studies that every year medical errors add $17 billion to $28 billion of cost, most of it in additional medical care that we end up paying for as consumers of health care. When you multiply that over the 10 years of this bill, that means it’s costing us $170 billion to $230 billion if we continue to ignore this problem. That’s why Democrats and the Institutes of Medicine are standing up for patients, and that’s why you should reject this motion to recommit.

You hear our friends talk about what happened in California in 1976 when they put a $250,000 cap on payments for quality-of-life damages. What they don’t tell you is that the value of that cap today in 2009 is $400,000, and if you adjust that cap at the same rate of medical inflation, it would be worth $1.9 million. That’s what’s wrong.

Mr. HOYER. I thank the gentleman for his comments.

My colleagues, I ask you to reject this amendment. Our colleagues on the other side of the aisle demanded 72 hours’ notice for the bill and they've got it. They've got 60 days’ notice. They gave us 72 seconds to consider this amendment.

This amendment deals with some very complicated subjects; and it provides, of course, as we are not surprised that this bill is for substantial billions of dollars back to the insurance companies. That’s what their objective is. And, yes, they say something about equity of distribution of money. No study.

We set up a very careful study to make sure that the people’s money is distributed to the States in an equitable, fair, effective fashion. That is why we ought to reject this amendment for which we received no notice, no consideration, no discussion in the public. The Republicans have been outdone for his comments.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.
The vote was taken by electronic device, and there were—yeas 428, nays 0, not voting 7, as follows:

[Roll of No. 888]

YEAS—428

Crowley [In]...
I particularly want to thank the outstanding staff of House Legislative Counsel who worked under the tireless direction of Deputy Legislative Counsel Ed Grossman: Jessica Shapiro, Megan Renfrew, Warren Burke, Henry Chirstrup, Larry Johnson, and Wade Ballou.

I also want to thank the talented staff of the Congressional Budget Office: Bob Sunshine, Pete Fontaine, Holly Harvey, Phil Ellis, Tom Bradley, and Kate Massey.

Finally, I want to thank the staffs of three committees that worked on this bill: Energy and Commerce, Ways and Means, and Education and Labor. Their expertise was remarkable, and their efforts—on both the Democratic and Republican side—Herculean.

In particular, I want to commend my committee Health staff, who worked under the direction of the incomparable Karen Nelson: Alvin Banks, Steve Cha, Bobby Clark, Brian Cohen, Alii Corr, Sarah Despres, Jack Ebeler, Tim Groninger, Ruth Katz, Purvey Kempf, Anne Morris, Andy Schneider, Camille Sealy, Naomi Seller, and Tim Westmoreland.

I yield at this time to the distinguished chairman of the Ways and Means Committee.

Mr. RANGEL. Thank you, Mr. WAXMAN, and also Chairman MILLER.

As most of you know, the legislation from the three committees was blended, but so were our great staffs blended. We are here to thank them all for the great work that they put in, the countless hours that they put in to make this legislation a reality.

On the staff of the Committee on Ways and Means in the office of the Health Subcommittee, I would like to thank Chairman PETE STARK, who worked on this legislation, Janice Mays, John Buckley, Cybele Bjorklund, Debbie Curtis, Chiquita Brooks-LaSure, Jennifer Friedman, Geoff Gerhart, Sydney Spey, Drew Crouch, Marci Harris, Tom Taan, Drew Dawson, Ruth Brown, John Barkert, Matthew Beck, Lauren Bloomberg, Brian Cook, and Cameron Branchley.

Because this legislation was the product of the three committees, I would like to thank the Health staffs of the Committee of Energy and Commerce as well as Education and Labor. We are indebted to our staffs for the work that they have done. We want to thank the capable analysts at the CBO and the Joint Committee on Taxation. We may not always agree with all of the work that we have done, but we have put in a lot of long hours. They’ve worked day and night for all of us, for the Congress, and for our great country.

Mr. WAXMAN. Reclaiming my time, I also want to single out Virgil Miller and Katie Campbell, who worked on Mr. Dingell’s staff and worked very closely with all of us.

AUTHORIZING THE CLERK TO MAKE CORRECTIONS IN ENVELOPMENT OF H.R. 3962, AFFORDABLE HEALTH CARE FOR AMERICA ACT

Mr. WAXMAN. Mr. Speaker, I ask unanimous consent that

RECOGNIZING 30TH ANNIVERSARY OF IRANIAN HOSTAGE CRISIS

The SPEAKER pro tempore. The unfinished business is the question on suspending the rules and agreeing to the concurrent resolution, H. Con. Res. 209.

The Clerk read the title of the concurrent resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New York (Mr. MCMAHON) that the House suspend the rules and agree to the concurrent resolution, H. Con. Res. 209.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the concurrent resolution was agreed to.

A motion to reconsider was laid on the table.

HONORING 60TH ANNIVERSARY OF DIPLOMATIC RELATIONS BETWEEN THE U.S. AND JORDAN

The SPEAKER pro tempore. The unfinished business is the question on suspending the rules and agreeing to the resolution, H. Res. 833, as amended. The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New York (Mr. MCMAHON) that the House suspend the rules and agree to the concurrent resolution, H. Con. Res. 209.

The question was taken; and (two-thirds being in the affirmative) the rules were suspended and the concurrent resolution was agreed to.

A motion to reconsider was laid on the table.

CONDITIONAL ADJOURNMENT TO MONDAY, NOVEMBER 9, 2009

Mr. CONNOLLY of Virginia. Mr. Speaker, I ask unanimous consent that
when the House adjourns today on a motion offered pursuant to this order, it adjourn to meet at 6 p.m. on Monday, November 9, 2009, unless it sooner has received a message from the Senate transmitting its concurrent in House Concurrent Resolution 210, in which case the House shall stand adjourned pursuant to that concurrent resolution.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Virginia?

There was no objection.

REVISIONS TO THE 302(a) ALLOCATIONS AND BUDGETARY AGGREGATES ESTABLISHED BY THE CONCURRENT RESOLUTIONS ON THE BUDGET FOR FISCAL YEARS 2010 THRU 2014

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from South Carolina (Mr. SPRATT) is recognized for 5 minutes.

Mr. SPRATT. Madam Speaker, under section 321 of S. Con. Res. 13, the concurrent resolution on the budget for fiscal year 2010, I hereby submit a revision to the budget allocations and aggregates for certain House committees for fiscal year 2010 and the period of fiscal year 2010 through 2014. This adjustment responds to House consideration of the bill H.R. 3962, the Affordable Health Care for America Act. A corresponding table is attached.

The revision represents an adjustment for the purposes of section 302 and 311 of the Congressional Budget Act of 1974, as amended. For the purposes of the Congressional Budget Act of 1974, as amended, this revised allocation is to be considered as an allocation included in the budget resolution, pursuant to section 427(b) of S. Con. Res. 13.

DIRECT SPENDING LEGISLATION—AUTHORIZING COMMITTEE 302(a) ALLOCATIONS FOR RESOLUTION CHANGES

(Fiscal Years, in millions of dollars)

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SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to: (The following Member (at his own request) to revise and extend his remarks and include extraneous material:)

Mr. SPRATT, for 5 minutes, today.

ADJOURNMENT

Mr. CONNOLLY of Virginia. Mr. Speaker, pursuant to the order of the House of today, I move that the House do now adjourn.

The motion was agreed to; accordingly (at 11 o’clock and 33 minutes p.m.), under its previous order, the House adjourned until Monday, November 9, 2009, at 6 p.m., unless it sooner has received a message from the Senate transmitting its adoption of House Concurrent Resolution 210, in which case the House shall stand adjourned pursuant to that concurrent resolution.

OATH FOR ACCESS TO CLASSIFIED INFORMATION

Under clause 13 of rule XXIII, the following Members executed the oath for access to classified information:

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 2 of Rule XXIV, executive communications were taken from the Speaker’s table and referred as follows:

H.R. 4601. A bill to grant the congressional gold medal to the members of the messen- 

and steward branches of United States Navy, Marine Corp, and Coast Guard that served 

during World War II, to the Committee on Financial Services, and in addition to the 

Committee on House Administration, for a period to be subsequently determined by 

the Speaker, in each case, and for the further consideration of such provisions as fall within the jurisdi- 

ction of the committee concerned.

By Ms. GIFFORDS:

H.R. 4605. A bill to allow certain improvements in the Post-9/11 Educational Assist- 

ance program; to the Committee on Veterans’ Affairs.

By Mr. HOLT (for himself, Ms. CORRINE BROWN of Florida, Mr. WU, Mr. 

MCGOVERN, Mr. CONYERS, Mr. CHAN- 

DLER, Mr. LOBRIESE, Mrs. MCMORRIS RODGERS, Mr. BISHOP of South Carolina, Mr. 

BLUMENAUER):

H.R. 4605. A bill to amend the Elementary and Secondary Education Act of 1965 to 

establish a partnership program in foreign lan- 

guages; to the Committee on Education and Labor.

By Mr. KAGEN:

H.R. 4606. A bill to amend the Internal Revenue Code of 1986 to make permanent the al- 

ternative fuel credit and the alternative fuel mixture credit; to the Committee on Ways and 

Means.

By Mr. MURPHY of New York (for him- 

self and Mr. JONES):

H.R. 4607. A bill to authorize interest-bear- 

ing transaction accounts at depository instit- 

utions, and for other purposes; to the Com- 

mittee on Financial Services.

By Mr. MICA (for himself, Mr. STUPAK, 

Mr. SCOTT of Georgia, Mr. STEFFENSON, Mr. 

BOOZMAN, Mr. WILSON of South Carolina, Mr. INGLIS, Ms. FOXX, Mr. 

OREBSTAR, Mr. LATRAN, Mr. RUS- 

SELL, Mr. BAUER, Mr. CHAFFETZ, Mr. 

PETRI, Mr. SHIMKUS, Mr. BRADY of Texas, Mr. SCALISE, Mr. GRAVES, Mr. 

GUTERIE, Mr. YOUNG of Alaska, Mr. BUCK, Mr. McCaul, Mr. CRENshaw, Mr. 

CAMP, Mr. TIBERI, Mr. DAVIS of Kentucky, Mr. BARRETT of South Carolina, Mr. LATTA, Mr. KUCINICH, Mr. 

KOSMAS, Mr. EHLERS, Mrs. 

BLACKBURN, Mr. HENSAHLING, Mr. 

OLSON, Mr. DYAN of Wisconsin, Mr. MCCARTHY, Mr. BHART, Mr. PAPST, Mr. 

HINCHFY, Mr. BROWN of Missouri, Mr. 

PARSLE:

H. Con. Res. 212. Concurrent resolution ex- 
presing the sense of Congress on the occa- 
sion of the 20th anniversary of historic events in Central and Eastern Europe, par- 

cicularly the Velvet Revolution in Czechos- 

lovakia, and reaffirming the principle of friendship and cooperation between the United States and the Slovak and Czech Repub- 

cles; to the Committee on Foreign Af- 

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cles; to the Committee on Foreign Af- 

MEMORIALS

Under clause 4 of Rule XXII, 219. The SPEAKER presented a memorial of the Senate of the Commonwealth of Puer- 

to Rico, relative to Senate Resolution 4855. "Militating the United States Congress grants grants to 

the Committee on Ways and Means, Energy and 

Commerce, and Education and Labor.

By Mr. ADLER of New Jersey (for him- 

self, Mr. HALL of New York, Mr. 

FATTH, Mr. SCHWARTZ, Mr. BRADY of 

Pennsylvania, Mr. SEXTAR, and Mr. 

WALZ).
ADDITIONAL SPONSORS

Under clause 7 of rule XII, sponsors were added to public bills and resolutions as follows:

H. R. 1162: Mr. Rooney.
H. R. 1428: Ms. Kosmas.
H. R. 1589: Ms. Richardson and Mr. Ryan of Ohio.
H. R. 2254: Mr. McIntyre, Mr. Crenshaw, Ms. Woolsey, Ms. Ginny Brown-Watte of Florida, Mr. Calvert, Ms. Wasserman Schultz, Ms. Kosmas, Mr. Fattah, Mr. Scott of Virginia, and Mr. Meek of Florida.
H. R. 2266: Mr. Arcuri.
H. R. 2607: Mr. Crenshaw.
H. R. 2698: Mr. McKeon and Mr. Rehberg.
H. R. 2710: Mr. Rothman of New Jersey and Mr. Boswell.
H. R. 2737: Mrs. Dahlkemper.
H. R. 2817: Ms. Baldwin.
H. R. 3012: Mr. Farr.
H. R. 3043: Mrs. Kirkpatrick of Arizona, Mr. Al Green of Texas, and Mr. Hinchey.
H. R. 3044: Mr. Flake, Mr. Wamp, and Mr. Bishop of Georgia.
H. R. 3186: Mr. Bishop of Utah.
H. R. 3496: Mr. Upton.
H. R. 3640: Mr. Chandler.
H. R. 3688: Mr. Cassidy and Mr. Kratovil.
H. R. 3948: Mr. Mariu Diaz-Balart of Florida and Mr. Manzullo.
H. R. 4022: Mr. Gao and Mr. Olson.
H. R. 4034: Mr. Watt.
H. J. Res. 42: Mrs. Bono Mack and Mr. Shuster.
H. Con. Res. 169: Mr. Paulsen.
H. Res. 577: Mr. McCaul, Ms. Fallin, and Mr. Lance.
H. Res. 664: Mr. Costello, Ms. Corrine Brown of Florida, Mr. Paschell, Mr. Kildee, Mr. Waxman, Mr. Kagen, Mr. Maffei, Mrs. Christensen, and Mr. Kirk.

PETITIONS, ETC.

Under clause 1 of Rule XXII, petitions and papers were laid on the clerk’s desk and referred as follows:

77. The SPEAKER presented a petition of Board of Education, Hawaii, relative to petitioning the Congress of the United States to support Hawaii House Concurrent Resolution No. 158; to the Committee on Natural Resources.
78. Also, a petition of Board of Education, Hawaii, relative to petitioning the Congress of the United States to support the Hawaii Senate Concurrent Resolution No. 62; to the Committee on Natural Resources.
79. Also, a petition of City Commission of Wilton Manors, Florida, relative to Resolution No. 3460 petitioning the Congress of the United States to support the Employment Non-Discrimination Act (ENDA); jointly to the Committees on Education and Labor, House Administration, Oversight and Government Reform, and the Judiciary.
Daily Digest

Highlights

The House passed H.R. 3962, Affordable Health Care for America Act.

Senate

The Senate was not in session today. It will next meet at 2 p.m., on Monday, November 9, 2009.

Committee Meetings

(Committees not listed did not meet)

No committee meetings were held.

House of Representatives

Chamber Action

Public Bills and Resolutions Introduced: 7 public bills, H.R. 4061–4067; and 1 resolution, H. Con. Res. 212 were introduced.

Additional Cosponsors:

Reports Filed: There were no reports filed today.

Speaker: Read a letter from the Speaker wherein she appointed Representative Jackson (IL) to act as Speaker pro tempore for today.

Suspensions—Proceedings Resumed: The House agreed to suspend the rule and pass the following measures which were debated on Friday, November 6th:

Amending the Small Business Act to improve the Microloan Program: H.R. 3737, amended, to amend the Small Business Act to improve the Microloan Program, and for other purposes by a 2/3 yea-and-nay vote of 405 yeas to 23 nays, Roll No. 876; Pages H12594–95

Small Business Microlending Expansion Act of 2009: H.R. 1838, amended, to amend the Small Business Act to modify certain provisions relating to women’s business centers, and for other purposes by a 2/3 recorded vote of 428 ayes to 4 noes, Roll No. 877; Pages H12595–96

Small Business Development Centers Modernization Act of 2009: H.R. 1845, to amend the Small Business Act to modernize Small Business Development Centers, and for other purposes, by a 2/3 recorded vote of 412 ayes to 20 noes, Roll No. 878; Page H12596

National School Psychology Week: H. Res. 700, to express support for designation of the week beginning on November 9, 2009, as National School Psychology Week, by a 2/3 recorded vote of 431 ayes to 1 no, Roll No. 879; Pages H12596–97

Expressing support for Chinese human rights activists Huang Qi and Tan Zuoren: H. Res. 877, to express support for Chinese human rights activists Huang Qi and Tan Zuoren for engaging in peaceful expression as they seek answers and justice for the parents whose children were killed in the Sichuan earthquake of May 12, 2008, by a 2/3 recorded vote of 426 ayes to 1 no, Roll No. 880; Pages H12597–98

Recognizing the 20th anniversary of the remarkable events leading to the end of the Cold War and the creation of a Europe, whole, free, and at peace: H. Res. 892, to recognize the 20th anniversary of the remarkable events leading to the end of the Cold War and the creation of a Europe, whole, free, and at peace, by a 2/3 recorded vote of 431 ayes to 1 no, Roll No. 883; Page H12623

Honoring the lives of the brave soldiers and civilians of the United States Army who died or were wounded in the tragic attack of November 5, 2009 at Ford Hood, Texas: H. Res. 895, to honor the lives of the brave soldiers and civilians of the United States Army who died or were wounded in the tragic attack of November 5, 2009 at Ford Hood, Texas, by a 2/3 yea-and-nay vote of 428 yeas with none voting “nay”, Roll No. 888; Pages H12968–69

Recognizing the 30th anniversary of the Iranian hostage crisis: H. Con. Res. 209, to recognize the
30th anniversary of the Iranian hostage crisis, during which 52 United States citizens were held hostage for 444 days from November 4, 1979, to January 20, 1981; and

Honoring the 60th anniversary of the establishment of diplomatic relations between the United States and the Hashemite Kingdom of Jordan and the 10th anniversary of the accession to the throne of His Majesty King Abdullah II Ibn Al Hussein: H. Res. 833, amended, to honor the 60th anniversary of the establishment of diplomatic relations between the United States and the Hashemite Kingdom of Jordan and the 10th anniversary of the accession to the throne of His Majesty King Abdullah II Ibn Al Hussein.

Affordable Health Care for America Act: The House passed H.R. 3962, to provide affordable, quality health care for all Americans and reduce the growth in health care spending, by a recorded vote of 220 ayes to 215 noes, Roll No. 887.

Pages H12596–H12968

Rejected the Cantor motion to recommit the bill to the Committee on Energy and Commerce with instructions to report the same back to the House forthwith with amendments, by a recorded vote of 187 ayes to 247 noes, Roll No. 886. Pages H12963–67

Pursuant to the rule, the amendment printed in part A of H. Rept. 111–330, perfected by the modification printed in part B of the report, shall be considered as adopted. Pages H12623

Agreed to:

Stupak amendment (printed in part C of H. Rept. 111–330) that codifies the Hyde Amendment in H.R. 3962. The amendment prohibits federal funds for abortion services in the public option. It also prohibits individuals who receive affordability credits from purchasing a plan that provides elective abortions. However, it allows individuals, both who receive affordability credits and who do not, to separately purchase with their own funds plans that cover elective abortions. It also clarifies that private plans may still offer elective abortions (by a yea-and-nay vote of 240 yeas to 194 nays with 1 voting “present”, Roll No. 884). Pages H12921–27 H12962

Rejected:

Boehner amendment in the nature of a substitute (printed in part D of H. Rept. 111–330) that sought to create Universal Access Programs that expand and reform high-risk pools and reinsurance programs to guarantee that all Americans, regardless of pre-existing conditions or past illnesses, have access to affordable care while lowering costs for all Americans. It would have prevented insurers from unjustly canceling a policy or instituting annual or lifetime spending caps. The amendment would have put in place medical liability reforms and give small businesses the power to pool together and offer health care at lower prices. In addition, the legislation would have provided incentive payments to states that reduce premiums and the number of uninsured. The bill would have allowed Americans living in one state to shop for coverage and purchase insurance in another. The legislation would have prohibited all Federal funds, whether they are authorized funds or appropriated funds, from being used to pay for abortion. The amendment would have created new incentives to save for future and long-term care needs by allowing qualified participants to use HSAs to pay premiums (by a yea-and-nay vote of 176 yeas to 258 nays, Roll No. 885).

Pages H12927–63

Agreed that the Clerk be authorized to make technical and conforming changes to reflect the actions of the House. Pages H12969

H. Res. 903, the rule providing for consideration of the bill, was agreed to by a recorded vote of 242 ayes to 192 noes, Roll No. 882, after the previous question was ordered by a recorded vote of 247 ayes to 187 noes, Roll No. 881. Pages H12621–22

Meeting Hour: Agreed that when the House adjourns today, it adjourn to meet at 6 p.m. on Monday, November 9, 2009, unless it sooner has received a message from the Senate transmitting its adoption of H. Con. Res. 210, in which case the House shall stand adjourned pursuant to that concurrent resolution. Pages H12969–70


Adjournment: The House met at 9 a.m. and adjourned at 11:33 p.m.

Committee Meetings

No committee meetings were held.

House

No committee meetings are scheduled.
Next Meeting of the SENATE
2 p.m., Monday, November 9

Program for Monday: After the transaction of any morning business (not to extend beyond 3 p.m.), Senate will resume consideration of H.R. 3082, Military Construction and Veterans Affairs Appropriations Act. Also, at 4:30 p.m., Senate will begin consideration of the nomination of Andre M. Davis, of Maryland, to be United States Circuit Judge for the Fourth Circuit, and after a period of debate, vote on confirmation of the nomination at 5:30 p.m.

Next Meeting of the HOUSE OF REPRESENTATIVES
2 p.m., Monday, November 16

House Chamber

Program for Monday: To be announced.