The Senate met at 9:30 a.m. and was called to order by the Honorable MARK L. PRYOR, a Senator from the State of Arkansas.

PRAYER

The Chaplain, Dr. Barry C. Black, offered the following prayer:

Let us pray.

Here we are again, Lord, a people in need of Your presence and power in order to meet life with courage and faith.

Today, strengthen the Members of this body with a faith that will ever choose the harder right over the easy expedient. Give them wisdom to follow Your example of sacrificial service, infusing them with the courage to do right as You give them the light to see it. Lord, lift from them the burden of loss and sorrow when forces beyond their control invade their lives and seek to rob them of Your peace. Bless them with the assurance that they are never alone, for You have promised never to forsake them. Fill their disappointments with Your strengthening presence, transforming their darkness into the glory of Your new dawn of hope and life.

We pray in Your great Name. Amen.

PLEDGE OF ALLEGIANCE

The Honorable Mark L. Pryor 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.

APPOINTMENT OF ACTING PRESIDENT PRO TEMPORE

The PRESIDING OFFICER. The clerk will please read a communication to the Senate from the President pro tempore (Mr. Byrd).

The legislative clerk read the following letter:

The Honorable MARK L. PRYOR, a Senator from the State of Arkansas.

To the Senate:

Under the provisions of rule 1, paragraph 3, of the Standing Rules of the Senate, I hereby appoint the Honorable MARK L. PRYOR, a Senator from the State of Arkansas, to perform the duties of the Chair.

ROBERT C. BYRD, President pro tempore.

Mr. PRYOR thereupon assumed the chair as Acting President pro tempore.

RECOGNITION OF THE MAJORITY LEADER

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

Mr. REID. Mr. President, I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

SCHEDULE

Mr. REID. Mr. President, following leader remarks, the Senate will be in a period of morning business for an hour. Senators during that time will be permitted to speak for up to 10 minutes each. The majority will control the first 30 minutes and the Republicans will control the final 30 minutes.

Following morning business, the Senate will proceed to the consideration of S. 1963, which is the Caregivers and Veterans Omnibus Health Services Act. Debate on the bill will be limited to 30 minutes equally divided and controlled between Senators AKAKA and BURR or their designees. The only amendment in order to the bill is the Coburn amendment relating to the funding priorities in this bill. Debate on the Coburn amendment is limited to 3 hours, with Senator COBURN controlling 2 hours and Senator AKAKA controlling the final hour.

At 2 p.m., the Senate will resume debate on the nomination of David Hamilton to be U.S. circuit judge for the Seventh Circuit. Debate until 2:30 is going to be equally divided and controlled between Senators LEAHY and SESSIONS or their designees.

At 2:30 p.m., the Senate will proceed to a series of three rollcall votes. Those votes will be on confirmation of the Hamilton nomination, in relation to the Coburn amendment, and on passage of the veterans omnibus bill.

HEALTH CARE REFORM

Mr. REID. Mr. President, we have traveled a great distance to get where we stand today. With the bill we unveiled last night, we begin the last leg of this historic journey.

The American people and President Obama have asked us for health insurance reform. There are two things we must have above all: No. 1, make it more affordable for every American to live a healthy life, and No. 2, do so in a fiscally responsible way that helps our economy recover. Senate Democrats have listened, and we have written a bill that will save lives, save money, and save Medicare.

Since yesterday evening, the bill has been on the Internet for all to see. You will find it at democrats.senate.gov, but here is a quick summary of what is in that bill. And I say, Mr. President, this is a big bill. I was at a meeting with some other Senators this morning, and everyone acknowledged that no one can ever remember a bill that affects everybody in America as this bill does. It is a bill that has a lot of pages in it. But, as we know, it is printed the way all bills are printed. If we wanted to print it in smaller fashion—as books are written, for example—it
would be much smaller. It is a lot of words, and every word in it is important and necessary. Since yesterday evening, as I have indicated, this bill has been on the Internet. Everyone in the world can see this bill.

As the President asked us to do, this bill will not add a dime to the deficit—quite the opposite, in fact: It will cut it by $130 billion in the first 10 years and by as much as $35 trillion in the first 20 years. We do this by keeping costs down. This critical reform will cost less than $5 billion a year over the next decade, well under President Obama’s goal.

We will make sure every American can afford quality health care. We will make sure more than 30 million Americans who do not have health care today will soon have it. We will not only protect Medicare, but we will make it stronger.

These numbers are as impressive as they are important for our Nation’s future, and though we are proud of these numbers, these figures, we owe it to our fellow citizens to overlook what this is really all about. More accurately, we cannot afford to overlook whom this is about.

This is about a parent who cannot take a child to the doctor because insurance is too expensive, their employer canceled it, or they lost their job. That is why we are making sure every American can afford good coverage.

This is about the small business in Nevada or someplace else in the country that had to lay off an employee because it couldn’t afford skyrocketing health care premiums. That is why we are cutting those small business taxes.

It is about the woman with high cholesterol or the man with heart disease or the family who cannot ever worry about their ability to get help and can’t get insurance. That is why we are stopping insurance companies from deciding they would rather not give health care to the sick.

This is about the family who has to make a terrible choice between their mortgage and their medications. When this bill passes, the only choice they will have to make is which insurance company offers them the best coverage. They will have the choice to make, and it is a good choice. The choice is, which best suits their family?

This is also about mothers and sisters and wives and daughters who cannot get cancer screening tests to detect breast cancer. It is inexcusable that women cannot get the tests they need. That is why we are making prevention and wellness a priority.

For these families and these businesses, for our economy’s renewal, our children’s future, and our Nation’s promise, the finish line is in sight. I am confident we will cross it soon. Once again, I am inviting my Republican colleagues to join us on the right side of history.

RECOGNITION OF THE MINORITY LEADER

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

HEALTH CARE REFORM

Mr. MCCONNELL. Mr. President, for months we have been warning the American people and Democrats’ plans to raise premiums, raise taxes, and slash Medicare in order to fund more government. Americans know that is not reform, and unfortunately the majority has not been listening.

While two committees have publicly reported legislation, the bill we are being asked to consider was assembled behind closed doors, out of sight, and without input from the public for over the last 6 weeks. We are being told we must rush to pass this legislation, even though most of its provisions will not take effect for another 5 years, until 2014. That is a little bit like being asked to pay your mortgage 4 years before you are allowed to move into your house. Americans deserve to know how much will it cost? Will their premiums go up? What is hidden in the fine print? Are favored interests or States getting sweetheart deals? The American people want to take the time to get this right.

Over here, we have the House bill and the Senate bill together, each of them roughly 2,000 pages. You see this massive bill to rewrite one-sixth of our economy, with stunning unintended consequences for ourselves and for our children and for our grandchildren.

The majority leader’s bill is 2,074 pages long. When fully implemented—and the way to look at the true cost of this bill is how much it will cost over a 10-year period when it is fully implemented—we have done it in order to make it look less expensive, in this proposal, is phasing in benefits and taxes at different times. But when this 2,074-page bill is fully implemented, it will cost $2.5 trillion.

According to CBO, Federal health care spending will actually go up, not down, as a result of this mammoth effort to rewrite one-sixth of our economy. It cuts Medicare by $465 billion—nearly $5 trillion in cuts to a program that is so important to our seniors. Hospitals, nursing homes, home health, hospice—all of those will be slashed in this $465 billion cut to Medicare. It raises taxes $493 billion. So you have here massive cuts in Medicare and massive tax increases.

Who gets hit? Who gets hit with the tax increases? You do. If you have insurance, you get taxed. If you do not have insurance, you get taxed. If you need a lifesaving medical device, you get taxed. If you need prescription medicines, you get taxed. There is also a new Medicare tax.

What is the bottom line here? After weeks of drafting a bill behind closed doors, the majority has produced a bill that increases premiums, raises taxes, and slashes Medicare by $2.5 trillion, to create a new government program. This is not what the American people want. I do not believe they think this is reform. This is not the direction to take.

I yield the floor.

RESERVATION OF LEADER TIME

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

MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Under the previous order, there will be a period of morning business for 1 hour, with Senators permitted to speak therein for up to 10 minutes each, with the time equally divided and controlled between the two leaders or their designees, with the majority controlling the first half and the Republicans controlling the final half.

The Senator from New Mexico is recognized.

Mr. UDALL of New Mexico. Mr. President, I ask unanimous consent, during the time we control for the next half hour, that we be able to engage in a colloquy with other Senators.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

HEALTH CARE REFORM

Mr. UDALL of New Mexico. Mr. President, for months we have gathered in this Chamber to talk about why we need a public option as part of health care reform. Almost every week the insurance companies provide another example of why a public option is critical to ensuring all Americans have access to quality, affordable health insurance. Our most recent examples come courtesy of two of America’s largest insurance companies—Humana and CIGNA. Wall Street just completed its third quarter earnings season, and Humana and CIGNA released their reports a couple weeks ago. Let’s just say that both companies did very well last quarter. Humana profits in the third quarter were up 92 percent over the same time last year. CIGNA profits in the third quarter were up 65 percent over the third quarter of last year. CIGNA profits in the third quarter were up 92 percent.

Senator BROWN has focused on the insurance company issue and has seen what is happening to the American people. This is happening at a time when 47 million Americans are without access to affordable health care. I will ask him to speak a little bit about the insurance company issue and what is happening.

Before doing so, the Republican leader was here on the floor, and he was talking about the numbers that were given by CBO. These are number crunchers. They are by nonpartisan folks. These are people who work very hard late at night. They have been
working to get out their numbers on the bill that we will have on the floor in a short while. I can’t believe we are now hearing they don’t like the CBO numbers. Both sides live by CBO numbers. That is the important thing for people to understand. I yield to Senator Brown.

Mr. Brown. Mr. President, we are also joined by Senator Reed of Rhode Island and Senator Merkley. They helped write the bill in the HELP Committee. We know Aetna’s CEO last year made $21 million. Of the top 10 insurance companies, the average CEO is paid $1 million per year. We know their profits have gone up 400 percent over the last 7 years. It is not so much that CEOs are paid so much. It is not just their profits and their CEO and top executive salaries, it is the business model that gets them there. When you think about what has happened to insurance companies, it is like a giant insurance company, you hire a bunch of bureaucrats to keep people from buying insurance, to invoke preexisting condition so somebody can’t get insurance or to put limits on coverage so people can’t get insurance. Then they hire bureaucrats on the other side to deny claims. Forty percent of claims are denied initially. They are appealed sometimes and then they get reimbursement customers, someone who files a claim. But the fact that they have to fight the insurance companies while they are sick anyway or while they are advocating for their parents or a sister or husband or wife, these huge profits and huge executive salaries are based in denying care on preexisting conditions, on squeezing profits from customers.

That is of all the small businesses in Rhode Island, Oregon, New Mexico, and Arkansas, all the businesses that say they can’t afford insurance anymore. They may have had huge price spikes because 1 person in a company out of 30 employees gets sick.

I don’t care all that much about profits and CEO salaries. I do think it is immoral. But what I care about is that those profits and salaries are based on hurting people who have insurance or keep having insurance.

Mr. Kaufman. How can a business do this? There is a real reason why they can do it. It is because there is no competition. Other companies can’t do that. They can’t treat the people who are customers the way the insurance companies do. When you look at the list, you can see why they get away with it. There is no competition. In the top 39 States out of 50, over 53 percent of the market share is with 2 companies. There is no competition right now in half of the States. That is the heart of why we need the public option. The reason for the public option is it allows us to have competition in these States where there is no competition at the present time. You can have gigantic profits. You can have CEOs making millions of dollars. You can have all these things. You can treat your customers poorly. You can do all these things because you don’t have to worry about the competition. That is the business and offering them a good or better deal. That is what the public option does.

Mr. Udall of New Mexico. I yield to Senator Merkley. I want to get him involved in this discussion.

Mr. Reed. I thank Senator Udall. Senator Kaufman has made an excellent point. What we have seen over the last several years, actually more than a decade, is increasing costs shifted to small business. Just this year, a 15-percent increase in small business premiums is anticipated, much higher than inflation. That is because there is no real competition. Rhode Island is on that map, where two companies control the market. That is not competition. They can do it. It is because there is no competition. Other companies can’t do this? There is a real reason why.

Mr. Merkley. We are in a very similar situation here, where we have a noncompetitive industry. If you are not satisfied with the cost of your insurance or the service you are receiving, then you should have multiple places to go. That is the underlying point of creating a health care marketplace or exchange, as it is called, so citizens can say: Here are all the plans competing against each other. What are they going to offer? A year later, if you are not happy, you get to switch, which says to every single insurance company, if we don’t do this, you will lose your customers. That is the marketplace. That is competition. That is what we need in America. It will be helped by having a public option.

Mr. Udall of New Mexico. Absolutely. No doubt about that.

Mr. Merkley. I can tell you a couple stories from Oregon. There was an article in the Bend Bulletin in October about two families.

One individual, Dale Evans, went to his doctor because he was experiencing pain in his chest. His doctor recommended he have an MRI to find out what was going on. The request was made three times. The insurance company turned it down three times. Because he didn’t have this test, there was no diagnosis made of the cancerous tumor he had. His tumor proceeded to damage the nerves in his spinal cord and left him unable to walk. Then it became too large to be operated on. Mr. Evans died the following year, in 2006. As a result of this experience, the insurance company, a for-profit insurance company, the test was not conducted and the individual died.
Richard Paulus of Bend, OR, has a similar case being filed right now. He, fortunately, is still alive. He was de-nied repeated requests for back surgery. His doctor argued for a second opinion. The request was made, turned down again. One would think, you would choose, they would be much more likely to create accountability with the company they are with right now.

Mr. UDALL of New Mexico. I wish to ask the Senator about those circumstances because he knows more of the details, but when you have insurance companies, these for-profit insurance companies we have been talking about that are making incredible profits, when you have insurance companies that are not paying out, to meet their bottom line, they will move quickly to the care. To do MRI, and then say: It is prescribed and they are going to say: It is not there that you have denied. They will not have this going around. They will not have all this administrative run-around. They will not have this going on.

Is that the Senator's understanding? Will they look at the situation you have right there that you have described and they are going to say: It is clear this gentleman needs an MRI because we need to find out what is going on. So they will do the MRI, and then they will move quickly to the care. To me, that is the difference between what the Senator described, where insurance companies are trying to find a way to not pay out, to meet their bottom line, and to raise profits; whereas, a public option would be doing the opposite, focusing on health care, focusing on future needs, focusing on providing what people need in the health care arena.

Mr. MERKLEY. Your point is well taken. The overhead in the private health care industry is now 25 to 30 percent. That is a whole lot of folks sitting around desks operating with paper rather than nurses and nurse practitioners and doctors practicing the craft of medicine, the craft of healing. Whereas, I look at Medicare, in steady 25 to 30 percent is somewhat around 3 percent—much less and, therefore, a lot more dollars going into actually assisting folks in getting well. Again, competition is going to drive that down.

Mr. UDALL of New Mexico. I say to Senator MERKLEY, the thing the American people should know about the health care plan Senator Reid was own is—that we have unveiled here in the Senate—is it has a public option in it. So the public option will be there to provide competition. It will be there to provide the very best care. And it will be there to make sure we keep these insurance companies honest. That is what we are trying to do here: to make sure there is competition in the market, to make sure the insurance companies are honest.

Mr. MERKLEY. Yes. The reason we have lost competition is twofold. One, in many markets, a single company dominates the market. Second, even if you have multiple companies, they are exempt from the antitrust laws and, therefore, they can communicate with each other, reduce rates or even eliminates real competition. That is why this is so important.

There is one feature of this public option that I think is important to recognize. It represents a huge compromise, and I think my folks back home—particularly elderly folks back home are quite sold on this idea, and we do not want to see it “forced on them.” Quite frankly, I think it would be good to have competition in the country, even everyone have more choices. But in deference to that Federalist tradition in America, in deference to the laboratory of State experimentation, a provision has been included in Senator Reid’s merged bill that says if a State does not want to participate, it can opt out.

So there is no Senator in this Chamber who should have any concern about saying my folks back home do not want this, and they are going to be forced to have it. They can opt out. So there is no Senator in this Chamber who should have any concern about saying my folks back home do not want this, and they are going to be forced to have it. They can opt out. What do the States that are not so convinced will have a choice to watch this unfold to decide if they wish to join this movement for competition? And I hope those States that are not so convinced will have a choice to watch this unfold to decide if they wish to join this movement for competition and choose later on. Mr. UDALL of New Mexico, I say to Senator MERKLEY, I think that is a great example of how we all work here together to find a compromise that works for everyone. I realize there are Democratic Senators and Republican Senators—and the same for Governors—who may want the things differently in their State. So what we have done here is give them the option of opting out in this public option we are providing.

I personally—looking at the facts, and looking at the situation—do not know why a State would want to opt out. But there is going to be the check and balance there of the legislature having to pass a law, the Governor having to sign it, and say: We do not want to have anything to do with the public option.

But we realize with a public option you bring competition to the market, you expose these high administrative costs you talked about. One of the things people do not realize, on administrative costs, is, the Federal Government runs the Medicare Program. Here you have a program that when I go to town hall meetings, I say: Raise your hand if you are on Medicare. They will put their hand up. And I will say: Keep your hand up if you like Medicare. So they will raise their hand, and they will keep it up. Ninety-five percent of the people like Medicare. Why? The public option will be there to provide competition.

Mr. MERKLEY. I say to the Senator, let me give you an example of how that competition can work in a health industry in your State, Senator Reid. I have been here on the floor with Senator Whitehouse—I know Senator REID was just here—participating in a conversation about Seniors health care. They still have this public option out there, you are going to drive down that overhead. It represents a huge compromise, and I think my folks back home are quite sold on this idea, and we do not want to see it “forced on them.” Quite frankly, I think it would be good to have competition in the country, even everyone have more choices. But in deference to that Federalist tradition in America, in deference to the laboratory of State experimentation, a provision has been included in Senator Reid’s merged bill that says if a State does not want to participate, it can opt out. So there is no Senator in this Chamber who should have any concern about saying my folks back home do not want this, and they are going to be forced to have it. They can opt out. What do the States that are not so convinced will have a choice to watch this unfold to decide if they wish to join this movement for competition? And I hope those States that are not so convinced will have a choice to watch this unfold to decide if they wish to join this movement for competition and choose later on. Mr. UDALL of New Mexico, I say to Senator MERKLEY, I think that is a great example of how we all work here together to find a compromise that works for everyone. I realize there are Democratic Senators and Republican Senators—and the same for Governors—who may want the things differently in their State. So what we have done here is give them the option of opting out in this public option we are providing.

I personally—looking at the facts, and looking at the situation—do not know why a State would want to opt out. But there is going to be the check and balance there of the legislature having to pass a law, the Governor having to sign it, and say: We do not want to have anything to do with the public option.
whether it is health insurance, whether it is workers compensation—you inject competition. And by injecting that competition, you make the marketplace work a lot better. That is what we are striving for here today.

Senator MERKLEY.

Mr. MERKLEY. There are folks who have said: Well, now, hold on. Isn’t this a government takeover of health care? Since that has been said so many times on this floor by those who oppose health care reform, I think we should address it directly. Introducing a competitor does not have the government taking over health care. It is an option citizens can choose—if they are not satisfied with the current performance—competing on a level playing field. This is exactly what you need when you have markets that have lost their competition.

It is important to note this phrase “government takeover” came out of a study that was advocated for by colleagues across the aisle to say: How can we defeat health care? They polled folks in America and said: What are the scariest terms we can use—even though we do not know what the plan is; even though we do not know whether the plan is going to invest in disease management; we do not know if the plan is going to have healthy choice incentives that will help improve the quality of life of Americans and decrease health care costs; we do not know if we will have insurance reforms that will get rid of dumping, the practice of throwing people off their health care plan once they get sick; we do not know whether there will be reforms that say there will be something that will be required of them to get care; their job to come and talk about how important it is to have insurance reforms so people are not barred because of pre-existing conditions, people are not dumped after a decade of being provided insurance because they get sick.

It is so important we have this debate, and I look forward to having it, and hope all colleagues will join in saying: Yes, no matter which side of this issue you are on, it is time to debate, and citizens have an opportunity to do.

Mr. UDALL of New Mexico. I say to Senator MERKLEY, thank you. Thank you for joining me in this colloquy today.

I thank the Acting President pro tempore and yield back any time at this point.

The ACTING PRESIDENT pro tempore. The Senator from Tennessee.

Mr. ALEXANDER. Mr. President, I wonder if you could let me know when I have consumed 9 minutes.

The ACTING PRESIDENT pro tempore. The Senator will be so notified.

Mr. ALEXANDER. Thank you, Mr. President.

HEALTH CARE REFORM

Mr. ALEXANDER. Mr. President, I was listening to my friends on the Democratic side. I wish they could have been in the Senate 4 or 5 years ago. Actually that would have reduced our numbers, so as much as I like them, I would not have wished that. If they had been here, they might have had some help in arguing to the Democrats who blocked Judge Pryor of Alabama from having an up-or-down vote, who blocked Judge Pryor of Alabama from having an up-or-down vote. The Democrats at that time seemed to argue a completely different point of view.

What we want on the Republican side is very simple.

You see this bill I am leaning against? This is the new bill. This is the Harry Reid—the distinguished majority leader’s health bill. We want to make sure the American people have a chance to read it and they have a chance to know exactly what it costs and they have a chance to know exactly how it affects them. That is not
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an unreasonable request, we don’t think. That is the way the Senate works. That is our job.

When it came to the Defense authorization bill, we spent a couple of weeks doing that. When it came to No Child Left Behind Education, we spent 7 weeks going through it, and neither of those bills was 2,074 pages long. The Homeland Security bill took 7 weeks. The Energy bill in 2002 took 8 weeks. A farm bill last year took 4 weeks. It is a little reading, a little reading, a little reading, a little work to do. We have done some preliminary reading, but what we want to make sure of is that the American people read the bill, know what it costs, and know how it affects them because health care is a very personal matter.

I have done some reading since the bill came out last night. I was also a little bit amused to hear our friends complain in terms of the Thanksgiving things down well. This bill has been hidden in the majority leader’s office for 6 weeks. He wouldn’t let any of us read it. I don’t know who he has been in there with writing it, but I guess it takes time to write a 2,074-page bill. But he didn’t bring it out until last night, and now we have it printed out. Now he wants to vote on Saturday. Well, that is all right with us if he wants to vote on Saturday or Sunday or Monday, or Thanksgiving Day. We are going to be here because these are the most important set of votes we are ever likely to take in this body, at least during the time I am here.

Let me give a preliminary report to the American people in terms of the Thanksgiving spirit about this bill. It came out with a lot of fanfare. It has been hidden in the majority leader’s office for 6 weeks, but here is my early verdict in terms of the Thanksgiving season. This is the same turkey you saw in August, and it is not going to taste any better in November. It is not much different than what worried you in August. In fact, it has gotten a little bit worse.

If I may, let me give just a few thoughts about the bill. Why would I say it is the same turkey you saw in August, and you didn’t like it in August, and it is not going to taste any better at Thanksgiving dinner on Thursday. We need to start over. We need to go in the right direction. We need to cut costs. Republicans have offered a number of ways to do that: small business health plans, reducing junk lawsuits against doctors, competition across State lines. All of these steps would cut costs. We don’t need a 2,074-page bill. We need to take it step by step in the right direction to cut health care costs. Republicans have offered a number of ways to do that.

The Acting President pro tempore recognized.

Mr. JOHANNIS. Mr. President, I wish to compliment the Senator on his very excellent presentation on a bill we just got in the middle of the night last night. I am a little bit tempted to ask the Senator if I could have a copy of that bill on my desk, but the less we have to handle it, the less we risk bodily injury, so that is all right. Just keep it right there by your desk.

I wish to zero in on one issue today. It is a very important issue to Nebraskans. It is a very important issue to Americans. That is the issue of abortion. An overwhelming majority of Americans suggest—take the position I should say—that we should not use Federal funds for abortions. Just yesterday, I was looking at an article and it said six in ten Americans favor a ban on using Federal funds for abortions. I have found over and over again that Nebraskans feel the same way.

A constituent in Gretna, NE, said to me, and I am quoting:
Please know that I do support some health care reform; however, I cannot in good conscience support any legislation that contains any abortion mandates.

Someone from Bellevue, NE, said, and I am quoting again:

I am writing to urge you to ensure that language is included in any health care reform proposal or bill to explicitly exclude abortion. . . . The use of my tax dollars forces me to support a procedure that is against my conscience.

So as we move forward, we need to focus on what people are saying to us. That is why in this bill we need the exact language in the House bill.

The Stupak amendment is the essence of a continuation of current law. Don’t be fooled by those who suggest this is something new and different. The Hyde law prohibits Federal funding of abortion through Federal programs such as Medicaid. It prohibits Federal funding for private health insurance policies that cover abortion. An example is the current Federal Employees Health Benefits Program. The 250 participating health plans do not cover elective abortions. Federal employees pay a share of the cost. The Federal Government pays the balance—or the taxpayers. Federal employees cannot opt for elective abortion coverage because taxpayer dollars are subsidizing the cost of the employee plans.

As I have said during this debate, if it is good enough for Federal employees, well, it should be good enough for the citizens.

The Stupak-Ellsworth-Pitts amendment says: New government subsidies could not be used to purchase an insurance plan that covers abortion. The proposed government insurance plan also could not cover abortion. However, the stark and alarming differences that exist in the Senate bill are immediately obvious.

The Senate bill says: People who receive a new government subsidy could—could—enroll in an insurance plan that covers abortion. It requires—at least one plan on the insurance exchange to offer abortion services.

Supporters say: Don’t worry. Public funds would be segregated, so they wouldn’t be used for abortion. But this provides no solace whatsoever. It is impossible to segregate funds. How will the government assure citizens who receive a subsidy to buy a health insurance plan do not use those Federal dollars to pay for health insurance premiums?

Put another way: citizens get charged a premium that includes abortion coverage. The taxpayers pay a percent of the premium. Who can determine what dollar went here or what dollar went there? Well, as many have pointed out already, it is a shell game, nothing more, nothing less.

The Senate is a sham detour from current law. The very clear line established by the Hyde amendment is obliterated. The Federal Employees Health Benefits Plan does not allow this shell game and neither should this new regime.

National Right to Life is not fooled by this game. They call this provision “completely unacceptable.” It was recently described by abandoning the language and saw through it. National Right to Life goes on to say that it “closely mirrors the original House language that was rejected by 64 Democrats.” I am going to quote:

It tries to conceal that unpopular reality with layers upon layers of exceptions and hollow bookkeeping requirements.

I stand here today to say to National Right to Life, thank you for standing up for life. I hope more will do the same. You are absolutely correct in saying that it would “require coverage of any and all abortions throughout the public option program. This would be Federal Government funding of abortion, no matter how hard they try to disguise it.” They weren’t fooled. My best view is that other pro-life leaders will courageously stand up today and tell Americans they should not be fooled either. We have to draw a line. This isn’t a partisan issue.

Last week, a Democratic colleague said:

What is clear is that for this bill to be successful, there can be no taxpayer funding for abortion.

Yet the Stupak-Ellsworth-Pitts protection is missing from this bill. Since it is not in the underlying bill, I want to be very candid, I don’t see it in the final bill. I don’t believe there are enough pro-life Senators to break a filibuster to make this a part of the final bill. That is why this motion to proceed will be voting on in hours has become the key vote on abortion. It is the key pro-life vote.

Some say cloture on a motion to proceed is just a procedural effort. It begins debate, and then you can do amendments and ultimately even vote the bill down. The facts suggest otherwise. Listen to this, from the Congressional Research Service: Between the 106th and 110th Congress, there were 41 cases in which the U.S. Senate approved a motion to proceed and eventually then voted on final passage; 40 of those 41 bills received final approval. In other words, all but one passed into law. Well, that tells us all we need to know. This motion to proceed on this bill is the key pro-life vote.

Some of my colleagues would argue that if we don’t like the bill, we must block the opportunity to amend it; therefore, they would say we should vote for the motion to proceed. I don’t think any pro-life Senator could take that position, and here is why: If we proceed to the bill, any changes will require 60 votes. I sincerely wish there were 60 pro-life votes in the Senate, but by my count I don’t get there; therefore, we must be able to change this. If there is a Senator willing to suggest otherwise, I respectfully invite him or her to come to the floor and share the list of 60 Senators who are willing to vote for a provision that ensures the Stupak amendment will be there. I don’t think that is going to happen.

So it comes down to this: If you don’t believe tax dollars should fund abortion, vote against the motion to proceed, said as this last chance to protect life in this debate.

Congressman STUPAK and about 40 of his Democratic colleagues stood strong on their pro-life convictions, and they literally changed the outcome in the House. They stood in the Speaker’s office, and said, about this procedural vote: Look, if it is not pro-life, we are not there. And the Speaker had no choice but to put the Stupak amendment up for a vote. Over 40 courageous Congressmen stuck to their convictions, and they made a difference.

Today in the Senate, we don’t need 40 Democrats to stand up for what is right; we need just 1. If just one pro-life Democrat would say: I will not vote to move this bill until it is fixed, until it is truly pro-life, that is enough. Those who say they are pro-life but refuse to take that stand, I worry they are not standing up for life.

I have a record of voting pro-life. I know how I am going to vote on this, because it is the right thing to do. I ask for a pro-life Senator to come down here and stand up on this bill. Pro-life Americans are waiting, and they are not fooled.

I yield the floor.

The PRESIDING OFFICER (Mr. BENNET). The Senator from Wyoming is recognized.

Mr. BARRASSO, Mr. President, here you have it, what we have been waiting for—weeks and weeks, what has been put together behind closed doors. People all across the country have seen the doors behind which people, in secret, have been writing this bill. It is 2,074 pages. Some people call it remarkable; I call it a monstrosity. The leader of the majority, Senator REID, has said that of all the bills we have seen, it will be the best. Mr. President, it is the best of the worst. It just looks like more of the same. All of the things I have been talking about—it still does those sorts of things. It still raises taxes on Americans, higher payroll taxes—and this is the Associated Press talking, not just me. Companies will pay a fee. That is from the Associated Press as well. It adds an array of tax increases, a rise in payroll taxes. That is from the Washington Post. It relies primarily on a new tax. That comes from the Washington Post as well. Then The New York Times says: New taxes and new fees. It is more of the same. It is the best of the worst.

What about Medicare cuts? Oh, they are in here, too, you better believe it. It is relying on cuts in future Medicare spending to cover costs. That is from the Associated Press. It is financed through billions of dollars in Medicare cuts. That is from the Washington Post. There will be reductions in Medicare. It is all in here—taking away the
health care of the seniors of this country, who have relied on Medicare and have been promised Medicare, to start a brandnew program which is in these 2,074 pages. It is just wrong.

Then look at the budget gimmicks. The legislation—as Senator ALEXANDER CBO came up with some number, but it is not what the real cost is. This thing is going to cost $2.5 trillion over a 10-year period. They try to get the number down. How do they do it? They start collecting taxes on day one, but until they implement the program—the things that are supposed to help Americans, they have delayed those things through 2014. Here we are in 2009, and the people who are watching at home and saying: This is going to help me next week, forget it, wait another 5 years. That is the way they maneuver and manipulate the numbers.

Here we have it—a bill that still raises taxes, still cuts Medicare, uses lots of the same gimmicks, and will cost the American people trillions and trillions of dollars.

Mr. President, obviously health care is one of the most important issues Congress is going to take up this year and different careers in the Senate. This may be the most important issue and bill we are ever asked to vote upon.

I travel home to Wyoming every weekend. I talk to people. I was there for 5 days over Veterans Day. I say to them: What do you need? What do you think? What are your thoughts on this?

They say: Deliver to Washington a clear and simple message: Fix what is wrong with the health care system. Whatever you do, don’t make things worse for me.

I have town meetings and ask people: Do you think it is going to cost more or less if this is passed? And I have had telephone townhall meetings with folks around Wyoming, and there is a way you can poll and ask people their ideas. None of them want to read this thing. None of them want to read it so that they know about the travesties in the bill and the impact it will have on them personally. It is the wrong prescription for America. And it is not just me saying that; it is also the AP, the Washington Post, and the New York Times. All along the way, it is higher payroll taxes, companies paying more for their people, as the debt continues to accumulate in our Nation and goes on to impact the young people of this Nation.

Yesterday, there was an article in the Wall Street Journal, and the dean of Harvard Medical School—it is in Boston, which is where they have this whole Massachusetts health care plan. He said that it is not working in Massachusetts and that this is not going to work for America. He gave the health care bill we are looking at in this Congress, a failing grade. It doesn’t do a good job in dealing with costs, access, or quality. It misses the boat on all of them.

The people who believe this is going to be helpful collectively are delusional, absolutely wrong. They have no idea how this will be for the health of the country. They are sold on what the gimmicks are looking at. As Senator REID says, what we have seen, of all the bills he has seen, it is the best. It may be, but it is the best of the worst. It looks like more of the same.

Some of the folks in Wyoming in townhall meetings say: Don’t take away my freedom to choose the plan I want. Well, this bill sort of does that. If they have something they like, this has a lot of numbers and mandatory sets in there. In some cases, they will take away freedoms of the people to choose specifically what they want because of all of the mandates this has to cover, and it has to cover this, that, and the next thing. A lot of people don’t want that.

People also say: Don’t cut my Medicare. I hear that all around Wyoming and the country. There are 11 million people on Medicare Advantage. That Medicare Advantage Program is what is in the Senate’s health care plan that does a good job of working on preventive care and coordinating care, and that is going to be slashed under this program. So we are going to take away prevention and the things that have to do with coordinated care. Just take a look at this monstrosity of over 2,000 pages.

People say: Don’t cut my Medicare or raise my taxes. We are looking at 10.2 percent unemployment right now. This is not the time. We are in the right direction, dealing with the things we can do to improve the system. Whatever you do, they say, don’t make matters worse for me. That is what people want, that is what they care about. None of them want to read this bill, and probably none of them will read the bill. It is on the Internet, after weeks behind closed doors. I hope the people in Wyoming and around America read it so that they know about the travesties in the bill and the impact it will have on them personally. It is the wrong prescription for America. And it is not just me saying that; it is also the New York Times, for the American people do not want.

The people say: Don’t make me pay more for my family’s health care. But that is what is going to happen across the board. Premiums are going to increase, the premiums for people who have insurance—the premiums people pay who have insurance. For the 85 percent of Americans who have insurance, those costs will go up. This plan was announced a year ago, to get costs down, to get premium costs down. This raises the premiums for the American people. People who are living in a time and in an economy when people say they can’t afford this sort of a bill. The American people don’t want it.

I travel around the State and visit with people. I visited with a young lady from Cody, WY, who has health insurance through her job, and she likes it. She takes care of her family. She found out that because of increasing premiums—which will get worse if this bill passes—the people think they are going to get will not be comprehensive. In some cases, you have had their pay cut a little bit so they can continue with the health care they have. They like the care, but they don’t like the cost of their care. Again, this doesn’t get the costs down for American families. Premiums will go up.

This is what we have been seeing all across the country. Whether it is independent people, whether it is people who work for government, whether it is for businesses, whether it is people who buy insurance or people who need insurance, across the board, people say these atrocious health care proposals will make matters worse for the families, for the men and women of this country. They are going to be paid for not just by them but also by the young people, as the debt continues to accumulate in our Nation and goes on to impact the young people of this Nation.

The people of Wyoming want practical, commonsense health care reform—the kinds of reforms that will drive down the cost of medical care, that will improve access to providers, that will create more choices. They don’t want things that will increase the costs or things that will limit access or things that will take away their choices.

Obviously, the majority leader and the Democrats in Congress have a very difficult plan in mind. Their legislation is going to force upon Americans higher health insurance costs through higher premiums, higher taxes, Medicare cuts, and more government control over health care decisions. That is not reform.

There are only two physicians in the Senate. The two of us bring a unique perspective to the health care debate. I practice medicine, taking care of families from all across the great State of Wyoming. I have dedicated my life’s work to helping patients live longer, live healthier, and stay well. I can say, without reservation, in this Nation, we do offer some of the finest medical care
in the world. I am not blind to the fact that our health care system has failings. I have seen them firsthand. We can fix a broken system in a way that actually works to get costs down, to get more people covered, to give people more choice. But we can’t do it in this atrocious plan, which raises taxes, cuts Medicare, and takes away choices from the American people.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. Morning business is closed.

CAREGIVERS AND VETERANS OMNIBUS HEALTH SERVICES ACT OF 2009

The PRESIDING OFFICER. Under the previous order, the Senate will proceed to the consideration of S. 1963, which the clerk will report.

The assistant bill clerk read as follows:

A bill (S. 1963) to amend title 38, United States Code to provide assistance to caregivers of veterans, to improve the provision of health care to veterans, and for other purposes.

SEC. 1003. REQUIREMENT TO TRANSFER FUNDS [Purpose: To transfer funding for United Nations Contributions to offset costs of providing assistance to family caregivers of disabled veterans]

The PRESIDING OFFICER. The Senator from Oklahoma.

AMENDMENT NO. 2758

Mr. COBURN. Mr. President, I call up amendment No. 2785.

The PRESIDING OFFICER. The clerk will report.

The assistant bill clerk read as follows:

The Senator from Oklahoma [Mr. COBURN] proposes an amendment numbered 2785.

Mr. COBURN. Mr. President, I ask unanimous consent that I be permitted to use my time on the bill and my time on the amendment as necessary.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To transfer funding for United Nations contributions to offset costs of providing assistance to family caregivers of disabled veterans)

On page 177, after line 10, add the following:

SEC. 1009. REQUIREMENT TO TRANSFER FUNDING FOR UNITED NATIONS CONTRIBUTIONS TO OFFSET COSTS OF PROVIDING ASSISTANCE TO FAMILY CAREGIVERS OF DISABLED VETERANS

The Secretary of State shall transfer to the Secretary of Veterans Affairs, out of amounts appropriated or otherwise made available in a fiscal year for “Contributions to International Organizations” and “Contributions for International Peacekeeping Activities”, such sums as the Secretaries jointly determine are necessary to carry out the provisions of this Act and the amendments made by this Act.

SEC. 1004. MODIFICATION OF ELIGIBILITY FOR FAMILY CAREGIVER ASSISTANCE.

(a) LIMITATION.—Section 1717A(b), as added by section 102 of this Act, is amended—

(1) in paragraph (1), by striking “and” at the end;

(2) in paragraph (2)(C), by striking the period at the end and inserting “; and”;

and

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

“(3) who, in the absence of personal care services, would require hospitalization, nursing home care, or other residential care.”;

(b) EXPANSION.—Such section 1717A(b) is further amended by striking “on or after September 11, 2001.”

Mr. COBURN. Inquiry, Mr. President.

It is my understanding that I am going to have 2 hours during this period of time under unanimous consent.

The PRESIDING OFFICER. The Senator is correct.

Mr. COBURN. I reserve the remainder of my time and yield to the chairman and ranking member.

The PRESIDING OFFICER. The Senator from Hawaii.

Mr. AKAKA. Mr. President, I ask unanimous consent that I be permitted to use my time on the amendment as necessary.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. AKAKA. Mr. President, as chairman of the Senate Committee on Veterans’ Affairs, I had the honor of speaking at the World War II Memorial this past Veterans Day. As I stood there remembering my own comrades and their families, I thought of what the brave men and women in the service give up every day so we can enjoy the freedoms that come with American citizenship.

It is in that spirit that I urge this body to pass S. 1963, the Caregivers and Veterans Omnibus Health Services Act of 2009 without further delay.

The Nation’s young veterans coming home from Iraq and Afghanistan have faced a new and terrifying kind of warfare, characterized by improvised explosive devices, sniper fire and counterr insurgencies. Military medicine, fortunately, is saving more of these young servicemembers’ lives than ever before.

In World War II, 30 percent of Americans injured died. In Vietnam, 24 percent died. In the wars in Iraq and Afghanistan, about 10 percent of those injured have died.

As more of the catastrophically disabled are returning home, more will require a lifetime of care. With our decision on S. 1963, we decide whether that care will be in their homes with the help of their family members or in institutions. If we want that care to be in the home, we need to help the families shoulder the burden of providing that care.

During the prior administration, the President’s Commission on Care for America’s Returning Wounded Warriors—known as the Dole-Shalala Commission—found that 21 percent of Active Duty, 15 percent of Reserves, and 21 percent of retired or separated servicemembers who served in the Iraq or Afghanistan conflicts said friends or family members gave up a job to be with them or to act as their caregiver.

By giving up a job, caregivers often give up health insurance, when they need it the most.

Studies also show family caregivers experience an increased likelihood of stress, depression, and mortality, compared to their noncaregiving peers.

Without a job, without health insurance, and in very stressful situations, family caregivers have worked to fulfill the Nation’s obligation to care for its disabled warriors.

S. 1963 would give these caregivers health care, counseling, support, and a living stipend. The bill would provide caregivers with a stipend equal to what a home health agency would pay an employee to provide care.

It would give the caregivers health care and make mental health services available to them. The bill also provides for respite care so caregivers can return to care for these veterans with renewed vigor and energy. It lets these young veterans return to their families and not to a nursing home.

While the caregiver program in this legislation will be limited at first to the veterans of the Iraq and Afghanistan wars, other provisions of the bill improve health care for all veterans.

There are provisions which make health care quality a priority, strengthen the credentialing and privileging requirements of VA health care providers, and require the VA to better oversee the quality of care provided in individual VA hospitals and clinics.

The bill will also improve care for homeless veterans, women veterans, veterans who live in rural areas, and veterans who suffer from mental illness.

About 131,000 veterans are homeless. S. 1963 would help these veterans obtain housing, pension benefits, and other supportive services. It would provide financial assistance to organizations that help homeless veterans.

Seventeen percent of servicemembers are now women. This legislation contains a number of provisions which are designed to improve the care and services provided to women veterans.

It would provide for the training of mental health professionals in the treatment of military sexual trauma and provide care for the newborn children of servicemen. It would give women veterans a quality of care that they have earned through their service to this country.

The bill also provides new assistance to veterans who live in rural areas. According to the VA, the 8 million veterans enrolled in VA health care, about 3 million live in rural areas. This legislation would bring more services into rural communities through telemedicine and increased recruitment and retention incentives for health care providers. It also would increase the VA’s ability to utilize volunteers at vet centers and create centers of excellence for rural health.

Finally, S. 1963 addresses the signature injuries of this war—PTSD and traumatic brain injury. According to a recent RAND report, one in three veterans returning from Iraq and Afghanistan will develop post-traumatic stress disorder. Countless others will suffer from traumatic brain injury and face...
significant problems in readjusting to life at home. Many studies have shown the importance of early intervention to the effective treatment of these invisible wounds.

This legislation contains provisions that allow Active-Duty military to seek mental health services at VA centers and increase access to care for veterans with traumatic brain injury.

Before concluding, I wish to share one of the many stories I have heard as I have worked to move this legislation through the Senate.

Sgt Ted Wade sustained a severe brain injury after his humvee was hit by an improvised explosive device in Iraq. His right arm was completely severed above the elbow, and he also suffered a fractured leg, broken right foot, and visual impairment, among other injuries.

His wife Sarah Wade became his caregiver and a dedicated advocate for her husband, as well as for others who are providing caregiver services.

In testimony before the House Veterans’ Affairs Committee earlier this year, Ms. Wade made the point that:

Young veterans with catastrophic injuries need not just to be around as long as the injuries they sustained in service to their country. Just like servicemembers need a team in the military to accomplish the mission, they need a team at home for the longer war.

I agree completely with that view.

Veterans need all the support we can provide. We, as a country, can give them options that veterans of my generation will never have. We can give them the option to really come home.

To those who are concerned about the cost of this legislation, I say we cannot turn our back on the obligation to care for those who fought in the current wars. When we as a body vote to send American troops to war, we have promised to care for them when they return.

I firmly believe the cost of veteran benefits and services is a true cost of war and must be treated as such.

I ask that our colleagues accept no more delays and act on this important legislation.

Mr. President, I reserve the remainder of my time and yield the floor.

The PRESIDING OFFICER. The Senator from North Carolina.

Mr. BURR. Mr. President, I thank and congratulate the chairman of the VA Committee. This is important legislation for this body, and I believe that this will move very quickly, as we can see from the short time agreement: one amendment—one amendment that I think is extremely important for all Members of the Senate to consider.

I rise in support of S. 1683, the Caregivers and Veterans Omnibus Health Services Act of 2009. This is actually the combination of two bills reported out of the Veterans’ Affairs Committee this year and it did enjoy bipartisan support.

The centerpiece of the legislation is the support it would provide to caregivers of severely injured veterans of current wars. The bill would provide counseling, support, living stipends, and health care for those caregivers.

As my colleagues know, family caregivers play an extremely important and, I might say, unique role in helping to meet the severely injured veterans’ personal care needs. For some veterans, family members serve as their primary caregiver; some of whom have lost their jobs but, more importantly, have lost their health care as a result of their commitment to that family member.

As the chairman spoke about a service member he had remembered in this—Ted Wade is a North Carolinian—he made the same impression with me. I also think about caregivers Edgar and Beth Edmundson from North Carolina as well, the parents of Eric Edmundson, a severely injured veteran from Operation Iraqi Freedom. They have been caring for Eric since the day he was brought out of a VA hospital because the VA basically had come to the point where they said they could not improve Eric’s life.

After Eric was injured on patrol along the Iraqi/Syrian border, he went into cardiac arrest while he was awaiting transport to Germany. It was in fact that cardiac arrest, that traumatic brain injury, that put Eric in a condition so severe that he could not walk and could not talk.

Eric’s father stepped to the plate and immediately began researching all the options for Eric’s treatment. Despite being told his son would not emerge from his vegetative state, Ed Edmundson pushed on. He sold his business, he cashed in his savings and retirement pay, all in an effort to provide Eric 24-hour care as a father.

Under his father’s constant attention and relentless pursuit of new options, Eric received the treatment he needed. Without his dad’s commitment, without the commitment of the rest of Eric’s family—who basically dropped everything else important in life to focus on his needs—Eric would not be doing as well as he is today. I might say he walks and he talks and he contributes to society. That, I think, speaks to debate.

I urge our colleagues to strongly consider supporting the amendment of Senator Coburn and let me explain why.

When the committee passed this bill, we would not limit it to current veterans of current wars; we would provide coverage for all veterans. Since it came out of committee in a bipartisan way, we have narrowed it down not to include all veterans. The amendment of Senator Coburn expands it to all veterans.

When the committee considered the caregiver bill, we considered it because we wanted to keep veterans out of nursing homes. That was the goal, to give them an alternative because the traditional role of the nursing long-term care facilities had not worked at improving the quality of care and the quality of life for these veterans.

That was our goal.

Senator Coburn brings some definition to who is eligible for this based on the fact that there’s simply a need.

There is a need toward the nursing home. We may tinker a little bit with the definition as to whether it is exclusive or totally as inclusive as we would like, but make no mistake, it is not different from the intent of the committee as to why the committee passed the caregivers act.

Let me mention one probably even more important piece of the amendment of Senator Coburn. It actually pays for what we are doing. We say the money shall be used. We say the money shall be used to implement everything in the caregiver bill. The amendment of Senator Coburn is going to say: You know what. We are going to take some money out of the funds that we pay to the U.N. and we are going to fund our veterans. I, for one, am tired of coming to the floor and spending money we don’t have.

Why don’t we take some of the money we have already appropriated and let’s shift it? This is something I believe for the Senate, but it is called prioritizing. Let’s prioritize where the Federal investment should go. Let’s make sure we pass the Caregivers and...
Health Care Act. Let’s make sure we pay for it with the Coburn amendment, and let’s pull that money out of already-appropriated funds so we can not only look at our veterans, but we can look at our children and tell them this is a good bill.

I yield the floor.

The PRESIDING OFFICER. The Senator from Hawaii.

Mr. AKAKA. Mr. President, I yield 10 minutes to the Senator from Washington, Mrs. Murray.

The PRESIDING OFFICER. The Senator from Washington is recognized.

Mrs. MURRAY. Mr. President, last week many of us spent time back home celebrating our veterans and honoring the great sacrifices they made for our country. I had the opportunity to commemorate Veterans Day at the Tahoma National Cemetery in Kent, WA. It was truly an honor to stand with veterans and their families as we paid our respect to those who have served.

This recognition is important, it is certainly deserved, but it is not enough. We owe it to our veterans to make sure our commitment to them extends beyond Veterans Day and that they have access to the health care and services they need.

Growing up, I saw firsthand the many ways that military service can affect both veterans and their families. My father served in World War II. He was one of the first soldiers to land in Okinawa. He never told us about his time as a disbarred veteran, and he was awarded the Purple Heart.

Like many soldiers of his generation, my dad did not talk about his experiences to us when he came home. In fact, we only learned about them by reading his journals after he passed away. That experience offered me a much larger lesson about veterans in general.

They are reluctant to call attention to their service. They are reluctant to ask for help. That is why we have to publicly recognize their sacrifices and contributions. It is up to us to make sure they get the recognition they have earned. Our veterans held up their end of the deal, now we have to hold up ours.

As a member of the Veterans’ Affairs Committee, I am keenly aware that we have a lot of work to do for the men and women who served us. Not only must we continually strive to keep up our commitments to veterans from all wars, but we have to also respond to the new and very different issues facing veterans who are returning from Iraq and Afghanistan today, wars that are being fought under conditions that are very different from the ones in the past. That is precisely what the caregivers and veterans omnibus health bill that is before us today aims to do.

One of the changes we have seen in our veterans population recently is the growing number of women veterans who are seeking care at the VA. Today more women are serving in the military than ever before, and over the next 5 years, in fact, the number of women seeking care at the VA is expected to double. Not only are women answering the call to serve at unprecedented levels, they are also serving in a very different capacity.

In Iraq and Afghanistan, we have seen wars that do not have traditional front lines; therefore, all of our service members, including women, find themselves on the front lines. So whether it is the check points or helping to search and clear neighborhoods or supporting supply convoys, women service members face many of the same risks from IEDs and ambushes as their male counterparts.

But while the nature of their service has changed, the VA has been very slow to change the nature of the care they provide for these women when they return home. Today at the VA there is an insufficient number of doctors and staff with specific training and experience in women’s health issues, and even the VA’s own special studies have shown that women veterans are underserved. That is why included in this veterans health bill we are talking about today is a bill I introduced that will enable the VA to better understand and ultimately treat the unique needs of our female veterans. That bill authorizes several new programs and studies, including a comprehensive look at the barriers women currently face in accessing care through the VA. It is a study of women who have served in Iraq and Afghanistan to assess how those conflicts have affected their health.

There is a requirement that the VA implement a program to train and educate and certify VA mental health professionals to care for women with sexual trauma, and there is a pilot program that provides childcare to women veterans who are seeking mental health services at the VA.

This bill is the result of many discussions with women veterans on the unique and very personal problems they face with their injuries.

Oftentimes after veterans meetings I held in which male veterans would speak freely about where they believed the VA wasn’t meeting their needs, women veterans would approach me afterwards and ask if I would just speak quietly and whisper about the challenges they face.

Some of these women told me they didn’t view themselves as a veteran yet, and therefore they didn’t seek care at the VA. Others told me how they believed the lack of privacy at their local VA was very intimidating, or about being forced into a caregiving role that prevented them from getting care. Some women could often be expected to struggle to find a babysitter just in order to keep an appointment. To me and to the bipartisan group of Senators who have cosponsored my women veterans bill, these barriers to care for women veterans were unacceptable.

As more women now begin to transition back home and step back into careers and their lives as moms and wives, the VA has to be there for them. This bill will be talking about today will help the VA modernize to meet their needs.

Another way this bill meets the changing needs of our veterans is in the areas of assisting caregivers in the home. As we have all seen in Iraq and Afghanistan, medical advances have helped save the lives of service members who, as we know, in previous conflicts would have faced the severity of their wounds. But these modern miracles also mean many of those who have been cast catastrophically wounded need round-the-clock care when they come home. In many of our rural areas, where access to health care services is limited, the burden of providing care often falls on the families of those severely injured veterans.

For these family members, providing care for their loved ones becomes a full-time job. Oftentimes we hear they have to quit their jobs, forgoing not only their source of income but often their own health care insurance as well. That is a sacrifice that is far too great, especially for families who have already sacrificed so much. That is why this bill also provides those caregivers with health care, with counseling, with support, and, importantly, a stipend.

This bill also takes steps to provide dental insurance to our veterans and their families and their caregivers.

It improves mental health care services and eases the transition from active duty to civilian life. It expands outreach and technology to provide better care to veterans who live in rural areas. It initiates three programs to address homelessness among veterans at these especially difficult economic times.

This is a bill that is supported by numerous veterans service organizations, both in VA and it is supported by many leading medical groups. It was passed in the Senate Veterans’ Affairs Committee with broad bipartisan support, after hearings with health care experts and VA officials and veterans and their families. Like other omnibus veterans health care bills before us, bills that have often passed on the floor with overwhelming support, it puts veterans before politics. It is a bipartisan bill designed to move swiftly so its programs can be implemented. It is a bipartisan bill designed to make sure our veterans do not become political pawns. Yet we have faced a lot of delays in getting here. Those delays are all too common here in the Senate. We have seen bipartisan nominations stalled, funding bills slowed down to a crawl. It has taken us months to pass a simple extension of unemployment benefits for people who are out of work.

Providing for our veterans used to be a one area where political affiliation and bipartisanship bickering fell to the wayside. I hope those days are not behind us. Our aging veterans and the brave men and women who serve in Iraq and
Afghanistan need our help now. How we treat them at this critical time is going to send a signal to a generation of young people who today might be considering military service.

As I have said many times, it is so important that we keep our promise, that Abraham Lincoln made to America’s veterans 140 years ago, “to care for the veteran who has borne in battle, his widow and his orphan.”

Our veterans have waited long enough for many of the improvements in this bill. We cannot ask them to wait any longer.

I spoke last week on the floor on the eve of Veterans Day urging colleagues to move quickly on this bill. I am so glad progress is now being made toward making that happen. As we wait to pass this bill, our promise goes unfulfilled to many of our Nation’s heroes. I urge my colleagues to pass this bill quickly so we can get to the work of providing our veterans with support and services they have earned.

I thank the Chair.

Mr. COBURN. Mr. President, the reason we are having the debate now is because nobody would have the debate earlier. It is important for the American people. I don’t have any opposition to veterans care. As a matter of fact, I support keeping our commitment. But the thing wound out, on October 28 it came to the floor. Part of my amendment, when it actually came out of committee, was in the bill. It was taken out before it came to the floor, not by the members of the committee. It was taken out. But the very fact that we make an issue, because somebody wants to debate a bill and offer amendments on a bill, and then we are supposedly antiveteran because we think maybe we ought to pay for some things we do around here, so because we want to pay for it, we are cast aspersions that we don’t want it to be debated. The worst thing that happens in this body is we pass bills that the American people have no idea about because we refuse to debate them.

I apologize to no one for having put a hold on this bill for a very good reason. The very good reason is this: Our veterans demonstrate courage greater than we ever demonstrate in this body. We owe a lot to our veterans. This bill will allow veterans to have their healthcare. What is the courage I am talking about? The courage to make priorities, to make sure we keep those commitments. This bill, as it is written now, will cost $3.7 billion over the next 5 years. I think we ought to do that for these veterans. But I also think their sacrifice should not be in vain and stolen and paid for by their grandchildren. I believe we ought to pay for what we are going to do.

It is disappointing that the Senator from Hawaii mentioned speaking at the World War II memorial. This bill, as written, excludes World War II veterans from the benefit. It excludes Gulf war veterans from the benefit. What about them? Is the reason the other veterans, the Vietnam war veterans, the Korean war veterans were not included is because we thought we couldn’t afford it? I think that is probably the reason. Which begs the question, on our behalf, as veterans, we ought to treat them the same, one, and we ought to have the courage to make hard choices about how we pay for it.

It is easy to charge this money to our grandskids. I have no doubt that is what we will end up doing. But the biggest threat facing our country today is not Islamic fascism and Islamic terrorism. The biggest threat facing the country today is the fact that every young child born today will encounter $400,000 worth of debt for benefits they will get nothing from. When we calculate the interest cost on that, by the time they are 25, they will have been carrying a debt load of $1,119,000.

As I looked at my colleagues who want to do this but don’t want to pay for it, I am bewildered to think that we can call and honor the courage and service of our veterans without taking some of the same courage to make some hard choices about other things that are not nearly as important as our veterans. We can’t do both. We can’t continue down the road we are on. We can’t continue to spend the money we are spending and borrowing, 43 cents of every dollar we borrow this year, by borrowing it from our grandskids. It won’t work. We will fail as a nation.

Look at President Obama’s recent trip to China. What was the message that emerged? They are worried about us financially. They are worried about our deficit spending. Why are they worried? Because they own close to $1 trillion worth of our debt. They now impact our foreign policy decisions only by the fact that they own so much of our debt.

Can we continue to do this and have a free America? Can we continue to do this and our children have opportunity, at least to the level we have experienced? What are our veterans fighting for? Why did they put their bodies at risk, if it is not for a greater future for the country?

When we think about this past year—and it will be worse next year, it will be 44, 45 cents borrowed of every dollar we borrow, that is how far we fall behind again to our grandchildren as well as our veterans? This isn’t even a hard vote. Our entire contribution to the United Nations is wasted in the fraud of the peacekeeping we contribute to. We contribute 25 percent of the United Nations money, and we have reports and studies and leaked documents that show the vast majority of the money we put in the United Nations gets defrauded from the United Nations.

We are going to get to make a choice with this bill. We will say we will treat all veterans the same, No. 1, and we are actually going to pay for it by saying it is a greater priority to take care of our veterans than to fund a corrupt, fraudulent peacekeeping force as run through the United Nations. That is what we are going to say. If this amendment passes, it will send a wonderful signal to the United Nations to clean up their act. It will send a signal to our children and grandchildren that we will finally start acting responsibly, and it will send a great message to veterans that we do care and we care enough to make sure the sacrifice they made will not be squandered by us not making hard choices.

We owe a lot to our veterans. The No. 1 thing we owe is to make sure what they fought for and the future we have is secure in our children and grandchildren’s generation. It is not secure today, based on the fiscal situation we find ourselves in.

I reserve the remainder of my time.

Mr. BEGICH. Madam President, I rise in support of S. 1963, the Caregivers and Veterans Omnibus Health Services Act of 2009. I am pleased we are now considering this bill. S. 1963 is comprehensive legislation that addresses many of the needs of our veterans and their families. The bill consists of a compilation of two earlier bills introduced by Chairman Akaka to improve veterans health care and provide much needed benefits to their caregivers. I thank the chairman of the Veterans Affairs Committee for his leadership on this bill and in committee.

He understands the importance of providing the Department of Veterans Affairs the necessary tools and policies to serve the needs of veterans. The legislation ensures that wounded warriors returning from Iraq and Afghanistan can receive care in their home by providing caregivers the necessary benefits to stay at home and care for them full time. This is especially important in rural States such as my State of Alaska where obtaining a caregiver from remote areas is extremely challenging. In those areas, families take care of their injured service members. To further help rural veterans, the bill authorizes special programs for severely disabled or require emergency care to seek medical attention at non-VA facilities without being billed. For a veteran in one of the many remote villages of Alaska, this is especially important, for they already face many economic challenges.

The bill takes other steps to alleviate shortfalls in rural veterans health care. Telemedicine program expansion, authority to collaborate with Indian Health Services and community organizations are just some of the additional efforts taken.

In addition to providing for caregivers and improving health care for
Mr. AKAKA. Madam President, I yield 3 minutes to the Senator from Montana, Mr. Tester.

The PRESIDING OFFICER. The Senator from Montana is recognized.

Mr. TESTER. Thank you, Madam President, and I thank Chairman AKAKA.

Madam President, I rise this morning to urge the Senate to pass the Caregivers and Veterans Omnibus Health Services Act of 2009. Chairman AKAKA has done a great job of explaining the particulars of this bill. I thank him and Senator BURR for their leadership in our committees.

I could also echo Senator AKAKA in explaining the reasons to vote for better health care for this county’s veterans. But, instead, I am going to boil it down to one reason. Madam President, we promised it—we promised it—we promised it—we promised it—to all the men and women who served in our military. We promised it, just as we promised our troops the resources they need when they are in battle. This is not a vote about politics or partisanship; it is about living up to the pledge we made to all our veterans.

Montana is a rural State, which means that all 100,000 veterans there are rural veterans. Many of them live in frontier communities. Sadly, that means they have a tougher time getting the care they have earned. Many of them still have to pay out-of-pocket travel expenses to get to a VA hospital for their health care. According to some studies, veterans who live in rural America do not live as long as veterans who live in urban places. That is not only sad, it is disgraceful, and it is unacceptable.

This bill contains provisions I included with the help of rural veterans and veterans service organizations in Montana. A vote for this bill is a vote to give veterans in rural America and frontier communities better access to health care.

This legislation is not the be-all and end-all, but it is a big step forward that is the result of putting politics aside and working together to do right by all of the men and women who have served our country.

Passing this legislation is living up to a promise. It is common sense. That is why I urge my colleagues to support it.

With that, Madam President, I yield the floor.

The PRESIDING OFFICER. Who yields time?

The Senator from Oklahoma.

Mr. COBURN. Madam President, may I inquire how much time I have remaining?

The PRESIDING OFFICER. The Senator from Oklahoma controls 112 minutes.

Mr. COBURN. Thank you, Madam President.

I want to go back to the start of this again. The American people need to know what a hold is. What is a hold? A hold is a hold. A hold is a hold. A hold is a hold. If a bill is pending, it has to go through the Senate without debate, without discussion, that by unanimous consent everybody agrees we ought to pass a bill the way it is. Unfortunately, 70 percent of the bills that go through the Senate pass that way. The American people get to hear no debate, get to have no knowledge about what is in the bill, whether there is controversy about what is in it. As a matter of fact, they do not know that the bill on the floor is actually different from the bill they read about on the committee. It has been modified, not with the vote of the committee but with the direction of the chairman only.

So the purpose of our holds is either you are against the bill—and I have no secret holds. Everybody here knows that. When I hold a bill, everybody knows the bills I hold, and I give a reason for why I hold them. I do not hold them sheepishly. The purpose for a hold is to develop debate, to have the very discussion we are having on the floor.

This bill was filed October 28. It was brought to the floor the week before November 19, 2009
I am for the Caregivers Act. I am for us doing all these things. But I am only for them if, in fact, we will start making the same hard choices our veterans make, the same hard choices everybody else in this country makes when it comes to making a decision about the future.

You see, a lot of people in our country today are underwater on their mortgages. They are underwater on their mortgages. Guess who else is. We are as a nation. We are underwater. Let me quote this chart, for example, what the financial situation is with our country.

Medicare is broke. Part A will run out of money in 2017. We have 50 million baby boomers—I am one of them—who are going into Medicare in the next 8 to 10 years. So not only is the cost per Medicare patient going to go up, but we are going to add 50 million to it, it is broke.

Medicaid. It is broke. It comes out of your paycheck; it is tax revenue. But the States are broke over their share of Medicaid.

The census. It is broke. It is going to cost 2½ times what the last one did. It is total mismanagement by the Federal Government.

Fanny Mae and Freddie Mac—broke to the tune of $200 billion of your money, each one of them; $400 billion that your kids get to pay back, your grandkids. They do not get the opportunities because they are both broke.

We have done such a wonderful job. Social Security. It is the easiest to fix, but it is essentially broke because we have stolen $2.6 trillion from it. And then we are not being honest with the American public about what our true deficit is because when I said a minute ago that our deficit was $1.43 trillion, that is not true. That is Enron accounting. That is Washington accounting. The real deficit is well over $1.5 trillion because we stole more money from Social Security. Guess what, Next year, for the first time in the history of Social Security, more money will be paid out than will be paid in. For the first time, it runs in the red next year. We owe money, so technically it is not broke yet—until some of that $2-plus trillion goes back into it—but it is essentially broke.

How about the post office? They just announced their loss for this year. They are going to have a bigger loss next year. It is huge.

Cash for clunkers. That was broke when it started.

The highway trust fund. It is broke. We do not have enough money for what we are obligated to pay out. It is broke.

Now we are talking about government-run health care? A $2.5 trillion program? That is what the real number is on it when you get the Enron accounting out of the bill that Senator Reid introduced last night—$2.5 trillion.

And now we are saying we do not have the courage to pay to take care of our veterans. I do not think the American people are going to tolerate this much longer, nor do I think they should tolerate it—that we will continue to steal the opportunity and future of our children.

I think the Senator from Alaska can be courageous enough for the future the abuse, fraud, and waste in the U.N. because in every country he mentioned, U.N. peacekeepers have been accused of rape and pillaging the very people they were supposed to have been protecting. In every country he mentioned, U.N. peacekeepers paid for by the very citizens they are supposed to be protecting. Yet we do not have the courage to say: Time out. We are not sending you any more money until you clean up the mess. No, we are not going to do that. We are not about to do that. What we are going to do is we are going to say we will take the money for the veterans from our grandchildren and we will not make the hard choice. I think it would be a wonderful message to the American people that maybe they ought to start being transparent about where the money goes. Do you realize nobody can know where the money goes? You don’t get to know. I, as a Senator, don’t get to know. The president pro tempore doesn’t get to know where the money goes. Yet your country puts $5 billion a year into that and have no idea. The only way we find out is occasional leaks.

By the way, of all those U.N. peacekeepers who have raped and pillaged, not one of them has been convicted. Not one of the agencies, in terms of their eight programs that have been incompetent and wasted money, have been convicted. They are immune to conviction. The waste, fraud, and abuse of this country is only exceeded by one organization, and that is the United Nations. Yet we don’t have the courage because the State Department is against this amendment, and they sent a letter outlining why they are against it. They are going to read into the Record why they are wrong. I ask unanimous consent that at the end of these remarks, my rebuttal statement in response be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered. (See exhibit 1.)

Mr. COBURN. The State Department Bureau of Legislative Affairs opposes this amendment. It lists a number of procedural reasons as reasons the U.N. and oppose the Coburn amendment. Many of the programs and activities the State Department listed have experienced severe problems in execution or are taking credit for activities by national governments or private entities.

Let’s take the recent elections in Afghanistan. The United Nations cannot account for tens of millions of dollars provided to the Afghan election commission, according to its own audits—these are official documents; they were not released; we just happened to be fortunate enough to have people who would give them to us—and interviews with
current and former senior diplomats. The Afghan election commission, with over $20 million in U.N. funding and hundreds of millions of dollars in U.S. funding, facilitated and helped mass election fraud and operated ghost polling places.

Should we keep sending them money for incompetence, waste, and fraud? “Everybody kept sending money” to the elections commission, said Peter Galbraith, former deputy chief of the U.N. mission in Afghanistan.

Nobody put the brakes on. U.S. taxpayers spent hundreds of millions of dollars on a fraudulent election.

This is a deputy to the senior U.N. official in Afghanistan. He was fired last month. He protested the fraud and he got fired by the U.N., that wonderfully competent organization.

As of April 2009, the U.N. had spent $72.4 million supporting the electoral commission, with $56.7 million of that money coming from the U.S. Agency for International Development. The Special Inspector General for Afghani-

In one instance, the United Nations Development Programme paid $6.8 million for transportation costs in areas where no U.N. officials were present. We paid transportation costs, but no U.N. officials were present. Why did we pay it? Where did that money go? Where is the money?

Overall, the audits found that U.N. monitoring of U.S. taxpayer funds was “seriously inadequate.”

In other words, it is there, they send it out, they don’t have any idea, but you can bet well-connected people at the U.N. are making millions off U.S. dollars.

How about the monitoring of nuclear programs in North Korea and Iran? In 2002, the North Korean Government used United Nations Development Pro-

In September 2009, North Korea announced to the United Nations Security Council that it was almost complete in weaponizing nuclear materials from its nuclear reactor. Last week, North Korea announced the processing was complete.

We helped finance it through the United Nations. We helped finance it through the United Nations.

As this morning, Iran had rejected the U.N. offer to send enriched uranium out of the country to prevent it from developing nuclear weapons.

We don’t know how much U.N. money has gone in there yet, but I promise I will try to find out. But I can guar-


U.N. peacekeeping operations are plagued by rape and sexual explota-

What would happen if U.S. troops were doing that? Yet we have no control.

In 2006, reported BBC News: Peacekeepers in Haiti and Liberia were in-

Just this month, Human Rights Watch reported that Congolese Armed Forces, supported by U.N. peacekeepers, in the eastern Democratic Republic of Congo, have brutally killed hundreds of civilians and committed widespread rape in the past 3 months in a military operation backed by the United Na-

Mr. DURBIN. Madam President, will the Senator from Oklahoma yield for a procedural question?

Mr. COBURN. I do not plan on con-

Mr. DURBIN. Could I ask unanimous consent that when the Senator breaks or prepares to yield the floor, at least temporarily, that I be recognized next?

Mr. COBURN. I have no objection to that.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DURBIN. I thank the Senator.

Mr. COBURN. Going back to the Congo, most of the victims were women, children, and the elderly. Some were decapitated. Remember, these are U.N. peacekeeping forces—peace-

They may not have been actual U.N. officers, but the U.N. was supplying all the logistics, all the transportation for this group of people. Where is the over-

U.N. contribution: Compiling fore-

The meeting was branded a failure within a couple of hours of its start after the 192 participating countries unanimously re-

The U.N. Environment Programme spends $1 billion a year—20 percent of it our money—on global warming and its effect on agriculture.

The U.N. has coordinated efforts by the global shipping industry and gov-

The United Nations is not only morally bankrupt in its leadership and effi-

I heard Senator TESTER speak about the wonderful things in this bill to help people who drive to VA clinics and VA hospitals. There is a better idea. If a veteran is deserving of care, give him a card. Let them go wherever they want.
If you think about what is happening in our country right now and how things are being shifted, what we are doing is, we are on the cusp of a dramatic change in our country in terms of balance. This huge bill, which I will talk about later, is a major move in that direction. Senator BYRD and I were talking this morning about this. In this bill is a 5-percent tax on cosmetic surgery. Just the day before yesterday, the U.S. Preventive Task Force Services recommended—because it is not cost effective—for women under 50 not get mammograms unless they have risk factors. You tell that to the thousands of women under 50 who were diagnosed with breast cancer last year with a mammogram. Tell them it is not cost effective. But also in this bill is a 5-percent tax on breast reconstruction surgery after they have had a mastectomy. They are going to tax having their breasts rebuilt after their breasts have been taken off because it is a "elective" plastic surgery. It is an elective cosmetic surgery. We are going to have a tax on it because we have taxed elective cosmetic surgery. We are in trouble as a nation because we have taken our eye off the ball. I see the majority whip is back. I told him I would be happy to yield. At this time, I will reserve the remainder of my time and yield the floor to the majority whip.

EXHIBIT 1

REBUTTAL OF STATE DEPARTMENT TALKING POINTS ON COBURN AMENDMENT 2785

The Senate Committee of Legislative Affairs opposes the Coburn amendment to S. 1983, the Caregivers and Veterans Omnibus Health Services Act of 2009 (S. 1983). In its formal opposition, it lists a number of programs as reasons to support the U.N. and oppose the Coburn amendment.

Many of the programs and activities that the State Department of Legislative Affairs opposes the Coburn amendment to S. 1983, the Caregivers and Veterans Omnibus Health Services Act of 2009 (S. 1983). In its formal opposition, it lists a number of programs as reasons to support the U.N. and oppose the Coburn amendment.

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Response: The United Nations cannot account for tens of millions of dollars provided to the traditional Afghan election commission, according to two confidential U.N. audits and interviews with current and former senior diplomats.

The Afghan election commission, with tens of millions of U.N. funding and hundreds of millions in U.S. funding, facilitated mass election fraud and operated ghost polling places.

"Everybody kept sending money" to the elections commission, said Peter Galbraith, the former deputy chief of the U.N. mission in Afghanistan. "Nobody put the brakes on. U.S. taxpayers spent hundreds of millions of dollars on a fraudulent election." Galbraith, a deputy to the senior U.N. official in Afghanistan, was fired after protesting fraud in the elections.

As of April 2009, the U.N. spent $72.4 million supporting the electoral commission in Afghanistan, according to a report by the U.S. Agency for International Development. The Special Inspector General for Afghanistan Reconstruction states that the United States provided at least $2.9 billion in funding for the elections.

In one instance, the United Nations Development Program paid $8.8 million for transportation costs in areas where no U.N. officials were present. Overall, the audits found the U.N. election monitoring and U.S. taxpayer funds were "seriously inadequate."
We have a difference of opinion on the matter before us. This bill, S. 1963, is the most important piece of veterans legislation this year for several reasons. I congratulate Chairman Akaka and Ranking Member Burr for bringing this matter to the Senate with a unanimous vote in committee, with both Democrats and Republicans supporting it, and for good reason.

In addition to the provision that was put in earlier by Burr, there is a dramatic change in the law to help women veterans. More and more returning veterans from Iraq and Afghanistan and around the world need special care. Unfortunately, the VA system wasn’t providing that care as we believed it should. This bill takes care of that. It is the most dramatic expansion for women veterans and their health needs we have seen.

The same is true for rural health care—when someone gets up, every morning Office is from downstate Illinois, as I am, and he knows the Marion VA Center is a critical part of the treatment of veterans in southern Illinois and the surrounding States. Literally thousands of hard-working people providing care for veterans, which they desperately need, close to their homes. This bill addresses the enhancement and improvement of rural care for veterans.

The same is true for mental health issues. It is an excellent bill. The part of the bill that is near and dear to me relates to caregivers assistance. It relates to the fact that many veterans who come home are not in institutional settings, not in a convalescent center; they are home. But they survive every day because of the loving care of a member of their family—a wife, a husband, a mother, a father, a sister, or a brother.

Great sacrifice cannot tell you exactly how many of these caregivers there may be. Estimates range as high as 6,000 or 8,000. I have met some of them, and I know them personally. I have heard their stories. They are heroic—just as heroic as the veteran who needs their care. They are literally giving their lives to keep that veteran alive, healthy and happy, at great personal sacrifice. Many times they cannot go to work. Many times they give up a business because they want to stay home with that husband they love.

A young woman came into my office the other day who is moving from North Carolina to the Chicagoland area after more than 5½ years. She has been the caregiver for her husband who was the victim of a traumatic brain injury in Iraq. For this young woman, who is in her thirties, it is an amazing show of love and sacrifice on her part.

We have also spoken of the family in North Carolina we know very well—
family of Eric Edmundson, a young solder who was the victim of a traumatic brain injury. He is alive today—I can say this without contradiction—because his dad quit his job, sold his business, and cashed in the value of his home. With his wife, they moved to take care of this son that little granddaughter. That is the most loving family I can remember seeing, and they are doing it for the son they love, but they are doing it, as well, for a veteran who served our country.

The purpose of this bill is to give these caregivers a helping hand and the medical training they need so they can do what is necessary to keep that veteran alive and as well as possible, improving if possible. It is also to give them a respite maybe for a week or two each year so they can go on vacation and have a visiting nurse or someone who will come and provide assistance. They need that with the stress and burden they are carrying. That needs to be lifted or temporarily—so they can recharge their battery and come home and be dedicated once again.

In the discretion of the Veterans’ Administration, it can give a monthly stipend or health care as well. The first thing the Senator from Oklahoma mentions is that when they sold the business was that they couldn’t afford to buy health insurance. Mom and dad are taking care of their son under the care of the Veterans’ Administration, and they have no health insurance. We are trying to find a way to provide health insurance for these caregivers. In my mind, it is simply fair and right that we would do this. That is why I thank Senator AKAKA and Senator BURR for including it in this bill.

I also want to address the issue before us, the pending amendment by the Senator from Oklahoma. The Senator from Oklahoma has come to the Senate floor several times and expressed his opposition to this bill, primarily for budgetary reasons. I understand that. But say to him I was worried this day would come. I was worried the day would come when the war, which we paid for by borrowing money, would generate victims and veterans who needed care, and when it came time to give them the care many of the people who voted to fund the war by going into debt would say: But we can’t help the veterans unless we pay for it. In all the family. If we vote to go to war, we vote to accept the consequences of war. That means an obligation that we have to these veterans. It is a solemn promise we gave them. We said to these men and women if they would hold up their hand, take an oath to defend the United States and risk their lives, we would stand by them when they come home. If they are injured, we will be there. If their family is disadvantaged, we will do our best to help them too. I think that is part of our solemn obligation to these veterans.

Now the question is raised as to whether we can afford to do that, unles we come up with a sum of money to pay for it at this moment. I say to the Senator from Oklahoma, and those who take his position, if we paid for this war to start with by borrowing money, how can we turn our backs on the veterans and caregivers who keep them alive arguing that it is simply budgetary justice? It is just not. It doesn’t track. I don’t believe those two approaches are acceptable.

Also, the Senator from Oklahoma does two things—this amendment I wish we could do—one I wish we could do. I have talked to him about it on the Senate floor—and that is to expand coverage for caregivers of those who served before 9/11. I would like to do that. Currently, we believe there are about 2,000 caregivers who would qualify for this caregiver amendment, this demonstration project. If we expand it to all veterans caregivers, the number rises to over 52,000. It is a just thing to do. It is something we may ultimately decide to do. I am going to make that commitment, it is a dramatically larger commitment than this demonstration project, this bill for those who suffered serious injuries since 9/11. To increase the scope of it from 2,000 caregivers to 52,000 caregivers is to increase the cost of it dramatically. That is something we have to measure and decide at some point—whether we want to do that.

I will work with the Senator from Oklahoma on that. I think all veterans’ caregivers deserve this. I hope we can prove with this approach that it is a reasonable thing to do—that keeping these veterans home where they want to be, in a safe, happy surrounding, is not only right but it is cheaper than institutionalization.

The second part of Senator COBURN’s amendment related to this provision says the money would be available for caregivers if the veteran would otherwise need to be institutionalized. I think that may be drawing a line that is too harsh. I think there are those who need the help of a caregiver but may not technically need to be institutionalized. I think those who are suffering from post-traumatic stress disorder, a traumatic brain injury with seizures—to say they need to be institutionalized may be overstating. To say they need the help of a caregiver and then move forward to treatment, I understand that. I am not on that. But I think the Senator from Oklahoma expanded this bill from 2,000 to 52,000. On the other hand, he draws a line on institutionalization that may go too far. I think what we ought to do in this demonstration project is give the VA the authority to measure this and see what is appropriate. I think there are so many individual cases that, when we generalize like this, it is a mistake.

The Senator from Oklahoma believes the money to pay for this should come from the money set aside for international peacekeeping through the U.N. I will not stand here in defense of the U.N. I will not stand here in defense of international peacekeeping in areas of the world where I think it is critical. I visited the Democratic Republic of Congo 2 years ago with Senator BURR to back up the U.N. peacekeeping forces there, the massacres of innocent people would go unchecked.

This has been going on for over a decade. During this period of time, innocent men, women, and children have been literally hacked to death and killed. The international peacekeepers make a difference there. They make a difference in Haiti where I visited twice and have seen firsthand the degraded poverty in our own hemisphere and, unfortunately, the fact they are on the verge of violence almost every moment.

I also think it is a mistake for us to cut back on those international agencies that monitor the spread of nuclear weapons. If we want to keep an eye on Iran and make sure they don’t develop nuclear weapons to threaten their neighbors in the Middle East and the rest of the world, we need this international force to come in and do its inspection work. They are the only credible third parties that can come in and decide whether the Iranians have gone too far. Their judgment through the United Nations is one that is credible to other nations. To cut back in their efforts at monitoring the spread of nuclear weapons is, in my mind, shortsighted and invades a world that is already too dangerous.

I urge my colleagues to defeat the Coburn amendment. I say to my friend from Oklahoma, at the end of the day, after we start this program, if the Veterans Administration can find the resources through the appropriations to move it forward, I am open to working with him to expand it to caregivers from previous generations of veterans and to see if there is a way to make sure it is spent exactly where it is needed and as we have described it.

That is the nature of this work. We are not perfect in what we do, but we start with good intentions and hard work and try to put the language together. But at this moment, I say to the Senator from Oklahoma, first, I am glad he no longer put a hold on this bill. It is an important bill. I am glad he has had his chance to offer his amendment. I urge my colleagues to defeat it, but I say it in good faith to my friend from Oklahoma.

I will work with him on this bill, in fact, I am pleased the law and implemented to make sure it meets the goals we both share—fairness to all veterans and providing care to those who need
it. This is a good start, but let us promise to work together, if it is enacted, to make sure we continue in that vein.

I yield the floor.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. COBURN. Mr. President, the majority whip is a formidable orator and he is appreciated in lots of ways. We work together on subcommittees on the Judiciary Committee. I have a fondness for him. Although one area he did not agree to work with me is to pay for it.

Never have I said I don’t want us to do this for our veterans. Not once. The reason we are on the floor, the only reason we are on the floor having this debate is because of my hold; otherwise, we would never have gotten here to have the debate which I think is valuable, we would never have gotten to the floor to have this debate.

Mr. BURR. Mr. President, I wish to reiterate, as the ranking member of the Veterans’ Affairs Committee, this bill was reported out unanimously. I think it will receive unanimous support in its passage later this afternoon in the Senate.

Let me restate for Members, when the committee passed this bill out, we passed it out with all caregivers being included. It was after the committee reported it out that we narrowed it to OEF and OIF veterans and their caregivers. It was the intent of the committee to include all the people Senator DURBIN, the majority whip, said we might consider later on but not now. The committee’s intent was let’s do it in the future.

It was the also the committee’s intent that these were individuals who were targeted for us to provide this caregiver benefit to so we can keep them out of nursing homes because of the Ted Wades, because of the Edmundsons.

Senator COBURN’s amendment is consistent with the bill that was passed out of committee unanimously. The bill says the Secretary “shall,” therefore, by means he has to. The Secretary will then have to prioritize spending within the Veterans Administration to fund these programs. The third piece of what Dr. COBURN’s amendment does is rather than force the Secretary to prioritize within just VA programs, meaning there are going to be veterans who win and veterans who lose, why not say as a Congress: Why shouldn’t we do what we are supposed to do? Why should we not prioritize the spending here?

What my good friend from Illinois suggested was why should we prioritize for the United Nations? Let me say the answer is quite simple: It is our money. The suggestion that the Congress doesn’t have a fiduciary responsibility to fund programs we implement at a time we are borrowing 50 cents of every dollar we spend is ridiculous on its face.

I would suggest that the Senate, the Congress can operate any differently than a family in America suggests that we ignore the input of everybody who asked us to represent them. We do represent the American people, 100 individually who represent the entire country. How can we do it differently than any family who is out there struggling to meet their end-of-the-month obligations and when their revenue does not meet their expenses? What do they do? They either cut back their expenses or they find a place to raise more revenue.

Let me suggest this is as simple as, Is it time for us to prioritize where we are placing money? Members will have to decide: Is pulling money from the United Nations a worthwhile sacrifice place for us to pull money from to then spend on our country’s veterans?

I believe we have an obligation, I believe we have a promise, even for programs that did not exist prior to this time, that when we see it is in the best benefit of the quality of life of our troops, that we provide that benefit for them. But I believe we also have an obligation to this generation and the next one and the next one to pay for it. This is not a choice that is tough for Members. If you support the Coburn amendment, you support practically everything the committee supported and passed them. If you support the amendment, you believe we have an obligation to pay for it. The only reason you would vote against the Coburn amendment is because you don’t think it is appropriate for us to deprive the United Nations of this money to use as they see fit.

I suggest this is where the disconnect is with the majority of America. They would prefer the Senate to decide where that money went and to use it on these caregivers and these veterans programs.

I encourage my colleagues to support the Coburn amendment, support passage of this bill this afternoon when we take it up.

I wish to shift gears slightly because I think it is somewhat ironic that we are talking about expansion of services to our Nation’s veterans at a time when some herald the introduction of a bill that, in all likelihood, will deprive other Americans of the ability to have affordable health care.

We have gone through several months of debate now about health care being accessible and affordable for all Americans. We have talked about reforms; let’s change the system; let’s reform the system; let’s make it accessible and affordable; let’s bend the cost curve down. In the last 24 hours, some have come and said we have accomplished that, it is amazing.

Let me remind my colleagues, we have all said health care is
unsustainable in its current level of investment. 17 percent of our gross domestic product. I find it somewhat odd that we would start the debate given that it is unsustainable in its current financial investment with how much more money does it cost to reform health care? The obvious answer is it should cost zero. If you are already spending too much, we should look at the reforms before we look at the coverage expansion.

I urge every American ought to be covered. As a matter of fact, Dr. COBURN and I have offered comprehensive bills to do that. But it is matched with real reform.

What was heralded in the last 24 hours is, in fact, a $2.5 trillion health care bill—$2.5 trillion—over a 10-year period of collecting the revenues and paying out the expenses. This is where gimmicks, smoke and mirrors—whatever you want to call it—are used in Washington. If you collect revenue for 10 years, you don't get a true picture of what it is going to cost over 10 years. You get a true impact of the revenue stream which is over $800 billion.

From where will that $800 billion in new tax revenue come? Taxes. Then we collect $493.6 billion—$493.6 billion. We will cut $464.6 billion out of Medicare. A $2.5 trillion we are going to take from a program with a designated population of beneficiaries of our Nation's seniors and those who are classified as disabled and we are going to take $2.5 trillion from Medicare and shift it over to meet the new burden of a health care plan yet to be constructed.

Why is this problematic? It is $1,063 per Medicare beneficiary every year. Over the 10-year cycle of this health care plan, we are going to steal from every senior in this country $10,363 worth of health care money. We are going to take it from their program, and we are going to put it over in this new program because it is paid for. Legitimately, when you raise taxes, when you raise fees, when you raise revenue, you are making tough choices. I think when you go in and tax health plans and that raises $149.1 billion; when you go in and tax health plans, you are making tough choices. I think when you raise fees, when you raise revenue, that raises $1.3 increase a penalty for a nonqualified health savings account and you get $1.3 billion; when you increase a penalty for a nonqualified health savings account and you get $1.3 billion—these are revenues. They are legitimate.

It is no smoke and mirrors. I don't think American people believe for a minute this is deficit neutral. I don't believe for a minute they believe we are going to take $464 billion out of Medicare. If they do believe it, they know we are going to pay it back with future taxes on the American people.

This is fine, if that is what you want to prioritize. But health care reform affects every American. This is a very personal issue for every American and every family. It touches them unlike anything else we do. The truth is, they care, they take it and you put it in one pocket and you take it out of the other pocket, the effect on them either has not changed or it is negative.

Let me suggest to my colleagues this bill is 2,074 pages. I will admit—I may be the only one—I have not read it since it was introduced at 6 o'clock last night. I am not sure there are many Members who have or could have. But let me suggest there will be a question at some point in this process, we use taxpayer money to perform abortions. Personally, I believe that is wrong. I will not support a piece of legislation that does that. This bill does that.

An employer mandate, at a time when American companies are trying to be competitive in a global marketplace? We raised $28 billion in employer mandates. I am not sure that is making U.S. companies more competitive in a global marketplace. I think the economy is the No. 1 challenge we have in America. I think 10.2 percent unemployment and going up—if it were a disease, we would be on the floor of the Senate calling it an epidemic and we would be spending whatever to help turn it around. But we are doing nothing. As a matter of fact, we are doing everything we can to try to drive up unemployment, to dry up the economy, and to make companies less competitive in a global market.

The President said one of the objectives of health care reform was we need to bend the cost curve down, we need to make sure there are cost savings in health care. Everybody is saying that is what we want. Let me ask you what is the CBO score of that? What happens after the budget past that 20-year number? The truth is, it starts to get into the trillions and trillions of dollars for which the Federal Government is obligated, based upon the premiums and the benefits people have assigned to it, that they pay out.

If you eliminated these two gimmicks, just on its face this bill would be $189 billion out of balance, in the red. It would not be paid for.

We are the laughingstock of the world on the way we applied the stimulus. There may be one or two. My State of North Carolina was $4 billion out of balance. Last year, the Federal stimulus was $2 billion of closing the gap. That $2 billion, by the way, we didn't have. We borrowed to give to North Carolina and other States to create jobs. It was used to close budget gaps so they didn't have to make tough decisions. As a matter of fact, we found out this week, on one of the news channels, there is $96 billion that didn't have anything to do with stimulus.

We are the laughingstock of the world on the way we applied the stimulus package. But the sad part is not the fact that it has been uncovered, it is that it didn't put Americans to work. Now we are saying to the States we are going to put another $25 billion on you.

In Medicare, we are going to cut from the fee-for-service payments $192 billion. So we already have $247 billion over here that we are getting from doctors if we go through with the payment cuts. Now we are targeting another $192 billion out of Medicare reimbursements, right out of the pockets of doctors and hospitals. Is there a community hospital in America that will be able to survive, given the cuts that are getting ready to hit them? We cut Medicare Advantage $118 billion. Some
cheer that. I tell you who doesn’t cheer it: the 20 percent of America’s seniors who chose Medicare Advantage as their preferred choice to traditional Medi-care because it required of them less out-of-pocket obligation, it didn’t hit them for a little bit the day they walked into a hospital. What about those 20 percent of our Nation’s seniors when they lose Medicare Advantage? What about the $43 billion in DSH, disparity payments, we pay the hospitals to make up for the uncompensated care they deliver? I guess the authors of the bill would say we are covering everybody so there is no uncompensated care. Wrong: 24 million are stills about health insurance. There is going to be uncompensated care, and we are taking away the money we are providing the hospitals to make up for the uncompensated care they delivered, meaning it is coming right out of their pockets. They will not be eligible for subsidy. If they currently have coverage but they may be below income and for some reason their employer has to drop their health care or cut back on the plan because—maybe they are not as great and so the cost is less. But now, all of a sudden we are saying that is not important.

There are 162 million Americans who currently have employer-based health care. In this bill, regardless of what that employer does, they will not be eligible for subsidy. If they currently have coverage but they may be below income and for some reason their employer has to drop their health care or cut back on the plan because—maybe they are not as great and so the cost is less. But now, all of a sudden we are saying that is not important.

The cost of the subsidies alone in the exchange is estimated by CBO to grow at 8 percent a year. If we had real reforms that worked, the cost of the subsidy would decline 8 percent a year. I yield.

The PRESIDING OFFICER. The Senator from Texas is recognized.

Mrs. HUTCHISON. Mr. President, as has been mentioned several times, the majority leader unveiled the Democrats’ health care reform bill yesterday around 5 o’clock. This bill was drafted behind closed doors. There was no Republican input. It didn’t have any transparency until yesterday at 5 o’clock, despite the promises we have heard that government would be more transparent in this new administration. The 2,000-page bill released yesterday is expected to have a vote to proceed to it within the next 2 days. The bill is 354,000 words. To put it in perspective, we have 451 pages of S1,000 in 463 words; Lincoln’s Gettysburg Address contained 266 words; the Ten Commandments has 297 words. This is over 350,000 words. Why don’t we have time to read this bill, digest it, allow our amendments to be put in the bill language, because, clearly, this bill will need amendments?

The health care of our citizens may be the most personal of all things to every person and every family. We are a democracy and the American people have a right to be heard on all issues but especially on this type of issue. We should be given the opportunity to read and hear what is in this bill, to hear it discussed, to hear from our constituents because it ought to be on the Internet. That is why we have the Internet access to bills that are introduced in the Senate. But by the time our constituents have a chance to read it, we will be voting on whether to proceed to the bill.

Even after a cursory review, I know this bill includes changes that are disastrous to families, health care providers, and the economy. Higher taxes, mandates—especially for small businesses—penalties, cuts to Medicare, higher premiums, restricted choices, a government plan—the list goes on. The bill includes almost $1 trillion in taxes, including a new Medicare payroll tax; an excise tax on medical device companies which study pharmaceutical companies, and medical device companies which study much money as medical malpractice premiums, and doctors have fitted themselves in case they get sued. The majority leader unveiled the health care reform in the bill. Yet there is probably not anything that will save as much money as medical malpractice reform, that puts common sense standards in place for frivolous lawsuits or lawsuits at all.

I will offer an amendment, or at least prepare one and hope to be able to offer it, that would cap damages, reduce malpractice premiums, and encourage doctors to practice in medically underserved areas, especially rural areas, have no doctors. There are counties in Texas that don’t have a doctor within hundreds of miles and several counties. That is because the medical malpractice premiums are so high, they cannot afford to do it.

The small business premiums are going to go up, if this bill is passed. Small businesses already have a hard time offering coverage to their employees. Why would we make the problem worse, especially when we have the highest unemployment in decades? We should be allowing small businesses to pool together and buy plans. We have
championed that proposal for years in the Senate, but we have never been able to get over the hurdles to pass a small business health plan. If we could do that, we could spread the risk. The bigger risk pools would produce lower premiums and allow more small businesses to come together and offer their employees affordable health care coverage. Allowing businesses to pool doesn’t cost the government anything. Therefore, it would not require tax increases, as we see in the bill before us.

The Democrats are trying to address the problem of unaffordable insurance by offering credits to small businesses to offset the cost of premiums. But the credit only lasts for 2 years. That is hardly anything that is going to encourage businesses to take on the added cost when the credit lasts for 2 years. I will be preparing amendments that at least double that to 4 years, expand the eligibility and duration of these credits so we can help small business along. But even a 4 years is not enough. We should offer credits all the way through.

Offering tax incentives. There are small businesses and individuals in this country who have no access to affordable coverage. They are not going to get any individual who purchases their own health insurance the same tax break a corporation gets for offering health care coverage to their employees? Employers who receive insurance through their employment do not pay taxes on the premiums they spend for insurance. Why should individuals who purchase their own health care coverage be treated differently? I have a bill, with Senator DeMINT, that will help provide insurance for more Americans through tax credits and competition. Our approach would be a tax credit for every individual, $2,000 per year, and for families $5,000 per year for their purchase of health insurance. This would allow individuals to purchase their own health care coverage and they would not have to be affected by what their employer offers or if they change jobs. This is the kind of reform that could make a difference.

How about creating a transparent marketplace online for consumers to go in and shop and hopefully have bigger risk pools, more competition, bringing the cost down? That is not the kind of marketplace that is in this bill. This exchange has so many mandates on the plans that, like the Massachusetts exchange, it would raise the cost of premiums and would not help in any way bring the cost down so that premiums are more affordable. These are the ideas that would improve competition in the marketplace. I can tell you, from the input I have received from my constituents since the bills have been out of committee, before the bill came to the floor or is on its way to the floor yesterday, they are hearing from the constituents who wrote bills that were put together and released yesterday. I have listened to what people say. I can tell you they don’t want Medicare cuts. They don’t want more taxes. Small businesses certainly don’t want more mandates. They don’t want government-run insurance. They know that a government plan is eventually going to crowd out the private insurance company plans throughout the country.

I am going to be preparing an amendment that will allow States to opt out without penalties, not just of the government insurance plan but of all the harmful mandates we have in a government opt-out by States, if they are going to still have to pay the higher taxes, if they are going to have to pay higher premiums to pay for the other States that have the plan? States should not be forced to participate in the government plan, nor subsidize and pay for such a plan through increased taxes.

I will prepare amendments that will exempt individuals and employers from the mandate to buy insurance, if this bill causes premiums to rise above their currently projected values.

The solution to health care issues is not to give more power to the government. The solution is to give more power to the American people. They deserve that. That is what makes America will have the best health care in the world.

Which brings me to the new government task force that came out this week that is causing confusion at best, but that did offer some guidelines regarding screening for breast cancer. Breast cancer is the second leading cause of death in women in this country. Whether and when to screen for breast cancer has been debated for decades. In 1993, the Clinton administration proposed the government take over health care. In that proposal put forward by the Clinton administration, there would be no payment for mammograms for women under the age of 50; under the age of 40. But when the government plan in the last 15 hours. I am so worried we are now beginning to see the handwriting on the wall. The President said once there is no reason we should not be catching breast cancers that are common as government decides where finite tax dollars are allowed to go. That is a quote from the Wall Street Journal today.

The American Cancer Society came out with this incredible recommendation and said, with its new recommendations, the task force is essentially telling women that mammography at age 40 to 49 saves lives, just not enough of them. So if the screening is too early to save you from your mother’s or your sister’s or your wife’s, would that screening be worth it?

Decisions about care must be between a doctor and a patient, not a doctor who has a loyalty to anyone but the patient, not a doctor who is working for the government and having to maintain government task force guidelines, such as the one we have just seen. That is the crux of the debate on this health care bill that has been released in the last 15 hours. I am so worried we are now beginning to see the handwriting on the wall. The President said once there is no reason we should not be catching breast cancers that are common as government decides where finite tax dollars are allowed to go.
where we have the chance, to change what we see is wrong.

Thank you, Mr. President.

The PRESIDING OFFICER (Mr. Udall of New Mexico). The Senator from Arizona.

Mr. KERRY. Madam President, I wish to compliment the Senator from Texas for sounding this warning. Being from Texas, she is undoubtedly aware of a great country-western song out right now by Brad Paisley called "Welcome to the Future." I think we have seen a glimpse of the future under Obamacare here by this pronouncement of the U.S. Preventive Services Task Force recommending against the routine screening of women between ages 40 and 49 for breast cancer.

I want to speak for about 60 seconds about this issue to go into the actual numbers from the study to which Senator Hutchison referred. The rationale of the study is that you would need to screen 1,399 women in their fifties to save one life, screening is not worthwhile. But since you would need to screen 565 additional women—in other words, 1,904, to be precise—in their fortieths to save 1 life, screening is not worthwhile. That is the kind of cost-benefit analysis that Senator Hutchison is talking about. That is precisely Senator Hutchison's point that this is how rationing begins.

Welcome to the future.

Mrs. HUTCHISON. Mr. President, if the Senator will yield, I appreciate him giving us these statistics because it is 1 life out of 1,904 to be saved, but the choice is not going to be yours; it is going to be someone else who has never met you, who does not know your family history.

That was in the Clinton government reform, takeover of health care in 1993, and it was soundly rejected. It was soundly rejected. It was part of the reason it was soundly rejected—that this mam-mogram rationing before the age of 50—because screening is not worthwhile. And every woman in the Senate at the time rejected—that plan, rejected keeping women under the age of 50 from having mammograms paid for by insurance plans.

So I thank the Senator from Arizona for connecting this and showing the statistics because this is not the American way of looking at our health care coverage. It is not the American way, and we must stop this government takeover of health care.

Mr. President. I yield the floor.

Mr. KERRY. Madam President, I speak in opposition to amendment No. 2765 to the Caregivers and Veterans Omnibus Health Services Act. This amendment, offered by Senator Coburn, would cut funding for international organizations, including U.S. contributions to NATO and the United Nations. This would gravely undermine our vital national security interests at a critical time. We all strongly support strengthening our global capabilities, including the nation's veterans, but Senator Coburn's amendment sets up a completely artificial choice between protecting the health of America's veterans and ensuring that our Nation meets its national security objectives and international obligations.

To be clear, this amendment would cut funding from the contributions to NATO's peace account, which provides the assessed dues to the U.N. and NATO, APEC, OAS, OECD, and the OCPW, as well as take funding from the contributions to international peacekeeping operations account. That is why I oppose this amendment, for several critical reasons:

First, we obviously need as much support as we can get from our NATO allies for our joint mission in Afghanistan. We cannot, and should not, carry this burden alone and how can we ask NATO to do more while we are at the same time cutting our NATO contributions? This would seriously undermine our standing with NATO and with our NATO allies at a time when we can least afford it. We simply cannot allow that to happen.

Several other international organizations are also threatened by this amendment. Funding for the Organization of American States, which addresses throughout the Americas security, from terrorism to narcotics, would be cut. The Organization for Economic Cooperation and Development, which promotes economic growth in 30 member states and more than 20 countries of the United States, would lose funding. The Asia-Pacific Economic Cooperation, which promotes trade, security, and economic growth throughout the Asia-Pacific region, and which the United States will host in 2011, would also be cut. The Organization for the Prohibition of Chemical Weapons, which ensures worldwide implementation of the Chemical Weapons Convention, as well as the World Trade Organization, which provides the stable framework for international trade that our country and the United States, would suffer funding cuts.

Second, our United Nations contributions fund a wide range of U.N. activities in support of key United States foreign policy priorities. U.N. organizations are monitoring nuclear programs in North Korea and Iran. We need the best information possible about the nuclear programs in Iran and North Korea, and the last thing we need to be doing is cutting funding for the very organization that is doing on the ground monitoring. The U.N. is also providing vital assistance for the upcoming elections in Iraq, which will be critical to the future of democracy there. U.N. food and agriculture agencies are combating food insecurity in the wake of several successive tropical storms devastated the country. The mission in Haiti is in the midst of a successful transition from keeping the peace to enhancing security for the people of that country. In the 1990s, Florida faced wave after wave of illegal Haitians trying to escape from the failed state. Should this mission be abandoned? Should we abandon the people of Darfur?

Fourth, the President has stated his commitment to paying U.S. dues to international organizations to support and pay our bills. Our dues to the United Nations and other international organizations are treaty obligations. The full payment of assessed contributions affects the standing and influence that the U.S. has at these organizations. Going into arrears undermines U.S. credibility and negatively influences world opinion regarding U.S. respect and appreciation for the role of multilateral organizations that support and advance U.S. foreign policy.

We all want our veterans and their families to have the best care possible—they have earned it many times over—but this amendment presents us a false choice between caring for our veterans and protecting our global interests: we must do both. It is for these reasons I oppose Senator Coburn's amendment and urge my colleagues to oppose the amendment as well.

Mrs. BOXER. Mr. President, I rise today in opposition to amendment No.
2765 to the Caregivers and Veterans Omnibus Health Services Act of 2009.

This is a deeply flawed amendment that may hurt certain veterans of the wars in Iraq and Afghanistan. And for that reason, I must vote against it. Several decades after young veterans often need someone to care for them in the home. The family members of these veterans often shoulder the burden of this care, which can take a significant financial, psychological, and emotional toll. This bill would provide a family member caregiver with health care, counseling, support and a monthly stipend.

But amendment No. 2765 actually seeks to shut certain Iraq and Afghan-istan veterans out of this new benefit by mandating that only those who require "hospitalization, nursing home care, or other residential care" are eligible.

The Wounded Warrior Project characterized the impact of the amendment as such that it would "set a much higher bar" by requiring that the "veteran be so helpless as to require institutional care if personal care were not available."

This would potentially shut out veterans suffering from severe mental illness, or those learning to adapt to life at home with blindness or amputations.

The Disabled American Veterans also echoed this concern as a reason for opposing this amendment, writing that the amendment’s "new restrictive eligibility language could actually reduce the number of severely wounded and disabled veterans returning home from the wars in Iraq and Afghanistan eligible for such services."

For these reasons, I urge my colleagues to defeat this amendment, which is also opposed by the American Legion, the Iraq and Afghanistan Veterans of America and Swords to Plowshares.

It is long past time to pass the underlying bill. This legislation is too important to our veterans to sit in Congress because of the stall tactics of one lone senator.

It includes important health care improvements for women veterans including requiring the Department of Veterans Affairs to train mental health care specialists on how to better treat military sexual trauma. It also implements programs to provide child care to women veterans who require medical care.

In addition, the bill includes two important provisions from bipartisan legislation that I authored with Senator Boxer.

The first gives active duty service members access to vet centers, which are community-based counseling centers run by the Department of Veterans Affairs where veterans can receive mental health care services.

The second provision authorizes vet centers to counsel former servicemembers on their rights to present their medical records for review to ensure that the discharge process they underwent was fair. This is particularly important for servicemembers who may have been discharged improperly with a personality disorder and therefore are not entitled to benefits when in fact they do suffer from a combat-related condition such as post-traumatic stress disorder.

We owe our veterans an enormous debt of gratitude, and the best possible treatment and care for injuries sustained in service to our country. This bill is an important step toward fulfilling that obligation.

Mr. AKAKA. Mr. President, can you tell me how much time I have remaining?

Mr. AKAKA. Mr. President, let me make further comments about the pending bill on the floor and speak particularly about the cost of war.

To those who are concerned about the cost of this legislation, let me say I firmly believe we cannot renege on the obligation we have voluntarily and honorably serve our country. When we as a nation vote to send American troops to war, we are promising to care for them when they return. The cost of veterans health care is a true cost of war and must be treated as such. The cost associated with the underlying bill does not need to be offset. The price has already been paid many times over by the service of the brave men and women who wore our Nation’s uniform.

Regardless of what my colleagues may think about the United Nations and its role in international affairs, this is not the time or place to debating those issues. At this moment, we are talking about meeting veterans’ needs.

Iraq and Afghanistan Veterans of America agrees. IAVA writes that:

The amendment to S. 1963 brought to the floor is just the latest in a long series of delaying tactics that plays political games with veterans’ health care and services.

This bill would provide family caregivers—who typically have full-time jobs—with health care, counseling, support, and a living stipend. This modest stipend would be equal to what a home health agency would pay an employee to provide similar services.

To assert that this legislation requires excessive spending is simply wrong. This spending is critical when taking into account the sacrifices these men and women have made for the Nation.

The sponsor of the amendment we are considering has expressed the view that S. 1963 unfairly discriminates against veterans because its caregiver assistance provisions focus on OEF and OIF veterans. While it is correct that the caregiver provisions target the veterans of the current conflicts, I do not believe that constitutes discrimination.

The reasons for this targeting, at the least, are three: one, the needs and circumstances of the newest veterans in terms of the injuries are different—different—from those of veterans from earlier eras; two, the family situation or the younger veteran is different from that of older veterans; and three, by targeting this initiative on a specific group of veterans, the likelihood of a successful undertaking is enhanced.

I note that most major veterans groups support this bill and the caregiver provisions. I do not believe they would do so if they felt it was discriminatory.

As my colleagues know, I am a veteran of World War II. If we can provide help to the newest veterans in ways that were not available to the veterans of my generation, I support that 100 percent.

Caregivers from Iraq and Afghanistan are returning home today to face new and different challenges. In World War II, a third of those injured on the battlefield did not make it home. Today, 90 percent of those injured make it home but often with catastrophic and life-threatening injuries. Some of these injuries leave invisible wounds. Unprecedented rates of post-traumatic stress disorder and other mental illnesses are affecting these young men and women. These veterans will be cared for somewhere, and by what we do today, we may decide whether that care occurs in a nursing home or in their own home. The soldiers of my generation had no such choice. I say, let’s help the Nation’s newest veterans to really come home, and let’s help their families.

According to a report from the Center for Naval Analyses, 84 percent of caregivers for veterans were either working or in school prior to becoming a caregiver. An employed caregiver will lose, on average, more than $600,000 in wages, pension, and Social Security benefits over a “career” of caring. The young veteran’s family, the more wages a caregiver will lose. We can no longer ask our newest generation to bear the cost of the Nation’s obligation to care for its wounded warriors.

The premise of the amendment seems to be, if it is good for some, it is good for all. But the needs of veterans are not the same, and expanding a benefit to any veteran who might benefit could overwhelm the entire program. The underlying bill already includes a provision directing VA to report to Congress within 2 years after the law’s enactment on the feasibility of expanding the provision of caregiver assistance to family members of prior service. Such an approach is not discriminatory; it is the responsible way to approach the issue.

I note that other health care improvements which would result from this bill help virtually every group of veterans, including women veterans, homeless veterans, and veterans who live in rural areas.
November 19, 2009

I urge this body to reject the amendment and pass S. 8, 1963 today for the sake of all our Nation’s veterans.

Questions have been raised about the scope of the caregiver provision. When the bill came out of the Veterans’ Affairs Committee, it included a 2-year delay before the caregiver benefit could have been expanded. The bill as reported said the Secretary of VA could have expanded it to all veterans if it made sense. Under the bill now before us, the Congress will continue to have the option to expand it beyond the current provision.

Mr. President, I yield the floor and reserve the remainder of my time.

The PRESIDING OFFICER. The Senator from Florida is recognized.

Mr. LeMIEUX. Mr. President, 25 years ago—I will never forget this—I came home, the day I was 3 years old. I was in high school, and my mom and my dad sat me down and my mom told me that she had breast cancer. After that, as any kid would, I worried about whether my mom was going to live and what life would be like without a mom. It was a very difficult time for our family.

The good news is that my mom, through self-examination, found a lump, and she is today, 25 years later, a breast cancer survivor. But I am not sure that my mom or any other woman today would tell about the positive result that occurred if she had not undertaken that self-exam, if she had not received the care she was given so quickly and so effectively because she found the lump after having been trained and encouraged to do self-exams.

So she is a success story, and millions of women across this country are success stories because they have heed ed the advice of preventive medicine. They followed the advice for many years now from the American Cancer Society and other experts that self-exams and mammograms for women in their forties prevent breast cancer, and they prevent us from losing our moms and our sisters and our daughters. But this week, a task force, a government task force, kind of ironically named the “U.S. Preventive Services Task Force,” contradicted their previous recommendations and said women in their forties shouldn’t be having mammograms on a regular basis. That makes absolutely no sense.

We are in a world where everyone agrees the best advice today and tomorrow to reduce health care costs and to increase longevity of our people is through preventive medicine. We know through the success we have had in recent years that self-exams and mammograms save women’s lives.

There are going to be what the call false positives, women who find something that turns out not to be a lump. And, sure, they are going to be anxious during that time period while it gets checked out. But would you rather have your mom, your sister, your daughter be anxious for a couple days and get a good result or would you rather have them, on the other hand, not do the self-exam, not get the mammogram, and get cancer and potentially die? It doesn’t make sense.

We know these mammograms for women in their forties save lives. We know self-exams save lives. It is not just me saying it; the facts show it. The American Cancer Society notes that deaths from breast cancer from 1990 to 2004 declined by 2.3 percent, and they have declined 3.3 percent for women in their forties and fifties. Lives are being saved.

So why would this government task force that is supposedly focused on prevention want to do away with self-exams and mammograms on a regular basis for women in their forties? What could be the reason?

The reason why any colleague from Texas so eloquently stated, is cost. It doesn’t make sense anymore because we are not saving enough lives for the money that it is costing for mammograms. Our moms and our daughters and our sisters are worth that cost.

If you were aware of where we are going with this new health care proposal and you want to know what the future is for how the government and your insurance company are going to view your health care, just take a look at what is going to happen in the next 30 days and what they are going to do next going to say the same thing about men getting prostate exams in their forties? Are we going to start making these cost-based decisions or really furthering them to a degree that we haven’t seen before? Are we going to lose our family members because we are rationing health care? These are big issues.

The American people, as my colleague from Texas said, need to wake up and they need to watch what is going to happen in this Senate, this great body that debates the important issues. Never has there been an issue as important in modern times as what is going to happen over the next month or 6 or 8 weeks as we discuss these issues that are going to affect our health and our families’ well-being.

I sent a letter to Secretary Sebelius yesterday on this issue. I saw her comments yesterday where she disagrees with the recommendation. Are they going to take that. Women do not need to get the message now that they shouldn’t be doing self-exams. Women should not be getting the message that they shouldn’t be getting regular mammograms in their forties. They need to do both this because it is going to help save their lives. No government task force, based on lack of any new information, should contradict its prior recommendations that they do just that.

I had a chance to speak with the Surgeon General of the State of Florida, Dr. Ana Viamonte-Ros, yesterday about this issue, and she concurs with me, as does the American Cancer Society and other groups, including the American College of Obstetricians and Gynecologists, that women should still do self-exams, and they should still get mammograms on a regular basis in their forties.

I wish to read for this Chamber a letter I received today from a friend of mine down in Broward County from my home State of Florida. She writes:

Please thank the Senator for his efforts on this important issue. I am a breast cancer survivor who was first diagnosed before 50 years of age having a mammogram. Subsequent to the mammogram, my tumor was removed surgically. Unfortunately, within 5 years, I was diagnosed again with breast cancer in the other breast and had to undergo surgery and chemotherapy. The second time I found the tumor through self diagnosis. Every day I thank God that I had a life-saving mammogram and that my doctor showed me how to do a self examination.

Just recently I learned through TV that there are also recommendations that women should not utilize self exam as a way to detect breast cancer. It’s too unreliable. More women who have developed breast cancer found their tumors through self-exam. Please ask the Senator to dispel any efforts or notions that self exam is not a good means of detection.

This is an important issue. We need to get the message out to the women of America that these recommendations are wrong. I only can stand here today with this good story about my mom because if she wouldn’t have done that self-exam, she might not be here with us.

So I hope the American people will, as my colleague from Texas said, wake up and see what this means and what this portends for the future.

With that, I yield the floor.

The PRESIDING OFFICER. The Senator from Hawaii is recognized.

Mr. AKAKA. Mr. President, I wish to make further comments on some of the concerns our speakers have had.

The amendment that the Senate has stated his primary goal is to increase veteran eligibility for caregiver assistance. It appears, however, that the amendment could well have the opposite effect and deny caregiver assistance to many OEF/OIF veterans by significantly narrowing the eligibility criteria for caregiver assistance.

The amendment would add a provision that would require that in addition to sustaining a serious injury and requiring the personal care of a veteran, the caregiver would have to be so helpless as to require institutional care if personal care services were not available. This proposed modification is problematic because not all veterans in need of caregiver assistance would be appropriate for institutional care.

To illustrate, consider the example suggested by the Wounded Warrior Project, one of the principal advocates for the caregiver legislation: A veteran who is recovering from severe wounds, suffers from PTSD and depression, and needs help with feeding, dressing, and getting to the bathroom, under the provisions in S. 1963 this veteran would...
be eligible for caregiver assistance. However, since the veteran in this example would not necessarily benefit from or require institutional or residential care, the veteran would not be eligible for caregiver assistance under the changes proposed by the amendment. Given the veteran's co-occurring PTSD and depression, however, the VA's failure to provide that assistance could have a severe impact on the veteran's mental health and well-being. PTSD, one of the signature wounds of the current war, is a condition which many long-term institutional care settings and nursing homes are not prepared to handle or treat. As a result, the inclusion of this new eligibility condition would exclude many veterans in critical need of caregiver assistance.

There is another problem raised by the amendment's proposed expansion of the caregiver assistance to all veterans. By expanding eligibility for caregivers to all severely injured veterans, the amendment would convert a manageable initiative targeted on the veterans of the current conflicts into a huge undertaking that would surely encounter many problems.

The reasoning behind initially administering services to a smaller pool allows for greater efficiency and the opportunity to improve before expanding such services to a larger universe of veterans.

I note that the Disabled American Veterans argues against the pending amendment because of its potential impact. DAV writes, and I quote: "While the amendment proposed by Senator Coburn seeks to extend caregiver services to veterans from all eras, its new restrictive eligibility language could actually reduce the number of severely wounded and disabled veterans returning home from the wars in Iraq and Afghanistan eligible for such services. For this and other reasons, DAV does not support the Coburn amendment to S. 1963."

I ask unanimous consent that this letter be printed in the RECORD. There being no objection, the material was ordered to be printed in the RECORD, as follows:

DISABLED AMERICAN VETERANS.

Hon. Daniel K. Akaka, Chairman, Senate Veterans' Affairs Committee, Washington, D.C.

Dear Chairman Akaka: On behalf of the Disabled American Veterans (DAV), thank you for the quick feedback you received the floor S. 1963, "The Caregiver and Veterans Omnibus Health Services Act of 2009." DAV strongly supports Senate approval of this legislation as introduced, and urges all Senators to support its passage.

S. 1963 combines the content of two prior measures (S. 252 and S. 801) into a single VA health care omnibus bill that would make significant enhancements in VA health care services. This legislation contains vital provisions to help assure equal access to and quality of care for women veterans. S. 1963 would also provide desperately needed support to family caregivers of severely disabled veterans, particularly those returning from combat injuries, as well as expand mental health services, improve traumatic brain injury care and aid homeless veterans.

As we have shared with you in testimony earlier this year, DAV believes that disabled veterans of all eras could benefit from family caregiver support services. While the amendment proposed by Senator Coburn seeks to extend caregiver services to veterans from all eras, its new restrictive eligibility language could actually reduce the number of severely wounded and disabled veterans returning home from the wars in Iraq and Afghanistan eligible for such services. For this and other reasons, DAV does not support this Coburn amendment to S. 1963.

Mr. Chairman, we look forward to continuing to work with you, Ranking Member Burr, your counterparts in the House and others to craft an expansive and effective caregiver assistance program that we can achieve. Again, thank you for your vigorous leadership on this legislation and for all you have done to support disabled veterans and their loved ones who care for them.

Sincerely,

Joseph A. Violante,
National Legislative Director.

Mr. AKAKA. Mr. President, the proponent of this amendment has expressed the view that this veterans omnibus bill should fund and seek to do so by directing a transfer from the State Department to VA of funds appropriated for "Contributions to International Organizations" and "Contributions for International Peacekeeping Activities," both of which are categories of huge U.S. payments to the United Nations.

Regardless of any Senator's beliefs about the role of the United Nations or U.S. support for the U.N., this is neither the time nor place to be debating those issues. For that reason alone, I believe the amendment should be rejected.

I understand from CBO, however, this amendment does not even accomplish what I believe the amendment's author intends. According to CBO, the cost of the bill would still be estimated at the same level. According to CBO, having the State Department transfer funds to the VA is no different than having VA fund it through its own appropriations accounts.

It also appears that the amendment would change nothing with respect to U.S. payments to the U.N. Again, according to CBO, if the amendment's author wishes to have the State Department transfer funds to VA instead of contributing to the U.N., the amendment would have to be made to the State, Foreign Operations, and Related Programs Appropriations Act, and not to the pending measure which is an authorization bill.

This legislation has been delayed too long. To continue to obstruct this vital veterans bill while attempting to link it completely to unrelated U.N. spending is simply unacceptable.

This amendment should be rejected and S. 1963 should be passed by the Senate.

I yield the floor and reserve the remainder of my time.

The PRESIDENT pro tempore. The Senator from Oklahoma is recognized.

Mr. COBURN. Mr. President, I listened very carefully to the chairman of the Veterans' Committee. He misses one major point: If, in fact, we don't send the money to the U.N., we will have money to pay for the veterans—if we don't send the money.

That is what this amendment does. It prohibits that money from going from the State Department's budget to the U.N. I admit it is fungible, but that is money we will not send to something that is low priority, that is wasteful, that is nontransparent, and that the calls say we think you can agree we get very little value from when we send that money to the U.N.

I also take issue with my friend's words that it is time. I think the chairman will agree that this bill was not noticed until October 29. That is when this bill was noticed. When the bill was noticed, the next day a unanimous consent request came through to say pass this without any debate, without any discussion, pass it through the Senate. I said, no, we ought to have a debate.

At the same time, we gave the veterans' Committee a list of some 20 options of things that are lower priority than helping our veterans. They were rejected out of hand, which is the problem I have been describing on the floor earlier.

Every time it comes down to making a choice, the majority of this body chooses not to make a choice, not to choose a priority, not to do what we get paid to do, not to do what is in the best interests of the Nation. They choose to not choose. But by choosing not to choose priorities, we still choose, because what we choose is to take the money from our children. We choose to lower the standard of living of our children.

I want to tell you about veterans with whom I have spoken. I have had a lot of calls on this, because how dare somebody hold up a veterans bill before Veterans Day. The vast majority of the calls say we think you ought to support veterans, but we also think you ought to pay for it. Our country can't keep doing what we are going to do. So on the last appropriations bill through this body, I gave you an opportunity. We have heard three Senators today say there is no price we should not give to support our veterans. Direct quotes. "No price is too great"? There is one price that is too great, because all three of those Senators who spoke today have said, we think you ought to earmark your pay for veterans in the VA-MILCON bill. They all voted against paying for it in the MILCON bill by eliminating the unrequested items they had earmarked for them in the VA-MILCON bill. So, yes, there is a price that is too great—the price of helping yourself and your own constituency on a parochial basis and putting that ahead of the best interests for our veterans.

So the words "there is no price too great" ring hollow. We put our parochialism ahead of it.

I ask unanimous consent to add Senators Inhofe and Burr as cosponsors of my amendment.
The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. COBURN. Mr. President, as we talk about this debate, as my colleagues know me very well, the debate isn't about veterans; it is not about the waste, it is not about the mismanagement of some fiscal sanity in Washington of which we have none. This bill here—the health care bill that was released last night—over the next 10 years will spend $2.5 trillion. That is what it will spend. We don't know the accuracy of CBO. They certainly haven't done very well in the past on health care, as to whether it saves money. What we do know is that it doesn't cut the cost of health care, which is the problem. It transfers $2.5 trillion under the guise of the control of the Federal Government, which is not efficient.

I have not heard one colleague defend the United Nations. Nobody will get up in this body and defend the atrocities, the waste, and the fraud of the U.N. Nobody will say that. But those same people who actually agree with it but won't do anything about it will vote against this amendment. They will vote against the amendment. They won't defend what has very accurately been called the behavior, the lack of fiscal sanity, the fraud and theft, the waste, and the pillage by the peacekeepers, the lack of oversight, and the total lack of transparency. They will vote against that with their words, but they will defend it with their vote. They are going to absolutely defend it with their vote. Once again, they are going to refuse to make the hard choice. Most of them listening to this agree, but it is the wink and nod that we play around this body. They know the U.N. is a big mess. They know it is a big problem. But they won't do anything to fix it. They will vote for complete transparency and vote to condition our funds on transparency. They say get the conference, they will take it out. They will look good on the outside, but the inside of the cup will be absolutely filthy.

When is it we will see a turnaround in Washington that will match the courage of our veterans and meet the expectation of the citizens of this country when is that going to happen? I will tell you when it is going to happen: It is going to happen when the Chinese start selling our bonds or quit buying them when it doesn't happen. Then we are not going to be able to make those decisions based on our choice. They are going to be dictated to us. They are going to be rammed down our throats.

The fact is that $3.7 billion is a lot of money. It is $3,700 million. That is hard to think about when you start talking about billions. Yet we are going to pass it. By the way, this bill that is so critical to get passed right now has no money in it for veterans for this process. This amendment that I offered—which was rejected—only related specifically to the caregivers. And we could have, with the VA-MILCON amendment I offered—which was rejected—made that happen next month—at least the planning in the first 6 months of that—so that by March or April caregivers could actually start receiving this money.

I have tremendous worry for our Nation. If you open your eyes, you will, too, because we cannot keep doing what we are doing.

Just some numbers. These are accurate, based on GAO, OMB, and Congressional Budget Office:

Ending September 30, not counting the supplemental, the Federal Government spent $33,880 for every household in this country. But we only collected an average of $18,000 per family. We borrowed, per family, $15,603 last year. Those numbers are going to be bigger next year. We are going to spend more, we are going to borrow more, and we are going to collect less. What is the implication of that? What is the implication of borrowing money? We don't have and we are spending it on things that are not a priority, such as caring for veterans? The implication is that it will come to an abrupt halt in a very damaging and painful way—maybe not for us in this body but certainly for my children and my grandchildren, and certainly for those who follow us.

There is a bigger worry than the financial aspect of it. It is that we are losing, as we do this, the very integral part of what makes our Nation great. It is called “sacrifice.” That is why we honor our veterans. It is because they sacrifice, they put themselves on the line. Our heritage has been, from the founding of this country, to the very people who risk their lives and fortunes to initiate this country—the heritage has been of one generation sacrificing so the next generation has greater opportunity and greater freedom for greater liberty.

As I said earlier, when we come back and get down to the actual voting on this amendment most people will say: We can't do that. It is not time to make a hard choice.

I want to tell you, those veterans who have closed-head trauma made a hard choice. Those veterans who lost their lives and family made a hard choice. Those veterans who have severe disability and their families made a hard choice.

In a little while, we are going to dishonor that, because we are going to refuse to make a hard choice and rationalize in a way that it isn't going to do any good or make any difference, and we are not going to even attempt to get the out-of-control spending in Washington under control. We will reject the notion that you can, in fact, look at something and see what it is like, such as the corruption, such as the waste, such as the rape and pillage of the U.N. peacekeeping troops, and say, this isn't important, and what is important is that we keep doing it the way we have always done it. We will continue to do it the way we have always done it.

The way we have always done it for the past 20 years does not honor what built this country. It doesn't honor making that sacrifice. It does not honor saying I will make a tough vote, even though the administration doesn't want me to make this vote. I will make that vote because that is right for this country, right for the future, right for our kids and our grandkids. I will make that vote.

We will not see that today. We will not see the courage mustered up to say that what we are doing is such a sloppy, ill-run organization into which this country pours billions of dollars every year and continues unabated and uncontrolled and without oversight because we refuse to make a choice.

Just some facts. These are accurate, based on GAO, OMB, and Congressional Budget Office:

When their standard of living is 35 percent below the standard of living we experienced today—by the way, that is what is forecast as the government takes over 40 percent of the GDP of this country and as we end up with interest costs in excess of $1 trillion a year just to fund the excesses of what we are doing today, which is less than 5 years away, and we will be spending $3 trillion a year in interest by the time we get there and we will have no recollection of this vote. We will have no recriminations against us. We will have just voted and said that is
another amendment to try to make us make a choice, but we refuse to make one.

By voting against this amendment, you are defending the audacity, corruption, inefficiency, and fraud that the United Nations does, and what you are doing. Nothing can be cut. Have you noticed that? Nothing is not important to the politicians of this city. Everybody has an interest group. Oh, we can’t go against that. That is an absolute formula for disaster for our country.

I wish to enter into the RECORD some additional information on the United Nations. I only touched the surface on the account of outlandish things that have gone on in the United Nations. I did not mention Oil for Food, billions of dollars, and of the people who took all that money, none of them got prosecuted. The U.N. Headquarters renovation is going to cost $2 billion. That should cost about $800 million. I did not talk about that or the lack of transparency in terms of the State Department, in terms of reporting how our money is spent at the United Nations.

I ask unanimous consent to have printed in the RECORD this information.

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

AMENDMENT 2785

REDIRECT U.S. DUES TO THE UNITED NATIONS TO THE VETERANS CAREGIVER PROGRAM

The United States taxpayer is the single largest contributor to the United Nations system that is estimated to be at least $30 billion. No one knows for sure how big the U.N. really is—not even the U.N. itself since it operates in an opaque, unaccountable fashion, refusing even the most basic of transparency requests.

The budget that is rife with waste, fraud, and abuse, and the U.N. budget is far worse. Its funding is complicated by diplomatic immunities, spends across international boundaries that are impossible to control, and is spent by U.N. agencies that levy taxes and fees on each other.

This amendment to the Veterans’ Caregiver Bill reduces the contributions that the United States makes to the United Nations by a sufficient amount to provide caregiver benefits to ALL severely disabled war-time veterans, not just veterans injured after September 11, 2001. The current bill discriminates against veterans injured prior to that date, and does not provide them the same care that it would provide to individuals after that date.

The national debt just passed $12 trillion and the Congress must pass a debt limit increase, and the United States has cut its U.N. dues because it cannot afford to pay. The United Nations cannot account for the $2 billion spent after most projects were complete. OIOS audited the United Nations Environment Program and found evidence of administrative malpractice, the U.N. management has taken no steps to rectify that. The report also stated that the investigation into these cases is being undermined by bribery and witness intimidation by U.N. personnel.

In 2006, the U.N. peacekeepers in Haiti and Liberia were involved in sexual exploitation of refugees. In 2007, leaked reports indicate the U.N. has been linked to these offenses in the past three years ranging from rape to assault on minors. In all of these cases, there is no known evidence of an offending U.N. peacekeeper being prosecuted. Just this month, Human Rights Watch reported that Congolese armed forces, supported by U.N. peacekeepers in the eastern Democratic Republic of Congo, have brutally killed hundreds of civilians and committed widespread rape in the past three months in a military operation backed by the United Nations.

Most of the victims were women, children, and the elderly. Some were decapitated. Others were chopped to death by machete, beheaded with clubs, or shot as they tried to flee. The UN peacekeeping mission provides substantial operational and logistical support to the soldiers, including military firepower, transport, rations, and fuel.

The attacking Congolese soldiers made no distinction between combatants and civilians, shooting many at close range or chopping their victims to death with machetes. In one of the hamlets, Katanga, Congolese soldiers shot three young men, cut off their arms, and then threw their heads and limbs 20 meters away from their bodies. The soldiers then raped 16 women and girls, including a 12-year-old girl, later killing four of them.

The U.S. now pays 27% of all UN peacekeeping operations. Reducing our contribution to 5% would help ensure that UN peacekeepers are not funding widespread rape and exploitation of refugees.

The United Nations cannot account for tens of millions of dollars provided to the troubled Afghan election commission, according to two confidential U.N. audits and interviews with current and former senior diplomats.

The Afghan election commission, with tens of billions in U.N. funding and hundreds of millions in U.S. funding, facilitated mass election fraud and operated ghost polling places.

"Everybody kept sending money" to the elections commission, said Peter Galbraith, the former deputy chief of the U.N. mission in Afghanistan. "Nobody knows. U.S. taxpayers spent hundreds of millions of dollars on a fraudulent election."

Galbraith, a deputy to the senior U.N. official in Afghanistan, was fired last month after protesting fraud in the elections.

As of April 2009, the U.N. spent $72.4 billion supporting the electoral commission, $56.7 million of which was provided by the U.S. Agency for International Development. The Special Inspector General for Afghanistan Reconstruction states that the United States provided at least $293 million in funding for the election.

In one instance, the United Nations Development Program paid $9.8 million for transportation costs in areas where no U.N. officials were present. Overall, the audits found that U.N. monitoring of U.S. taxpayer funds was "seriously Inadequate."

Oil for Food

In 1996, the United Nations (UN) Security Council and Iraq began the Oil for Food program to address Iraq's wartime situation after sanctions were imposed in 1990. More than $67 billion in oil revenue was obtained through the program, with $31 billion in humanitarian assistance delivered to Iraq.

The Oil for Food program had weaknesses in the four key internal control standards—risk assessment, control activities, information and communication, and monitoring—that facilitated Iraq's ability to obtain illicit revenues ranging from $7.4 billion to $12.8 billion. In particular, the UN did not provide for timely assessments to address the risks posed by Iraq's control over contracting and the program's expansion from emergency assistance to other areas.

According to GAO, the Oil for Food program was flawed from the outset because it did not have sufficient controls to prevent the Iraqi regime from manipulating the program.

GAO identified over 700 findings in these reports. Most reports focused on U.N. activities in Iraq, including inspections and oversight of the U.N. Compensation Commission, and the implementation of U.N. inspection contracts. In the north, OIOS audits found problems with coordination, documentation, asset management, and cash management. For example, U.N. agencies had purchased diesel generators in an area where diesel fuel was not readily available and constructed a health facility subject to frequent flooding. An audit of U.N.-Habitat found $1.6 million worth of construction material on hand after most projects were completed. OIOS audits of the U.N. Compensation Commission found poor internal controls and recorded income that was reduced by more than $500 million.

UN HEADQUARTERS RECONSTRUCTION

In 2008, the United Nations began construction associated with its Capital Master Plan to renovate its environmental complex in New York City. As the UN's host country and largest contributor, the United States taxpayer has a vested interest in the way funds are spent in renovating these buildings.

The United Nations headquarters renovation, now estimated to cost $2 billion from the $1.2 billion originally estimated, was found to be almost $100 million over its budget before breaking ground on the project. Part of

The U.N. Environment Program spends over $1 billion annually on global warming initiatives but there is almost no auditing or oversight being conducted. The U.N. Environment Program has one auditor and one assistant to oversee its operations. According to the task force it would take 17 years for the auditor to oversee just the high-risk areas already identified by the task force.

The United Nations Human Settlements program, knows as UN-Habitat, only has one auditor, and it would take him 11 years to audit operations. In cases where the U.N. auditors and investigators found evidence of administrative malpractice, the U.N. management has taken no steps to rectify that.

The United Nations Peacekeeping Operations program has the sole purpose of which is to promote a positive image of the international body. Further, the $1 billion for U.N. Peace Keeping Operations is part of U.N. advocacy efforts all over the world.

The United Nations management has taken no steps to rectify that. The report also stated that the investigation into these cases is being undermined by bribery and witness intimidation by U.N. personnel. In 2006, the UN peacekeepers in Haiti and Liberia were involved in sexual exploitation of refugees. In 2007, leaked reports indicate the U.N. has been linked to these offenses in the past three years ranging from rape to assault on minors. In all of these cases, there is no known evidence of an offending U.N. peacekeeper being prosecuted.
the cost increase is due to previously hidden “scope options” for “environment friendly” options like planting grass on the roof and electricity-producing wind turbines. First, UN officials failed to adequately maintain its complex after 50 years of deterioration and decay. The U.N. paid millions of dollars to an Italian design firm that had to be fired after three years of work without ever producing a single workable plan for the renovation project.

The UN renovation project is just another example of the U.N. losing control of expenditures. The U.N.’s purported $2 billion renovation budget includes over $550 million for expected increased costs and other “contingencies.” U.S. officials are responsible for at least $485 million in the renovation of the U.N. buildings. However, this figure is likely to rise as GAO has assessed that there exists a high risk that the project will cost much more than anticipated.

Unfortunately, the U.N. renovation program is carried out by the same system responsible for the Oil-for-Food Program. The U.N.’s own internal audits suggest that the entire procurement system is plagued by corruption.

The current cost of the UN renovation is as follows: $800 million for construction, $350 million budgeted future escalation in costs, $200 million for redundancies (extra generators, additional fiber optic lines, etc), $40 million “sustainability” (wind turbines, grass on roof, etc). The U.N. General “palace” renovation

In addition to housing a massive bureaucracy in New York, the United Nations also keeps a European headquarters, in scenic Geneva, Switzerland. The similarity is striking, as this 70 year old building that used to house the League of Nations is reportedly in need of a billion dollars to fully renovate the “Palais de Nations,” as the U.N. building is known, because the building suffers from 70 years of neglect, rustyst pipes, asbestos, and a roof caving in.

For cost comparison, $1 billion could build 407,244 square meters of office space in Geneva, Switzerland which is about the size of the Empire State Building, and five times the size of the main building at the Palais des Nations.

Keeping the Palais des Nations could cost more than double what it would take to build a new home from scratch. The large building group says, is also larger than the entire humanitarian action appeal for all countries served by UNICEF, the United Nations Children’s Fund, which requests additional funds to address $8 of humanitarian emergencies around the world in 2008.

$1 billion could also go a long way to feed the hungry. Oxfam America reports on its Web site that “$20 buys enough maize to feed a family of four” there for six months—enough food and water to feed millions and flood the valley.

The Director General in Geneva renovated his office this year, though the U.N. would not say how much the changes cost and did not specify whether a member state paid for the work. A spokesman said that his office was often overheated by the sun, and he had an air conditioner installed to cool it.

As the United States is responsible for 22% of the U.N.’s budget, it is entirely reasonable to expect that the U.S. taxpayer would be responsible for $200 million of the renovations of the U.N.’s Geneva offices.

Any major work on the Palais de Nations would likely come after the $1.9 billion renovation of the New York headquarters is complete, which is at least 4 years away barring further delays. The director general’s figure of one billion dollars isn’t on the U.N. budget yet and is an estimate that would have to be evaluated by a team of architects.

Largest money grab in U.N. history while ignoring reform

Despite these and the dozens of other examples of U.N. mismanagement and fraud and exhortation by the U.N.’s largest donor, the United States, to stop wasting U.S. taxpayer dollars. Instead, the U.N. is receiving even increasing amounts of new funding from the U.S. and other donors.

According to the State Department, the U.N. 2008/2009 biennial budget represents the largest increase for a funding request in the U.N.’s history.

The 2008/2009 UN budget is in excess of $5.2 billion. This represents a 25% jump from the 2006/2007 budget that was only $4.17 billion and a 193% increase from the 1998/1999 budget.

The overwhelming majority of the U.N. budget goes to staff salaries and common staff costs including travel to resorts to discuss global warming—rather than direct humanitarian assistance or conflict prevention.

The U.N. has never identified offsets in existing funding in order to pay for new U.N. spending, a position supported by a U.N. General Assembly resolution.

Following the U.N. Secretariat’s poor example, the ¾ of the U.N. not covered by the U.S. budget has experienced massive budget growth due to a complete inability to control spending. Peacekeeping is growing by 40%, the U.N. tribunals by 15% and numerous other U.N. programs are no better off.

The State Department is willfully ignoring the law in reporting transparency on U.S. contributions to the United Nations

The U.S. taxpayer should not give billions in funding to the U.N. and then be refused basic information about that contribution. The Office of Management and Budget and the State Department are willfully ignoring the law regarding congressional reporting requirements for U.N. contributions.

In the National Defense Authorization Act of 2007, and the National Defense Authorization Act of 2010, the Director of the Office of Management and Budget (OMB) is now required by law to report annually to Congress the total cash and in-kind contributions to the U.N. from the United States. OMB has passed this responsibility to the State Department, and unfortunately, our lead agency on U.N. matters in the OMB has failed to meet this law in 2007, and when it finally provided the required funding reports in 2008, it appears that the reports are missing over $1 billion worth of funding information. The State Department has not submitted its report for 2008.

Ranking Member Ileana Ros-Lehtinen of House Foreign Affairs Committee comments on the U.N. lobbying for more contributions from the U.S.

“Last year, American taxpayers ponied up nearly $5 billion for the UN system. The U.S. is by far the world’s largest donor to the UN. The U.S. pays the piper, and it’s time for the UN to step up and live up to the expectations they have set for themselves—please keep the peacekeeping operations. The U.S. responds to emergency appeals. We are always on deck.

‘Yet, the head of the UN comes to Congress and scolds us for not doing enough! He demands yet more money from us while making little progress in cleaning up the badly-broken UN.

‘The UN’s ineffectiveness is not from a lack of cash, but the result of a corrupt system which wastes money and apologizes for dictatorships.

‘The UN has been hijacked by a rogues’ gallery that uses our funds to undermine peace and security. Dictatorships use the Human Rights Council and Durban 2 conference process to restrict universal freedoms and protect extremists. The UN Relief and Works Agency (UNRWA) aid violent and funding for other UN agencies and banks under U.S. sanctions or under U.S. investigation for financing Islamist militants.

The UN Peacekeeping Fund (UNPFP) pays the legal fees of its corrupt officials but refuses to protect whistleblowers.

‘While Iran, Syria, and North Korea endanger the entire world, the UN is preoccupied with condemning democratic states like the U.S. and Israel.

‘Moreover the UN is facing serious economic challenges here at home. How can a morally bankrupt UN ask our taxpayers to bail them out?’

Mr. COBURN. Mr. President, I will finish and give the chairman the last word. What the chairman and his committee are attempting to do is honorable. It is the right thing to do to help our veterans and to secure and help those who are helping our veterans. I say to the American people to see that we ought to do that on the backs of our children. I think we ought to do it on our backs. We ought to carry that load. Our children and our grandchildren should not have to carry that load. We owe it to the future to ensure that we are making the sacrifices to pay for the sacrifices they have made for us. This bill does not do that.

This bill takes the easy route. It says you do not have to pay for it, it is not required. There is not anything we can get rid of. After I offered all these options to the committee in terms of what they could get rid of that would pay for it.

If we don’t pay for it from what I offered, then get rid of our own earmarks, the things that make us look good. We chose to keep our earmarks and charge it to our grandkids. It is a wonderful choice and a wonderful thing for the Federal Government is too big. They know we can do better. They know the Federal Government is too big. They know the Federal Government is inefficient. They know we can do better. They are just wondering when we are going to start. When will it start? We have the opportunity in the first time we make a hard choice? I regret it is not going to be on this bill because it is symbolic. If there ever was a bill on which we should start to make the hard choices, it should be on a bill that honors and takes care of the people who have made hard choices for us, the people who have sacrificed their lives and their future and their families for us.
The third thing, regrettably, that they are going to see is that we are going to continue to play the game the way it has been played: Get the votes to defeat the amendment; we will take a little bit of heat; maybe somebody will notice. I will tell you. Twenty years from now, our kids are going to notice, our grandkids are going to notice.

One final thought. If you are under 25 in this country, pay attention to me right now. If you are under 25—there are 70 million of us. Twenty years from now, you and your children will each be responsible for $1,919,000 worth of debt of this country for which you will have gotten no benefit—none. The cost to carry that will be about $70,000. That is not per family, that is per individual. The cost to carry that will be about $70,000 a year before you pay your first tax.

Ask yourself if you think we are doing a good job when we are going to take away your ability to educate your children, when we are going to take away your ability to own a home, and we are going to take away your ability to have the capital formation to create jobs in this country. Watch and see. That number is going to grow every time we do something like this without paying for it, without offsets, without getting rid of something less important.

I yield back the time and yield the remainder of my time to the chairman of the committee.

The PRESIDING OFFICER. The Senator from Hawaii is recognized.

Mr. AKAKA. Mr. President, I wish to make a point of clarification. This bill, the pending measure, is made up of two bills which is now S. 1963. It was S. 252, which was reported in July, and S. 801, which was reported in mid-October. Both bills were held at the time they went into the calendar. No amendment was prepared to either bill. The first amendment was proposed on Monday of this week, 2 weeks after the bills were combined as S. 1963.

In closing, the debate about the United Nations is not one which belongs to a veterans bill. The underlying bill is a bipartisan approach to some of the most urgent issues facing all veterans—for women veterans, for homeless veterans, to help with quality issues to help disabled veterans.

This bill, by the way, also includes construction authorization for six major VA construction projects already funded by the VA spending bill. I urge our colleagues to reject the amendment to S. 1963.

Mr. AKAKA. I yield back my time.

I suggest the absence of a quorum.

The PRESIDING OFFICER (Mr. FRANKEN). The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. LEAHY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.
have been repeated in editorials in the Washington Times and by Republican opponents in the Senate. They resort to twisting and contorting his judicial record and his views, and ignore the record before the Senate. Those distortions are recent ones. It is soundly refuted earlier this week by the senior Senator from Indiana, Senator LUGAR. I doubt that I will add to his sound and thoroughgoing rebuttal. Judge Hamilton’s critics are wrong and have been wrong all along.

Senator LUGAR and Senator BAYH believe Judge Hamilton is superbly qualified and a mainstream jurist. I agree. Yet Republican critics of Judge Hamilton are determined to ignore the knowledge and endorsement of these home State Senators as well as Judge Hamilton’s long, mainstream record on the bench to paint an unfair caricature of him. They are wrong to ignore Judge Hamilton’s record of fairly applying the law in hundreds of cases and his “well qualified” rating by the American Bar Association. These critics ignore Judge Hamilton’s testimony before the committee when he said, “I make decisions based on the facts and applicable law of each case.” He stated that sympathy “has no role in the process” of judging. Instead, they construct and then seek to impose their own “litmus tests” and contort his record in their end-oriented effort to find him wanting.

Republican Senators did not object when Chief Justice Roberts testified at his confirmation hearing that “of course, we all bring our life experiences to the bench.” Republican Senators did not criticize Justice Alito at his confirmation hearings in 2006 for describing the importance of his background when evaluating discrimination cases. Justice Alito said: “When I get a case about someone, I have to think about people in my own family who suffered discrimination because of their ethnic background or because of religion or because of gender. And I do take that into account.”

I remember one nominee who spoke during his confirmation hearing of his personal struggle to overcome obstacles. He made a point of describing his life as:

[One that required me to at some point touch on virtually every aspect, every level of our country, from people who couldn’t read and write to people who were extremely literate, from people who had no money to people who were wealthy. So when I bring to this Court, I believe, is an understanding and the ability to stand in the shoes of other people across a broad spectrum of this country.]

That is the definition of empathy. And that nominee was Clarence Thomas. Indeed, when President George H.W. Bush nominated Justice Thomas to the Supreme Court he touted him as, “a delightful and warm, intelligent person who has a friendly and a wonderful sense of humor.” Justice O’Connor, who had a long and distinguished record of evenhandedness on the Supreme Court, explained recently: “You do have to have an understanding of how some rule you make will apply to people in the real world. I think that there should be an awareness of the real-world consequences of the principles of the law you apply.”

Yet now Republican Senators seek to apply a newly constructed “litmus test” that rejects what they had previously viewed as positive attributes as disqualifying. Their opposition to President Bush’s nomination of Justice Alito was so virulent that they act as if they must oppose anything he supports. If he sees value in judges with real world perspectives who consider the real impact of various readings of the law on everyday Americans, they must react in knee-jerk opposition. They use a distorted lens to review a 15-year judicial record in which he has not substituted empathy for the law to somehow conclude that he will if confirmed to the new appointment. It is reminiscent of the Salem witch trials. They see what they want to see.

Senator LUGAR noted this week that the President of the Indiana Federalist Society endorsed Judge Hamilton as an “excellent jurist and fine intellect” with a “judicial philosophy well within the mainstream.” Senator BAYH reinforced that conclusion with his statements in support of the nomination.

Republican critics are slavishly channeling the talking points of far right narrow special interest groups to twist a handful of the Judge Hamilton’s 8,000 cases to make biased and unfair attacks on the character and record of a moderate judge and a good man. For example, they have misrepresented two of his cases, Hirnichs v. Bosma, 2005, and Grossbaum v. Indianapolis-Marion County Bldg. Authority, 1994, to falsely describe Judge Hamilton, the son of a Methodist minister, as hostile to religion and sent a 2005 House session were sectarian, illegal, and challenged the practice of offering sectarian prayers at the beginning of sessions as a violation of establishment clause. The Seventh Circuit only reversed Judge Hamilton on this technical threshold question after the Supreme Court and in the Seventh Circuit interpreting the establishment clause of the first amendment.

The critics of Judge Hamilton who have made much of the fact that Judge Hamilton’s decision was overturned by the Seventh Circuit ignore the fact that it was overturned only on the technical issue of standing, not on the merits of Judge Hamilton’s opinion. In fact, even on this narrow technical point the Seventh Circuit initially upheld Judge Hamilton’s 2005 decision that taxpayers had standing to sue the Indiana House of Representatives, challenging the practice of offering sectarian prayers at the beginning of sessions as a violation of establishment clause. The Seventh Circuit only reversed Judge Hamilton on this technical threshold question after the Supreme Court and in the Seventh Circuit interpreting the establishment clause of the first amendment.

These same critics have gone so far as to claim that Judge Hamilton favors Muslim prayers to Christian ones by allowing prayers to Allah, while forbidding prayers to Jesus Christ. This slur led to a Washington Times editorial denouncing the nomination. As Judge Hamilton explained in a ruling on a post-trial motion in Hinrichs, closely following Supreme Court precedent from Marsh v. Chambers, 1983, mere use of the word for “God” in another language, such as the “Arabic Allah, the Spanish Dios, the German Gott, the French Dieu, the Swedish Gud, the Greek Theos, the Hebrew Elohim, the Hindu Dio” does not make a prayer sectarian, because it does not “advance a particular religion or disparage others.” However, as Judge Hamilton testified in response to a question from Senator GRAHAM, under the reasoning of his ruling in Hinrichs, “a prayer that the Prophet would ordinarily be considered a sectarian Muslim prayer” and impossible.

The plaintiffs in Hinrichs had challenged the Christian orientation of most of the prayers delivered during the 2005 Indiana House session. So, as part of his analysis, Judge Hamilton reviewed the 45 available transcripts of Christian opening prayers they were offered during that session. He relied on undisputed testimony of scholars and clerics of different faiths who themselves concluded that “many of the legislative prayers delivered during the 2005 House session were sectarian, Christian in orientation, and sent a strong message of non-inclusion to those who are not Christian.” His careful ruling did not depart from settled precedent. It followed the settled law from the Supreme Court and in the Seventh Circuit interpreting the establishment clause of the first amendment.
Senators who charge that Judge Hamilton’s ruling allows Muslim prayers whole forbidding Christian ones have either not read the case or choose to ignore what it says. Judge Hamilton’s analysis of the 33 opening prayers that were delivered by an Indian Hills High School student in the 2005 legislative session, found that all but one were delivered by Christian ministers or ministers identified with Christian churches. He noted that the one prayer that was not, which was delivered by a Muslim man, unlike the vast majority of the prayers from Christian clergy, was ‘‘inclusive and was not identifiable as distinctly Muslim from its content.’’

Judge Hamilton also faithfully applied binding precedent when deciding Grossbaum. In that case, Judge Hamilton correctly relied on then-current Supreme Court and Seventh Circuit precedent interpreting the free speech clause of the first amendment to reach his decision that the Indianapolis building authority acted lawfully in refusing to allow a rabbi to display a menorah in the lobby of the county-county building. His decision relied on a 1990 Seventh Circuit decision, Lubavitch Chabad v. City of Chicago, which upheld a decision by the city of Chicago to put a Christmas tree in the O’Hare Airport and, at the same time, to exclude private displays of religious symbols.

As with Hinrichs, right wing critics point to the Seventh Circuit’s reversal of Judge Hamilton’s decision to argue that he got it wrong and did not apply the law. What this account leaves out is that the Supreme Court case relied on by the Seventh Circuit to reverse Judge Hamilton did not come down until 1995, after Judge Hamilton issued his decision in Grossbaum. In reversing Judge Hamilton’s decision, the Seventh Circuit noted that Judge Hamilton acted without benefit of the Supreme Court’s new guidance in this area provided by Rosenberger v. Rector & Visitors of the University of Virginia, 1995.

Having ignored the binding precedent in certain religion cases to make his decision based on personal beliefs and not the law, he would have been an activist going beyond his role as a district judge. As I read these cases, I had in mind the words of Senator LUGAR who said when he testified in support of Judge Hamilton: ‘‘I have known David since his childhood. His father, Reverend Richard Hamilton, was our family’s pastor at St. Luke’s United Methodist Church in Indianapolis, where his mother was the soloist in the choir. Knowing first-hand his family’s character and commitment to service, it has been natural for me to see that David’s life has borne witness to the values learned in his youth.’’

Senator LUGAR knows Judge Hamilton’s character. And the case critics would have us believe that show nothing more than that Judge Hamilton’s decisions stand, again in Senator LUGAR’s words, ‘‘the vitally limited, role of the Federal judiciary faithfully to interpret and apply our laws, rather than seeking to impose their own policy views.’’

Critics have similarly twisted and disparaged Judge Hamilton’s record on reproductive rights to paint him as an activist. They cite a single case, A Woman’s Choice v. Newman, 1995, even though in that case he carefully applied Supreme Court precedent.

In A Woman’s Choice, Judge Hamilton blocked enforcement of part of an Indiana abortion law that required pregnant women to make two trips to a clinic before having an abortion. Judge Hamilton applied the law set forth by the Supreme Court in Planned Parenthood v. Casey, 1992, and, after carefully examining the facts, concluded that many Indiana women would not be able to make a second trip to a hospital or a clinic. Therefore, under the standard in Casey—the standard Judge Roberts and Justice Alito pledged to follow as binding precedent when nominees before the Judiciary Committee—Judge Hamilton concluded that the law undermined a woman’s constitutionally protected right to choose.

Critics have seized on a split decision from the Seventh Circuit reversing Judge Hamilton’s decision to grant a pre-enforcement injunction of the informed consent provision to mischaracterize his decisions in that case as activist. However, in reversing Judge Hamilton on the injunction, noted conservative icon Judge Easterbrook was criticized by another judge on the panel for ‘‘disregarding’’ the standards that were established by the Supreme Court in [Casey] and was criticized for ‘‘brush[ing] aside the painstakingly careful findings of fact’’ that Judge Hamilton made. Even the concurring opinion recognized that Judge Easterbrook’s opinion embraced dissenting opinions in other cases. Critics have also seized on a falsehood that Judge Hamilton blocked enforcement of the law for seven years, ignoring his modification of the initial injunction to permit Indiana to enforce most of its informed consent law after the Indiana Supreme Court ruled on a State law question of first impression that Judge Hamilton had certified so that he could be guided by the State’s highest court on a question of State law, and ignoring Indiana’s choice not to appeal Judge Hamilton’s timely-issued decisions on the injunction until after trial, which Indiana had asked Judge Hamilton to postpone. Judge Hamilton’s decisions in that case show that he was a careful judge showing appropriate deference to Indiana when addressing a matter of first impression in that State, not an ideologue or an activist.

Senators painting a false picture of Judge Hamilton’s record have also cherry-picked his long record on the bench of handling criminal cases to focus on one or two cases they assert show that he is too lenient on criminals. Like the other charges against Judge Hamilton, this does not hold up to scrutiny. In his 15 years on the bench, the government has appealed only 2 of the approximately 700 criminal sentences Judge Hamilton has handed down. Judge Hamilton’s critics cite cases like U.S. v. Turner, 2006, in which Judge Hamilton sentenced a defendant to 100 years in prison. They ignore U.S. v. Clarke, 1999, in which Judge Hamilton sentenced a defendant to 151 months on three counts of drug distribution. He sentenced 60 months on a firearm charge, denying the defendant’s motion for a reduced sentence citing the defendant’s ‘‘dangerous role in the distribution network.’’ They ignore cases like U.S. v. Garrido-Ortega, 2002, in which Judge Hamilton sentenced a defendant to 70 months imprisonment for possession of counterfeit alien registration receipt cards and for being found in the United States as an alien previously deported after conviction, then denied the defendant’s motion for a reduced sentence. They ignore decisions like U.S. v. Steele, 2009, U.S. v. Hagerman, 2007, and U.S. v. Ellis, 2007, in which Judge Hamilton imposed heavy sentences for drug dealing, obstruction of justice, and for tax evasion. This charge against Judge Hamilton simply does not hold up.

Finally, we have heard repeatedly the falsehood that Judge Hamilton is an activist judge who will try to amend the Constitution through his votes. However, Judge Hamilton testified in response to written questions from Senators that he believes that ‘‘judges do not ‘add’ footnotes to the Constitution and that ‘constitutional decisions must always stay grounded in the Constitution itself.’’

In response to Senator Sessions, Senator GRASSLEY and others, Judge Hamilton wrote: ‘‘The phrase ‘footnotes to the Constitution’ as described by my late colleague Judge S. Hugh Dillin, refers to the case law interpreting the Constitution. By that phrase, I believe he meant that the general provisions of the Constitution themselves and the meaning in their application to specific cases, that the case law is not the Constitution itself, and that constitutional decisions must always stay grounded in the Constitution itself. In my view, judges do not ‘add’ footnotes to the Constitution itself. They apply the Constitution to the facts of the particular case and add nothing to its meaning.’’

Further, in response to another question from Senator Sessions, Judge Hamilton testified: ‘‘I have not added footnotes to the Constitution. I believe the constitutional decisions I have made have been consistent with the expression and original intent of the Founding Fathers.’’ I am hard-pressed to understand why Senators would ask such questions if they do not consider the nominee’s clear answers.

I hope that Senators now considering whether to support this mainstream nominee resist the partisan effort to build a straw man out of one or two opinions in a 15-year record.
on the bench. I hope they do not allow right wing talking points to overshadow Judge Hamilton's long and distinguished record on the bench. Instead, I urge Senators to heed the advice of Senator Lugar who urged that "confirmation decisions should not be based on generalities and considerations, much less on how we hope or predict a given judicial nominee will 'vote' on particular issues of public moment or controversy.''

This is a nomination that should be confirmed and should have been confirmed months ago. David Hamilton is a fine judge and will make a good addition to the United States Court of Appeals for the Seventh Circuit.

Mr. President, I ask unanimous consent to have a copy of the Washington Post article to which I referred printed in the RECORD.

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

[From the Washington Post, Nov. 19, 2009]

THE GOP’S NO-EXIT STRATEGY

(EY. J. Dionne, Jr.)

Normal human beings—let’s call them real Americans—cannot understand why, 10 months after President Obama’s inauguration, we are tied down in a procedural torture chamber trying to pass the health-care bill Obama promised in his campaign.

Last year, the voters gave him the largest popular-vote margin won by a presidential candidate in 20 years. They gave Democrats their largest Senate majority since 1976 and their majority since 1966.

Obama didn’t just offer bromides about hope and change. He made specific pledges. You’d think that the newly empowered Democrats would want to deliver quickly.

But what do real Americans see? On health care, they read about this or that Democratic senator prepared to bring action to a screeching halt out of dislike with some aspect of the proposal. They first hear that a bill will pass by Thanksgiving and then learn it might not get a final vote until after the new year.

Is it any wonder that Congress has miserable approval ratings? Is it surprising that independents feel that their government is incapable of solving a few problems, are becoming impatient with the current majority?

Democrats in the Senate—the House is not the problem—need to have a long chat with themselves and decide whether they want to engage in an act of collective suicide.

But it’s also time to start paying attention to how Republicans, with Machiavellian brilliance, have hit upon what might be called the Beltway-at-Rush-Hour Strategy, aimed at snarling legislative traffic to a standstill so Democrats have no hope of reaching the exit.

We know what happens when drivers just sit there while they’re supposed to be moving. They get grumpy, irascible and start turning on each other, which is exactly what the Democrats are doing.

Republicans know one other thing: Practically nobody is noticing their delay-to-kill strategy. Who wants to discuss legislative procedure when there’s so much fun and profit in psychoanalyzing Sarah Palin?

Yet there was a small break in the Curtain of Obstruction this week when Republican senators unashamedly ate every word they had spoken. Sen. W. Bush was in power about the horrors of filibustering nominees for federal judgeships. On Tuesday, a majority of Republicans tried to block a vote on the appointment of David F. Hamilton, a rather moderate jurist, to a federal appeals court.

Sen. Jeff Sessions of Alabama explained the GOP’s about-face by saying: "I think the rules have changed."

That was actually a helpful comment, because he seems to have changed the rules on Senate action up and down the line. Hamilton’s case is just the one instance that finally got a laugh.

Thankfully, this filibuster failed because some Republicans were embarrassed by it. But Republican delaying tactics have made Obama’s confirmation decisions likely to be embroiled in controversy. He is well behind his predecessor in filling vacancies, a no-brainer in light of the dismal economy. The bill ultimately cleared the Senate this month by 98 to 0.

The vote was 58-32. Republicans launched three filibusters against the bill and tried to lard it with unrelated amendments, delaying passage by nearly a month. And you wonder why it’s so hard to pass health care?

Defenders of the Senate always say the Founders envisioned it as a deliberative body that can force the House to compromise. But Sessions unintentionally blew the whistle on how what’s happening now has nothing to do with the Founders’ design.

The rules have changed. The extra-constitutional filibuster is being used by the minority, with extraordinary success, to make the majority look foolish, ineffectual and ineffective. By using Republican obstructionism as a vehicle for forcing through their own narrow agendas, supposedly moderate and conciliatory Democratic senators will only make themselves complicit in this humiliation.

The PRESIDING OFFICER. The Senator from Alabama is recognized.

Mr. SESSIONS. Mr. President, we moved three judges through committee today, and I think, all in all, Senator LEAHY is working us to death. But we are making some progress.

I would note for the record, if anybody would like to know, there are 21 circuit vacancies for circuit courts in America. The President has nominated 14 people for those vacancies. There are 76 district court vacancies, and as of November 16 the President has nominated 10. He has more vacancies than President Bush had at this time and he has nominated fewer people. But a lot of things are happening. They will catch up. You can’t have backgrounds on nominees, and they should not just throw up names for the sake of throwing up names.

Most of his nominations are receiving bipartisan support. Unfortunately, I have to mention Judge Hamilton, and I would like to explain a few of the things that concern me, particularly about his judicial philosophy and about his rulings. I think they are significant. I wish they weren’t. He is not a bad person, but a lot of people in America today have a philosophy that I think is not appropriate for the Federal bench.

In Hinrichs v. Bosma, Judge Hamilton ordered or issued an order prohibiting the speaker of the Indiana House of Representatives, the duly elected speaker, from allowing a sectarian prayer, as he described it, because some of those prayers had mentioned Jesus Christ, and therefore, they “might advance a particular religion, contrary to the mandates of the Constitution.”

Judge Hamilton also ordered the speaker to make sure to advise any official who is delivering a prayer that a prayer must be nonsectarian, must not advance any one faith or disparage another, and must not use “Christ’s name or title or any other denominational appeal.”

I note parenthetically that every day we have a paid chaplain who commences the Senate with a prayer. Heaven knows we need it. Hopefully we recognize we need it. I notice the words up there on the wall, “In God We Trust.” haven’t been chiseled out by the secularists as of this date. We are a nation that believes in freedom of religion, and the Constitution says Congress shall make no law respecting the establishment of a religion or prohibiting the free exercise thereof. We have come full circle. I think that out, in my opinion, in some of these matters.

So he made that ruling and that injunction to the speaker. In a later ruling denying the speaker’s request to stay this injunction, Judge Hamilton produced a novel notion that prayers in the name of Jesus would be sectarian and, therefore, prohibited, but prayers in the name of Allah would not be sectarian and, therefore, would be allowed. They had an Islamic Imam pray there in Indiana.

The real example Judge Hamilton wrote:

Prayers are sectarian in the Christian tradition when they proclaim or otherwise communicate the beliefs that Jesus of Nazareth was the Christ, the Messiah, the Son of God, or the Saviour, or that he was resurrected, or that he will return on Judgment Day or is otherwise divine.

He went on to say:

If those offering prayers in the Indiana House of Representatives choose to use the Arabic Allah . . . then there’s no risk that the choice of language would advance a particular religion or disparage others.

In other words, that would be OK. I find it hard to justify that position intellectually. Frankly, I thought saying he is anti-religion. I am saying this judge’s approach to the law is confused about an important legal question involving religion.

The Seventh Circuit reversed Judge Hamilton, finding that the taxpayers are лиц к 9. eing sued in the first place. The court of appeals did not reach the merits of the case, but the question naturally arises: Why did
Judge Hamilton skip over the very basic preliminary legal issue of standing and instead move directly to the merits of the case, if the standing didn’t exist? I submit he perhaps des res to rule on the merits because he favored the outcome he produced.

In A Woman’s Choice v. Newman, Judge Hamilton succeeded in blocking the enforcement of a reasonable informed consent law for 7 years, an Indiana law. In 1995, the Indiana Legislature enacted a statute that required certain medical information to be provided to women seeking an abortion at least 18 hours prior to the procedure. The Supreme Court, in Planned Par enthood v. Casey, a very important case, had already held very similar requirements were constitutional and did not restrict the right to an abortion. It just required that the information provided to you 18 hours in advance. Notwithstanding the Supreme Court precedent, Judge Hamilton granted a preliminary injunction against enforcement of the law. In other words, he stopped the law from going into effect. He assumed the role of a legislator. He took out his judicial pen and struck some of the language from the statute, language he didn’t like.

The statute required that women receive this information in person, not through some third person. Judge Hamilton modified the injunction so as to prevent the State from enforcing the requirement that the information be provided “in the presence of” the pregnant woman. He later entered a permanent injunction that prohibited enforcement of the law, in essence vetoing the law.

Finally, the case reached the Seventh Circuit. In an opinion by Judge Easterbrook, the court reversed, concluding that Judge Hamilton had abused his discretion. A Federal judge with a lifetime appointment has power over judges. He says the Constitution is violated by what a State does, the judge has the power to invalidate what the State does. But this is an awesome power and ought to be used carefully. When this case reached the Seventh Circuit, this is what the opinion said:

[For 7 years, Indiana has been prevented from enforcing a statute materially identical to a law held valid by the Supreme Court in Casey, by this court in Karlin, and by the fifth circuit in Barnes. No court anywhere in the country (other than one district judge in Indiana) has held any similar law invalid in the years since Casey v. Indiana (like Pennsylvania and Wisconsin) is entitled to put its law into effect and have that law judged by its own consequences.

If it is a bad law, the people would change it. They have the power to do so.

I suggest that is a pretty stark criticism and a very serious one. One single judge has frustrated a law that was constitutional for 7 years.

In U.S. v. Woolsey, Judge Hamilton disregarded a defendant’s prior conviction for a felony drug offense in order to avoid imposing a mandatory sentence for a felony drug offense. Here the defendant was convicted of drug and firearms offenses after police executed a search warrant at his home where they discovered a half pound of cocaine, 31 pounds of marijuana, 2 pounds of methamphetamine—and that is a lot of methamphetamine—a cache of guns, and $16,000 in currency. Because the defendant had two prior felony drug convictions, the defendant was subject to re conviction penalties under Federal law. Judge Hamilton was reversed because he ignored one of those prior convictions, reversed unanimously by the circuit court on which he now wants to sit.

This is what they said about his willfulness:

[We have admonished district courts that the statutory penalties for recidivism . . . are not optional, even if the court deemed them unwise or an appropriate response to repeat drug offenders.

They were saying: Judge, you have been letting your own personal views override what you are required to do by the law. You are a judge. You are supposed to follow the law. The oath you took is not only under the Constitution and the laws of the United States. You are not above it.

The opinion makes clear that Judge Hamilton either made several unnecessary errors or intentionally ignored the law.

In Grossbaum v. Indianapolis-Marion County Building Authority, Judge Hamilton denied a request by a rabbi to place a menorah in a county building: A unanimous panel of the Seventh Circuit reversed Judge Hamilton’s ruling, noting that two Supreme Court cases were directly on point.

For 8 years the plaintiff in this case had been able to display a menorah during Chanukah until the ACLU challenged the display as violation of the first amendment. Because of the ACLU’s challenge in 1993, Marion County unanimously adopted a “policy on seasonal displays.” They set up a policy to try to make everybody happy. It was done to try to keep the courts happy by preventing a menorah from being displayed.

In 1994, when the plaintiffs submitted a request to display the menorah, they were denied.

Mr. President, I know my time is up, and I ask unanimous consent for an additional minute.

Mr. LEAHY. Provided there is an additional minute.

Mr. SESSIONS. Without objection, it is so ordered.

Mr. LEAHY. Provided there is another minute on this side.

Mr. SESSIONS, I understand.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SESSIONS. Mr. President, there are other matters that I don’t have time to go into in detail. Any nominee is entitled to a fair hearing. They ought to have their record distorted. As the Senator said, no one can make mistakes sometimes. But I think the pattern is such that it indicates to me there are extraordinary circumstances that justify an objection to the nomination because the nominee has shown a willfulness to override the law. A judge must be under the law.

I offer the following more detailed explanation to try to go into even more detail and to fairly analyze the judge’s record and why I think they are unacceptable.

There have been some accusations that we have mischaracterized Judge Hamilton’s record, and, specifically, some of his cases. I would like to take a few minutes to say why I am concerned about Judge Hamilton’s judicial philosophy and demonstrate how we have not mischaracterized his rulings.

In Hinrichs v. Bosma, 400 F. Supp. 2d 1103, S.D. Ind. 2005, the Indiana ACLU, representing some taxpayers, brought suit against the Speaker of the Indiana House of Representatives claiming that “most” of the prayers that opened legislative sessions were sectarian Christian prayers in violation of the First Amendment. Although the Speaker and the Indiana ACLU opposed the Speaker’s request to display a prayer book with 29 out of 45 of the prayers for which there were transcripts were Christian, many prayers were offered by state legislators, a rabbi, and a Muslim imam.

Nevertheless, Judge Hamilton enjoined the speaker from allowing sectarian prayers because some of them mentioned Jesus Christ and therefore might “advance a particular religion, contrary to the mandate of the Establishment Clause.” Judge Hamilton also observed the speaker and a representative of the ACLU both acknowledged that a prayer must be nonsectarian, must not advance any one faith or disparage another, and must not use “Christ’s name or title or any other denominational appeal.”

In so holding, Judge Hamilton relied on what I think is a flawed reading of the Supreme Court’s decision in Marsh v. Chambers, 463 U.S. 783, 1983, which held that a legislative body may open its session with a prayer, much like we do in the Senate. Judge Hamilton said that the Marsh case did not expressly permit prayers that were "explicitly Christian or explicitly Jewish." But the Supreme Court in Marsh did.

The content of the prayer is not of concern to judges where there is no indication that the prayer opportunity has been exploited to proselytize or advance any one, or to disparage any other, faith or belief. That being so, it is not for us to embark on a sensitive evaluation or to parse the content of a particular prayer.

Judge Hamilton ignored the Supreme Court’s clear directive that the content of such prayers should not be of concern to judges. He had concerns about whether he would parse through the content by dictating from the bench what constitutes sectarian prayer. In fact, in a later ruling denying the speaker’s request to stay the permanent injunction, Judge Hamilton came to the conclusion that the speakers in the name of Jesus Christ would be sectarian and therefore prohibited, but prayers in the name of Allah would not
be sectarian and therefore allowed. He said:

Prayers are sectarian in the Christian tradition when they proclaim or otherwise communicate the beliefs that Jesus of Nazareth was the Christ, the Messiah, the Son of God, or the Savior, or that he was resurrected, or that he will return on Judgment Day or is otherwise divine. . . .

He went on to say:

If those offering prayers in the Indiana House of Representatives choose to use the Arabic Allah . . . the court sees little risk that the choice of language would advance a particular religion or disparage others.

I find it hard to believe that anyone would not associate a reference to Allah with Islam.

After full briefing and oral argument, the Seventh Circuit reversed Judge Hamilton’s decision, finding that the taxpayers lacked standing to bring the lawsuit in the first place. The court of appeals did not reach the merits of the case, but the question naturally arises: Why did Judge Hamilton skip over the very basic, preliminary issue of standing and instead move directly to the merits of this case? I submit that Judge Hamilton wanted to get to the merits because he sought this particular outcome.

In A Woman’s Choice v. Newman, 994 F. Supp. 1434, S.D. Ind. 1995, Judge Hamilton succeeded in blocking the enforcement of a reasonable informed consent law for years. In 1995, the Indiana legislature enacted a statute that required women seeking an abortion to receive certain medical information at least 18 hours prior to the abortion being performed. Specifically, the statute required that the women be informed of the following information:

1. The name of the physician performing the abortion.
2. The nature and the procedure or treatment.
3. The risks of and alternatives to the procedure or treatment.
4. The probable gestational age of the fetus.
5. The medical risks associated with carrying the fetus to term.
6. The availability of fetal ultrasound imaging.
7. That medical assistance benefits may be available for prenatal care . . . from the county office of the division of family resources.
8. That the father of the unborn fetus is legally required to assist in the support of the child.
9. That adoption alternatives are available and that adoptive parents may legally pay the costs of prenatal care, childbirth, and neonatal care.

The Supreme Court in Planned Parenthood v. Casey, 505 U.S. 833, 1992, had already held that very similar requirements did not restrict the access to abortions and that is an important point here.

Departing from the Casey decision, and an almost identical Seventh Circuit opinion Upholding a Wisconsin statute, the plaintiffs filed a lawsuit challenging the constitutionality of the Indiana law on the grounds that it was likely to impose an undue burden on a woman’s right to choose. I am not sure how knowing the name of the doctor who is performing an abortion imposes an undue burden. In support of their argument, the plaintiffs presented evidence that the law is likely to prevent abortions for approximately 11 to 14 percent of women who would otherwise choose to have them and the “medical emergency” exception would probably fail to meet constitutional standards as unduly burdensome.

Judge Hamilton granted the plaintiffs a preliminary injunction with certified questions to the Supreme Court of Indiana concerning the interpretation of the “medical emergency” exception under State law.

The Indiana Supreme Court answered the certified questions and basically held that Indiana’s law did not violate the Supreme Court holding in Casey.

The Indiana Supreme Court concluded:

The medical emergency provision of Public Law 187 is inconsistent with the informed consent requirements when the attending physician, in the exercise of her clinical judgment in light of all factors relevant to a particular case, concludes in good-faith that medical complications in her patient’s pregnancy indicate the necessity of treatment by therapeutic abortion. We add that the physician may do so with respect to serious and permanent mental health issues. A physician may not, however, dispense with the informed consent provisions as to health problems when they are temporary.

Notwithstanding, Judge Hamilton assumed the role of a legislator, took out his judicial pen and struck some language from the Indiana statute. The statute required that women receive this information in person. Judge Hamilton modified the preliminary injunction that he had issued so as to prevent the State from enforcing the requirement that the information be provided “in the presence of the pregnant woman.” Judge Hamilton later entered a permanent injunction that prohibited enforcement of the law—in essence vetoing the law.

Finally, the case reached the Seventh Circuit, which reversed Judge Hamilton’s ruling. In a 2-1 opinion by Judge Easterbrook, the court concluded that Judge Hamilton abused his discretion:

[For seven years Indiana has been prevented from enforcing a statute materially identical to a law held valid by the Supreme Court in Casey, by this court in Karlin, and by the fifth circuit in Barnes. No court anywhere in the country (other than one district judge in Indiana) has held any similar law invalid in the years since Casey . . . Indiana (like Pennsylvania and Wisconsin) is entitled to put its law into effect and have that law judged by its own standards.]

In a concurring opinion, Judge Coffee concluded:

[Judge Hamilton’s opinion which was] pronounced without the support of even one citation to the record, invades the legitimate province of and cloaks itself in the executive branches and places a straitjacket upon their power to regulate and control abortion prac-

tise. As a result, literally thousands of Indiana women have undergone abortions since 1995 without having had the benefit of receiving the necessary information to ensure that they make an informed choice. I am aware that the overwhelming choice is made upon the wealth of information available to make a well-informed and educated life-or-death decision.

I recognize that Judge [Judge Hamilton] abused his discretion when depriving the sovereign State of Indiana of its lawful right to enforce the statute before us. I can only hope that the number of women in Indiana who may have been harmed by the judge’s decision is but few in number.

Three different courts, including the Indiana Supreme Court, had looked at the Indiana statute and laws and concluded they passed constitutional muster. This apparently did not satisfy Judge Hamilton and so he ignored the precedent and ruled based on his own policy preferences.

In United States v. Wooley, 535 F.3d 540 (7th Cir. 2008), Judge Hamilton disregarded a defendant’s prior conviction for a felony drug offense in order to avoid imposing a mandatory sentence on a defendant convicted of a third felony drug offense. Judge Hamilton was reversed by a unanimous Seventh Circuit:

[We have admonished district courts that the statutory penalties for recidivism . . . are optional, and if district courts find them unwiseful or an inappropriate response to repeat drug offenders.]

Here, the defendant was convicted of drug and firearms offenses after police executed a search warrant at his home, where they discovered a half pound of cocaine, 31 pounds of marijuana, 2 pounds of methamphetamine, a cache of guns and $16,000 in currency. Because the defendant had two prior felony drug convictions in 1997 and 1974, the defendant was subject to recidivism penalties under Federal statute.

At sentencing, the government properly filed an enhancement information detailing the two prior convictions, which should have triggered a mandatory term of life imprisonment. Although the defendant conceded that his 1997 drug conviction would count for enhancement purposes, he contested the eligibility of the 1974 conviction. The defendant argued that he believed the 1974 conviction—possessing with intent to distribute 125 pounds of marijuana—should have been set aside upon successful completion of his probation pursuant to the Federal Youth Corrections Act. The Federal Youth Corrections Act allows previous sentences to be set aside in cases where there was prior non-dischargeable conviction and where the probationer had “demonstrate[d] good behavior to the sentencing court before the probationary period ended.”

Here, the Arizona district court that had sentenced the defendant did not grant the early discharge. The defendant claimed this was an oversight, so Judge Hamilton postponed the defendant’s sentencing to give him a chance to petition the Arizona court to have the 1974 conviction cleared. According to the opinion reversing Judge Hamilton, “the Arizona court was not inclined to grant the request.”
the defendant had another conviction beyond 1974, so perhaps he did not meet the good behavior requirement.

The Seventh Circuit also noted that the Federal statute:

bars any challenge to the validity of any prior conviction alleged under this section which occurred more than five years before the date of the information alleging such prior conviction . . . . [The defendant] never denied the conviction, and the five-year window closed some time ago.

At sentencing, Judge Hamilton chose to disregard the 1974 conviction and not impose a life sentence. He stated:

I believe it is inappropriate under the circumstances to not count the 1974 marijuana conviction for this purpose. On that issue, with respect to both the guidelines and the [federal statute], I will say that it seems to me that there is no apparent reason in this record why the defendant should not have been discharged early as to what is the customary practice as was intended and, in essence, the Court ought to treat as having been done what should have been done under general equitable powers.

The Seventh Circuit vacated the sentenc ing and admonished Judge Hamilton: 

"[the] Indiana district court was not free to ignore Woolsey's earlier conviction . . . . as Tuten makes clear, the court that imposed a sentence under the TCA should be the one to exercise the discretion afforded by the Act." The court further stated:

sentencing is not the right time to collater ally attack a prior conviction unless the prior conviction was obtained in violation of the rules which [the defendant] does not support. . . . Accordingly, the decision to disregard [the defendant's] prior conviction in light of what the court believed 'should have been done' three decades earlier was incorrect.

I think this opinion makes it clear that Judge Hamilton either made several unnecessary errors in his ruling or intentionally ignored the rule of law because he did not like the sentence. I believe it was the latter of the two.

In Grossbaum v. Indianapolis-Marion County Building Authority, 870 F. Supp. 1450 (S.D. Ind. 1994), Judge Hamilton denied a rabbi to place a menorah in a county building. A unanimous panel of the Seventh Circuit reversed Hamilton's ruling and noted that two Supreme Court cases were directly on point.

For 8 years the plaintiffs in this case had been able to display a menorah during Chanukah until the ACLU challenged the display as violative of the First Amendment. Because of the ACLU's 1993 Marion County unanimously adopted a "policy on seasonal displays" that prevented the menorah from being displayed. So in 1994 when the plaintiffs submitted a request to display the menorah, their request was ignored by the plaintiffs responded by filing a motion for a preliminary injunction to require the county building manager to allow them to display a menorah in the non-public forum lobby of the building, something they had done for all holiday seasons between 1985 and 1992.

Judge Hamilton denied the motion, stating that the First Amendment's free speech clause did not require Marion County to allow the display and that the county was reasonable in believing the establishment clause prohibited it from doing so. He refused to apply controlling Supreme Court precedent and instead embraced what appears to be an evolving standard based on something other than the law. He said: "[o]ne of the challenges . . . is to keep the structure of abstract analytic categories and logical tests in touch with the practical realities before the criminal.

Judge Hamilton also ruled that Marion County's policy was a permissible "subject matter restriction" under the first amendment, rather than prohibited "viewpoint discrimination." Specifically, he decided that the county could put up its own "secular holiday symbol," a Christmas tree, while excluding anyone from expressing a religious view of the holiday season. He then concluded that the county could choose to forbid any display that might be provoked by the display of religious symbols and that "practical considerations" justified his reading of the Constitution. Indeed, Judge Hamilton stated that the plaintiff's position could not be correct because, if it were, the result would be that:

every time a government [put] up a Christmas tree (or perhaps a wreath or some evergreen branches) in a "nonpublic forum," that government [would have] extended an open invitation to all interested private parties to display the religious symbols of their choice in the same area. As a practical matter, that result would be absurd.

In an opinion by Judge Ripple, the Seventh Circuit unanimously reversed. The court rejected Judge Hamilton's attempts to distinguish the case from the Supreme Court's decisions in Rosenberger and Lamb's Chapel, holding that the prohibition on the menorah's message because of its religious perspective was unconstitutional viewpoint discrimination. The court found that the county's policy: "clearly concerns 'seasonal displays' in its government lobby . . . clear is a prohibition of one type of seasonal display, namely religious displays and symbols."

The Seventh Circuit also said: the court's colloquy with counsel at oral argument made it quite clear that the policy challenged here was to prevent one thing: seasonal holiday displays of a religious character.

Because neutrality and equal access to the nonpublic forum lobby avoided establishment clause problems, the Seventh Circuit held the county's establishment clause defense was insufficient.

The Seventh Circuit saw very clearly what Judge Hamilton seems to have been far too distracted by "practical realities" to realize—that the government policy in question was based solely on the viewpoint expressed and, thus, was a violation of the First Amendment, by all accounts, has a talented legal mind. Therefore, I can only conclude that the "practical reality" Judge Hamilton was so concerned with was, in fact, the result he wanted to reach.

Finally, in United States v. Rinehart, 2007 U.S. Dist. LEXIS 19498, S.D. Ind. February 2, 2007, the defendant, a police officer who filmed himself having sex with a minor and the images of another minor, pled guilty to two counts of producing child pornography. Although Judge Hamilton sentenced him to the mandatory minimum of 15 years in prison, he took the highly unusual step of stating in the written opinion "so that it may be of assistance in the event of an application for executive clemency," an action that Judge Hamilton called "appropriate."
The defendant, a 32-year-old cop, engaged in "consensual" sexual relations with two young girls, ages 16 and 17. According to Judge Hamilton's opinion, the sexual relationships were legal under State and Federal law. However, the defendant took photos and videos of himself and the girls engaged in consensual sex, and sexual relations. These images were found on his home computer and he was charged under the Child Protection Act of 1984.

In his written opinion, Judge Hamilton noted his disagreement of the mandatory minimum and concluded by expressly injecting his personal views into the case:

This case, involving sexual activity with victims who were 16 and 17 years old and who could and did legally consent to the sexual act is, in very different. But because of the mandatory minimum 15 year sentence required by [the Child Protection Act of 1984] this court could not impose a just sentence in this case. The only way that Rinehart's punishment could be modified to become just is through an exercise of executive clemency by the President. The court hopes that will happen.

That last sentence embodies precisely the type of activist philosophy that I have been talking about. But here, we do not need to read between the lines. We do not need to infer a thing. Judge Hamilton laid it on in an opinion. And the opinion had the express aim of urging the executive to adopt his policy preferences. When a judge steps outside of his constitutional role of interpreting and applying the law as written, he undermines the entire justice system.

These are just a few of the problematic cases in Judge Hamilton's record. To date, the Seventh Circuit has been able to reverse these errors, but if he is elevated, only the Supreme Court will be able to reverse most of his errors. I am afraid the Supreme Court might not hear some of them. This body should elevate those judges who have performed admirably during lower court service, not those who have performed poorly.

I yield the floor.

Mr. CORNYN. Mr. President, I will not support Judge David Hamilton's elevation to the Court of Appeals for the Seventh Circuit. After close review, I believe Judge Hamilton's writings...
and statements show an unwillingness to serve as a neutral arbiter of the law.

At the time he was appointed to the district court for the Southern District of Indiana, the American Bar Association rated Judge Hamilton “not qualified.” This rating is still apt.

In a personal opinion written during his tenure on the district court, Judge Hamilton has displayed a lack of impartiality, a disregard for precedent, and a willingness to legislate from the bench. His writings also evince his partiality, a disregard for precedent, and statements show an unwillingness to value “an understanding of the world from another’s point of view” above an understanding of the facts of a case.

For instance, in striking down Indiana's popularly enacted informed-consent abortion law, Judge Hamilton radically ruled that the law unconstitutionally imposed an “undue burden” on the right to an abortion because it allegedly forced “women to make two trips to a clinic.” In A Woman’s Choice v. Newman, 305 F.3d 684, 688, 6th Cir. 2002. In making this ruling, Judge Hamilton flaunted the directly applicable precedents of the Supreme Court and the Seventh Circuit. He also, according to Seventh Circuit opinion that reversed Judge Hamilton, relied on a “faulty study by biased researchers who operated in a vacuum of speculation.” In A Woman’s Choice v. Newman, 305 F.3d 684, 689, 7th Cir. 2002.

Similarly, in a case where a child's complicity of drug dealers, who were officials about her mother's drug abuse led to the mother's arrest, Judge Hamilton suppressed the drug evidence against the mother on the ground that the police had violated her substantive due process right to “family integrity.” In United States v. McCoty, 2006 U.S. Dist. LEXIS 62777, S.D. Ind., July 13, 2006. To reach this conclusion, Judge Hamilton ignored controlling Seventh Circuit law and relied instead on the dissenting opinions of Ninth Circuit judges. And when the Seventh Circuit reversed Judge Hamilton, it chastised him for not properly considering the wrongs of the mother in the case, who “risked her relationship with her nine-year-old daughter by dealing drugs.” In United States v. Hollingsworth, 405 F.3d 795, 803 n.3, 7th Cir. 2007.

In these cases, and many more, Judge Hamilton has shown an unvarnished result-orientation and has confirmed his reputation as “one of the more ideological judges in the district.” In Almanac of the Federal Judiciary. This record has not earned him the honor of elevation to a higher court.

As President Obama’s first nominee, there is no doubt that Judge Hamilton possesses the empathy and desire to write “footnotes to the Constitution” that catch the eye of liberal activists and partisan politicians. But these qualities are not ones that a Circuit Judge of the United States should possess. Accordingly, I will vote no on the confirmation of Judge David Hamilton.

The PRESIDING OFFICER. The Senator from Vermont.

Mr. LEAHY. Mr. President, as I sit here and listen, I wonder who in Heaven’s name they are talking about. Judge Hamilton had 8,000 cases. Apparently, there is no problem with any of them except for a tiny handful of cases, and those have been so distorted by Judge Hamilton that I don’t even understand them. Basically, I think they are saying what he should have done is gone by his personal beliefs and not the law. Of course, then they could say he was an activist judge.

He is in a situation where they will try and get him either way. A judge can follow the law, do what they are supposed to do, try 8,000 cases, get strong support from people right to the left, and get the highest possible rating a judge can get. But don’t worry. We are going to take some case or two out of context from their 15 years on the bench. We will ignore 8,000 cases. We will call them a gender-driv- en bias. We will point to a single case, even though in that case they carefully applied Supreme Court precedent.

Come on. Let’s be fair. Eight thousand cases, the highest rating possible, endorsed by everybody who knows him, and strongly backed by Senators LUGAR and BAYH. Judge Hamilton is not an ideologue. Apparently, there is no problem with any of his 8,000 cases except a couple that people have taken out of context. Should we be the conscience of the Nation. We are above that, and we should vote for his confirmation.

AMENDMENT NO. 2785

Mr. President, I also want to take a couple of minutes to speak against Senator COBURN’s amendment to the veterans health bill we will be voting on shortly.

Senator AKAKA has already explained that we do not need the Coburn amendment to the veterans health bill. So do not be misled by all of the comments, and strongly backed by Senators LUGAR and BAYH. Judge Hamilton is not an ideologue. Apparently, there is no problem with any of his 8,000 cases except a couple that people have taken out of context. Should we be the conscience of the Nation. We are above that, and we should vote for his confirmation.

Is the United Nations perfect? Far from it, in my view. But one thing. Inventing facts is another. To say that the U.N. Development Program provided millions of dollars for North Korea which used the funds to buy conventional arms and ballistic missiles, when there is no proof of that, does not belong in this debate. I would say to those Senators who think the United States should not fulfill its treaty obligations to the United Nations, that we should renege on our commitments to support U.N. peacekeeping missions, and who favor walking away from our pledges to NATO, the International Atomic Energy Agency, the World Health Organization, and many other organizations we were instrumental in creating, then vote for this misguided amendment.

But if Senators believe that United States leadership in the world means paying our share and being able to use our influence, then I urge Senators to oppose Senator COBURN’s amendment.

Our assessed contributions to the United Nations, which the Coburn amendment would cut, support a wide range of activities that advance our own national interests. That was as true during the Bush Administration, which would have opposed this amendment, as it is today. The State Department opposes this amendment.

Here are some examples of what the funds are used for by the U.N. and other international organizations that Senator COBURN’s amendment would cut:

Preparing for and holding elections in Iraq.

Monitoring nuclear programs in North Korea and Iran. Do we really want to cut funding for the international nuclear inspectors who Iran finally allowed into one of their facilities?

Supporting NATO. I can’t imagine what Senator wants to cut our contribution to NATO, when we are asking our NATO allies to do more in Afghanistan.

Funding 17 U.N. peacekeeping missions, including in Haiti, Liberia, Lebanon, Darfur and the Congo. We don’t contribute troops for these missions; other nations like Bangladesh and Morocco do. But they rely on us to pay their share of the cost, and it is a lot less expensive than sending our own troops.

Supporting the Food and Agriculture Organization’s forecasts of global food production, identifying areas of drought and famine, to provide emergency food assistance.

Coordinating tsunami and earthquake relief in Indonesia and Pakistan.

Supporting the U.S. Centers for Disease Control and the U.S. Agency for International Development’s work to detect outbreaks of avian flu and Swine Flu and other infectious diseases and defending against a world pandemic.

Creating and maintaining protections for the intellectual property rights of American companies.

Coordinating international aviation safety standards.

Coordinating efforts by the global shipping industry and governments to combat piracy and respond to acts of piracy on the high seas.

These are organizations that are advancing our own interests.

President Obama has stated his commitment that the U.S. will pay its dues to U.N. peacekeeping and international organizations. The Appropriations Committee has acted on that commitment. We are once again in good financial standing at the United Nations. This amendment would put us back in arrears.

Our dues to the United Nations and other international organizations are treaty obligations. Not paying is not an option.
Let's stop acting like the United States doesn't matter. Let's not say that because the U.N. isn't perfect, we should cut our dues.

We are the world's leading military and economic power, and there is much we can achieve on our own. But we cannot stop genocide in Darfur alone any more than we can stop the spread of HIV/AIDS without the cooperation of other nations.

We need to lead by example in the United Nations, in NATO, at the World Health Organization, the International Atomic Energy Agency, the Organization for the Prevention of Chemical Weapons, the Food and Agriculture Organization, and the World Intellectual Property Organization. We can't do that without paying what we owe.

This body has already voted for the funds to support United Nations peacekeeping and these international organizations. Senator COBURN's amendment would cut those funds.

I also want to set the record straight on another misstatement of Senator COBURN's. He said his amendment to the fiscal year 2008 State and Foreign Operations appropriations bill was unaniuous, and thus, impossible for the conference committee to make any change. As anyone who reads the conference report knows, that statement was false.

The result was announced—yeas 59, nays 39, as follows: [Rollcall Vote No. 350 Ex.]

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The nominations were confirmed. The PRESIDING OFFICER will be immediately notified of the Senate's action.

The PRESIDING OFFICER. The Senate will resume legislative session.

The PRESIDING OFFICER. There will now be 2 minutes of debate equally divided on the amendment offered by the Senator from Oklahoma, Mr. COBURN.

The PRESIDING OFFICER. The President will be immediately notified of the Senate's action.

The question is on agreeing to the amendment, followed by a vote to pass S. 3275, Patient Medical Care Act of 2009.

Mr. AKAKA. Mr. President, I urge a "no" vote on the amendment. The amendment is about. There are a lot of reasons you can find to vote against it. It will take real courage to vote for it.

Every major veterans group supports the underlying bill because of what it means for all veterans—for women veterans, for homeless veterans, and for veterans of every era.

I urge a "no" vote on the amendment, followed by a vote to pass S. 1963.

The PRESIDING OFFICER. All time has expired.

The question is on agreeing to the amendment. The PRESIDING OFFICER. There is a sufficient second? There is a sufficient second.

The clerk will call the roll.

The assistant legislative clerk called the roll.

The PRESIDING OFFICER. Mr. DURBIN, I announce that the Senator from Montana (Mr. BAUCUS) and the Senator from West Virginia (Mr. BYRD) are necessarily absent.

The PRESIDING OFFICER. There are any other Senators in the Chamber desiring to vote?

The result was announced—yeas 32, nays 66, as follows: [Rollcall Vote No. 351 Leg.]

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The Senate from Oklahoma is recognized.

Mr. COBURN. This is a straightforward amendment. You get to decide whether you want to continue to send money to an organization that is bankrupt by fraud—peacekeeping troops that rape men, women, and children; has absolutely no transparency in spite of our law that demands it, or to pay for the courage and the support of people who do deserve it.

We always find a reason not to make the hard choice. I suspect we will find a good reason not to make the hard choice this time. But for $3.7 billion to help the people who help us and quit sending money that goes down the tube—half of everything we send to the United Nations gets wasted or defrauded—it is time for us to make the hard choice. That is what the amendment is about. There are a lot of reasons you can find to vote against it. It will take real courage to vote for it.

The PRESIDING OFFICER. The Senator from Hawaii is recognized.

Mr. AKAKA. Mr. President, I urge our colleagues to reject the pending amendment. For one thing, it appears that the amendment could end up defunding caregiver assistance to many OIF/OIF veterans by significantly narrowing the eligibility criteria for caregiver assistance. While the amendment seeks to "pay for" the costs associated with this bill, I understand from CBO, however, that this amendment does not even accomplish what I believe the amendment's author intends.
The amendment (No. 2785) was rejected.

Mrs. MURRAY. Madam President, I move to reconsider the vote.

Mr. DURBIN. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The question is on the engrossment and third reading of the bill.

The bill was ordered to be engrossed for a third reading and was read the third time.

Mrs. MURRAY. I ask for the yeas and nays.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 98, nays 0, as follows:

[Roll Call Vote No. 352 Leg.]

YEAS—98

Baucus  Byrd

Akaka  Feingold  Menendez
Alexander  Feinstein  Merkley
Barroso  Frank  Mikulski
Bayh  Gillibrand  Murkowski
Begich  Graham  Murray
Bennet  Grassley  Nelson (NE)
Bennett  Gregg  Nelson (FL)
Bingaman  Hagan  Pryor
Bond  Harkin  Reed
Boxer  Hatch  Reid
Brown  Hatchison  Risch
Brownback  Inhofe  Roberts
Bunning  Inouye  Rockefeller
Burke  Jackson  Sanders
Burris  Johnson  Schumer
Cardin  Kaufman  Sessions
Carper  Kerry  Shelby
Casey  Kirk  Snowe
Chambliss  Klein  Specter
Collins  Kohl  Stabenow
Cochrane  Kyl  Tester
Collins  Landrieu
Conrad  Lautenberg  Thune
Corker  Leahy  Udall (CO)
Corrigan  Lieberman  Udall (NM)
Crapo  Levin  Vitter
DeMint  Lieberman  Voinovich
Dodd  Lugar  Warner
Dorgan  Lugar  Webb
Durbin  McCain  Whitehouse
Enzi  McConnell  Wicker
Ezzi  McConnell  Wyden

NOT VOTING—2

Baucus  Byrd

The bill (S. 63, 1963) was passed, as follows:

S. 1963

Be it enacted by the Senate and House of Representa-
tives of the United States of America in Con-
gress assembled,

SEC. 1. Short title; table of contents.
Sec. 1. Short title; table of contents.
Sec. 2. References to title 38, United States Code.

TITLE I—CAREGIVER SUPPORT
Sec. 101. Waiver of charges for humanitarian care provided to family mem-
bers accompanying certain severely injured veterans as they receive medical care.
Sec. 102. Family caregiver assistance.
Sec. 103. Lodging and subsistence for attend-
ants.
Sec. 104. Survey of informal caregivers.

TITLE II—WOMEN VETERANS HEALTH CARE MATTERS
Sec. 201. Report on barriers to receipt of health care for women veterans.
Sec. 202. Plan to improve provision of health care services to women veterans.
Sec. 203. Independent study on health consequences of women veterans of military service in Operation Iraqi Freedom and Operation Enduring Freedom.
Sec. 204. Training and certification for mental health care providers on care for veterans suffering from sexual trauma.
Sec. 205. Pilot program on counseling in retreat settings for women veterans newly separated from service in the Armed Forces.
Sec. 206. Report on full-time women veterans program managers at medical centers.
Sec. 207. Service on certain advisory committees of women recently separated from service in the Armed Forces.
Sec. 208. Pilot program on subsidies for child care for certain veterans receiving health care.
Sec. 209. Care for newborn children of women veterans receiving maternity care.

TITLE III—RURAL HEALTH IMPROVEMENTS
Sec. 301. Enhancement of Department of Veterans Affairs Education Debt Reduction Program.
Sec. 302. Visual impairment and orientation and mobility professionals education assistance program.
Sec. 303. Inclusion of Department of Veterans Affairs facilities in list of facilities eligible for assignment of participants in National Health Service Corps Scholarship Program.
Sec. 304. Teleconsultation and telemedicine.
Sec. 305. Demonstration projects on alternatives for expanding care for veterans in rural areas.
Sec. 306. Program on provision of readjustment and mental health care services to veterans who served in Operation Iraqi Freedom and Operation Enduring Freedom.
Sec. 307. Improvement of care of American Indian veterans.
Sec. 308. Travel reimbursement for veterans receiving treatment at facilities of the Department of Veterans Affairs.
Sec. 309. Office of Rural Health five-year strategic plan.
Sec. 310. Oversight of contract and fee-basis care.
Sec. 311. Enhancement of Vet Centers to meet needs of veterans of Operation Iraqi Freedom and Operation Enduring Freedom.
Sec. 312. Centers of excellence for rural health research, education, and clinical activities.

TITLE IV—MENTAL HEALTH CARE MATTERS
Sec. 401. Eligibility of members of the Armed Forces who served in Operation Iraqi Freedom or Operation Enduring Freedom for counseling and services through Readjustment Counseling Service.
Sec. 402. Restoration of authority of Readjustment Counseling Service to provide general and other assistance upon request to former members of the Armed Forces not authorized counseling.
Sec. 403. Study on suicide of veterans.
Sec. 404. Transfer of funds to Secretary of Health and Human Services for Graduate Psychology Education program.

TITLE V—OTHER HEALTH CARE MATTERS
Sec. 501. Repeal of certain annual reporting requirements.
Sec. 502. Modifications to annual Gulf War research report.
Sec. 503. Payment for care furnished to CHAMPVA beneficiaries.
Sec. 504. Disclosures from certain medical records.
Sec. 505. Disclosure to Secretary of health plan contract information and social security number of certain veterans receiving care.
Sec. 506. Enhancement of quality management.
Sec. 507. Reports on improvements to Department health care quality management.
Sec. 508. Pilot program on use of community-based organizations and local and State government entities to ensure that veterans receive care and benefits for which they are eligible.
Sec. 509. Specialized residential care and rehabilitation for certain veterans.
Sec. 510. Expanded study on the health impact of Project Shipboard Hazard and Defense.
Sec. 511. Use of non-Department facilities for rehabilitation of individuals with traumatic brain injury.
Sec. 512. Inclusion of federally recognized tribal organizations in certain programs for State veterans homes.
Sec. 513. Pilot program on provision of dental insurance plans to veterans and survivors and dependents of veterans.
Sec. 514. Expansion of veteran eligibility for reimbursement by Secretary of Veterans Affairs for emergency treatment furnished in a non-Department facility.
Sec. 515. Prohibition on collection of copayments from veterans who are catastrophically disabled.
TITLED VI—DEPARTMENT PERSONNEL MATTERS

Sec. 601. Enhancement of authorities for retention of medical professionals.

Sec. 602. Limitations on overtime duty, weekend duty, and alternative work schedules for nurses.

Sec. 603. Improvements to certain educational assistance programs.

Sec. 604. Standards for appointment and practice of physicians in Department of Veterans Affairs medical facilities.

TITLED VII—HOMELESS VETERANS MATTERS

Sec. 701. Pilot program on financial support for entities that coordinate the provision of supportive services to formerly homeless veterans residing on certain military property.

Sec. 702. Pilot program on financial support of entities that coordinate the provision of supportive services to formerly homeless veterans residing in permanent housing.

Sec. 703. Pilot program on financial support of entities that provide outreach to inform certain veterans about pension benefits.

Sec. 704. Assessment of pilot programs.

TITLED VIII—RESEARCH AND EDUCATION CORPORATIONS

Sec. 801. General authorities on establishment of corporations.

Sec. 802. Clarification of purposes of corporations.

Sec. 803. Modification of requirements for boards of directors of corporations.

Sec. 804. Clarification of powers of corporations.

Sec. 805. Redesignation of section 736A of title 38, United States Code.

Sec. 806. Improved accountability and oversight of corporations.

TITLED IX—CONSTRUCTION AND NAMING MATTERS

Sec. 901. Authorization of medical facility projects.

Sec. 902. Designation of Robley Rex Department of Veterans Affairs Medical Center.

Sec. 903. Merrill Lundman Department of Veterans Affairs Outpatient Center.

Sec. 904. Modification on restriction of alienation of certain real property in Gulf Port, Mississippi.

TITLED X—OTHER MATTERS

Sec. 1001. Expansion of authority for Department of Veterans Affairs police officers.

Sec. 1002. Uniform allowance for Department of Veterans Affairs police officers.

SEC. 2. REFERENCES TO TITLE 38, UNITED STATES CODE.

Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

TITLED I—CAREGIVER SUPPORT

SEC. 101. WAIVER OF CHARGES FOR HUMANITARIAN CARE PROVIDED TO FAMILY MEMBERS ACCOMPANYING CERTAIN NONPROFIT RESEARCH AND EDUCATION CORPORATIONS AS THEY RECEIVE MEDICAL CARE.

The text of section 1784 is amended to read as follows:

"(a) IN GENERAL.—The Secretary may furnish hospital care or medical services as a humanitarian service in emergency cases.

"(b) REIMBURSEMENT.—Except as provided in subsection (c), the Secretary shall charge for care and services provided under subsection (a) at rates prescribed by the Secretary.

"(c) WAIVER OF CHARGES.—(1) Except as provided in paragraph (2), the Secretary may waive, or partially waive, charges provided under subsection (b) for care or services provided under subsection (a) to an attendant of a covered veteran if such care or services are provided to such attendant for an emergency that occurs while such attendant is accompanying such veteran while such veteran is receiving approved inpatient or outpatient treatment at—

"(i) a Department facility; or

"(ii) at which the veteran is receiving fee-basis care.

"(2) If an attendant is entitled to care or services under a health-plan contract (as that term is defined in section 1725(f) of this title) or other contractual or legal recourse against a third party, that in part, extinguish liability for charges described by subsection (b), the amount of such charges waived under paragraph (1) shall be the amount by which the charges exceed the amount of such charges covered by the health-plan contract or other contractual or legal recourse against a third party.

"(d) DEFINITIONS.—In this section:

"(1) The term 'attendant', with respect to a veteran, includes the following:

"(A) A family member of an eligible veteran.

"(B) An individual eligible to receive ongoing family caregiver assistance under section 1717A(e)(1) of this title for the provision of personal care services to the veteran.

"(C) Any other individual whom the Secretary determines—

"(i) has a relationship with the veteran sufficient to demonstrate a close affinity with the veteran; and

"(ii) provides a significant portion of the veteran's care.

"(2) The term 'covered veteran' means any veteran with a severe injury incurred or aggravated in the line of duty in the active military, naval, or air service on or after September 11, 2001.

"(3) Upon the successful completion by a family member of an eligible veteran who makes a joint application under subsection (a)(1)—

"(A) to identify the personal care services required by such veteran; and

"(B) to determine if the charges under such requirements could be significantly or substantially satisfied with the provision of personal care services from a family member (or other individual designated by the veteran) who makes a joint application under subsection (a)(1) to determine—

"(A) the basic amount of instruction, preparation, and training such family member (or designee) requires, if any, to provide the personal care services required by such veteran; and

"(B) the amount of additional instruction, preparation, and training such family member (or designee) requires, if any, to be the primary personal care attendant designated for such veteran under section 1717A(a)(1).

"(4) An evaluation carried out under paragraph (1) may be carried out—

"(A) at a Department facility; or

"(B) at a non-Department facility determined appropriate by the Secretary for purposes of such evaluation; and

"(C) at such other locations as the Secretary considers appropriate.

"(d) TRAINING AND APPROVAL.—(1) Except as provided in subsection (a)(2), the Secretary shall provide each family member of an eligible veteran (or other individual designated by the veteran) who makes a joint application under subsection (a)(1) the basic instruction, preparation, and training determined appropriate for purposes of such evaluation; and

"(2) The Secretary may provide to a family member of an eligible veteran (or other individual designated by the veteran) the additional instruction, preparation, and training determined to be required by such family member for the provision of care under section (a)(1) to carry out this section (a)(1) to determine—

"(A) to identify the personal care services required by such veteran; and

"(B) to determine if the charges under such requirements could be significantly or substantially satisfied with the provision of personal care services from a family member (or other individual designated by the veteran) who makes a joint application under subsection (a)(1) to determine—

"(A) the basic amount of instruction, preparation, and training such family member (or designee) requires, if any, to be the primary personal care attendant designated for such veteran under section 1717A(a)(1); and

"(B) the amount of additional instruction, preparation, and training such family member (or designee) requires, if any, to be the primary personal care attendant designated for such veteran under section 1717A(a)(1).
of basic instruction, preparation, and training provided under paragraph (1), the Secretary shall approve the family member as a personal care attendant for the veteran.

"(4) If a personal care attendant designated under subsection (e) subsequently fails to meet the requirements set forth in paragraph (2), the Secretary—

(A) shall immediately revoke the individual’s designation; and

(B) may designate, in consultation with the eligible veteran or the eligible veteran’s surrogate appointed under subsection (g), a new personal care attendant for the veteran under such paragraph.

"(5) The Secretary shall take such actions as may be necessary to ensure that the revocation of a designation under paragraph (1) does not interfere with the provision of personal care services to the veteran under such paragraph.

"(6) ONGOING FAMILY CAREGIVER ASSISTANCE.—(1) Except as provided in subsection (a)(2) and subject to the provisions of this paragraph, the Secretary shall provide ongoing family caregiver assistance to family members of eligible veterans (or other individuals designated by such veterans) as follows:

(A) To each family member of an eligible veteran (or designee) who is approved under subsection (d)(3) as a personal care attendant for the veteran, the Secretary shall—

(i) Direct technical support consisting of information and assistance to timely address routine, emergency, and specialized caregiving needs;

(ii) Counseling;

(iii) Access to an interactive Internet website on caregiver services that addresses all aspects of the provision of personal care services under this section.

(B) To each family member of an eligible veteran (or designee) who is designated as the primary personal care attendant for such veteran, the Secretary shall—

(i) through facilities of the Department that are appropriate for the veteran;

(ii) through contracts under section 1720B of this title;

(iii) if the Secretary determines that a primary personal care attendant designated under subsection (e)(1) is not providing the personal care services to an eligible veteran (or other individual designated by the veteran) as the primary personal care attendant for such veteran to be the primary provider of personal care services for such veteran.

(2) A primary personal care attendant designated for an eligible veteran under paragraph (1) shall be selected from among family members of such veteran (or other individuals designated by such veteran) who—

(A) are approved under subsection (d)(3) as a personal care attendant for such veteran;

(B) complete all additional instruction, preparation, and training, if any, provided under subsection (d)(3); and

(C) elect to provide the personal care services to such veteran that the Secretary determines such veteran requires under subsection (c).

(3) A primary personal care attendant designated for an eligible veteran under paragraph (1) shall—

(A) be appointed under subsection (g), and the Secretary shall determine under paragraph (3).

(B) for an eligible veteran as the Secretary determines, including the following:

(i) through consultation with the family member so designated by subparagraph (A) and the Secretary considers appropriate, a recommendation on the corrective actions that should be taken to ensure that the veteran receives the care the veteran requires.

(ii) The Secretary shall, in consultation with the primary personal care attendant and the veteran (or the veteran’s surrogate), provide respite care to the family member so designated by subparagraph (A) with respect to the veteran under such paragraph.

(iii) In determining that such family caregiver (or designee) can be the primary provider of such services, the Secretary shall determine the manner of oversight provided under paragraph (1) and the frequency of visits under paragraph (2) for an eligible veteran as the Secretary considers appropriate.

(4) The Secretary shall ensure that each eligible veteran receives personal care services under this section from a primary personal care attendant designated under subsection (e)(1) whom the Secretary considers appropriate.

(5) Provision of ongoing family caregiver assistance under this subsection for provision of personal care services to an eligible veteran shall terminate if the veteran no longer requires the personal care services.

"(4) Except as provided in subparagraph (a)(2), the Secretary may take such actions as the Secretary considers appropriate to ensure that the veteran receives the care the veteran requires.

(5) After receiving findings and recommendations, if any, under paragraph (4), the Secretary shall submit to the Secretary’s recommenda-

tion on the corrective actions that should be taken to ensure that the veteran receives the care the veteran requires, including, if the Secretary determines that the Department lacks the capacity to furnish such services in geographic areas other than the geographic area of an eligible veteran, the Secretary shall determine the manner of oversight provided under paragraph (1) and the frequency of visits under paragraph (2) for an eligible veteran as the Secretary considers appropriate.

(6) If the Secretary terminates the provision of ongoing family caregiver assistance to an eligible veteran, the Secretary shall provide to a primary personal care attendant designated under subsection (e)(1) for the provision of personal care services to an eligible veteran is not less than the amount of personal care services provided to an individual in the geographic area of the veteran to provide equivalent personal care services to the veteran.

(7) If personal care services are not available from a commercial provider in the geographic area of an eligible veteran, the Secretary shall take such actions as the Secretary considers appropriate to ensure that the veteran receives the care the veteran requires.

(8) If personal care services are not available from a commercial provider in the geographic area of an eligible veteran, the Secretary shall provide to a primary personal care attendant designated under subsection (e)(1) for the provision of personal care services to an eligible veteran is not less than the amount of personal care services provided to an individual in the geographic area of the veteran to provide equivalent personal care services to the veteran.

(9) If personal care services are not available from a commercial provider in the geographic area of an eligible veteran, the Secretary shall provide to a primary personal care attendant designated under subsection (e)(1) for the provision of personal care services to an eligible veteran is not less than the amount of personal care services provided to an individual in the geographic area of the veteran to provide equivalent personal care services to the veteran.
under subsection (f) to a family member of an eligible veteran (or other individual designated by the veteran) because of findings of an entity submitted to the Secretary under subsection (e) of this title, the Secretary may not provide compensation to such entity for the provision of personal care services to such veteran if the Secretary determines it would be in the best interest of such veteran to provide compensation to such entity to provide such services.

(1) TO REACH.—The Secretary shall carry out a program of outreach to inform eligible veterans and their family members of the availability and nature of family caregiver assistance under this section.

(2) CONSTRUCTION.—(1) A decision by the Secretary under this section affecting the furnishing of family caregiver assistance shall be considered a medical determination.

(2) Nothing in this section shall be construed to create an employment relationship between the Secretary and an individual in receipt of family caregiver assistance under this section.

(3) Nothing in this section shall be construed to create any entitlement to any services or stipends provided under this section.

(k) DEFINITIONS.—In this section:

(1) Family caregiver assistance includes the instruction, preparation, training, and approval provided under subsection (d) and the ongoing family caregiver assistance provided under subsection (f).

(2) The term ‘family member’ shall have such meaning as the Secretary shall determine in policy or regulation.

(3) The term ‘continuum of care services’, with respect to a veteran, includes the following:

(A) Supervision of the veteran.

(B) Provisions for the veteran.

(C) Services to assist the veteran with one or more independent activities of daily living.

(D) Such other services as the Secretary considers appropriate.

(2) Clerical Amendment.—The table of sections at the beginning of chapter 17 is amended by inserting after the item related to section 1717 the following new item:

“1717A. Family caregiver assistance.”

(3) Authorization for Provision of Health Care to Personal Care Attendants.—Section 176B(a) is amended—

(A) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively; and

(B) by inserting after paragraph (1) the following new paragraph:

“(4) a family member of a veteran (or other individual designated by the veteran) designated as the personal primary care attendant for such veteran under section 1717A(e) of this title who is not entitled to care or services under a health-plan contract (as defined in section 1725(f) of this title).”

(2) Construction.—Any family caregiver assistance furnished under section 1717A of title 38, United States Code, as added by paragraph (1), is in addition to any family caregiver assistance furnished under other programs of the Department of Veterans Affairs as of the date of the enactment of this Act.

(3) Effective Date.—The amendments made by this subsection shall take effect on the date that is 270 days after the date of the enactment of this Act.

(b) Implementation Plan and Report.—

(1) In General.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall—

(A) consult with the Committee on Veterans’ Affairs of the Senate and the Committee on Veterans’ Affairs of the House of Representatives a report on such plan.

(b) Consultation.—In developing the plan required by paragraph (1)(A), the Secretary shall consult with the following:

(A) Veterans described in section 1717A(b) of title 38, United States Code, as added by subsection (a)(1).

(B) Family members of veterans who provide personal care services to such veterans.

(C) Veterans, as recognized by the Secretary of Veterans Affairs for the representation of veterans under section 9902 of title 38, United States Code.

(D) National organizations that specialize in the provision of assistance to individuals with the types of disabilities that personal care attendants will encounter while providing personal family caregiver assistance under section 1717A of title 38, United States Code, as so added.

(E) Such other organizations with an interest in the provision of care to veterans as the Secretary considers appropriate.

(F) The Secretary of Defense with respect to matters concerning personal care services for members of the Armed Forces undergoing medical discharge from the Armed Forces who are eligible to benefit from family caregiver assistance furnished under section 1717A of title 38, United States Code, as so added.

(3) Report Contents.—The report required by paragraph (1)(B) shall contain the following:

(A) The plan required by paragraph (1)(A).

(B) A description of the veterans, caregivers, and organizations consulted by the Secretary under paragraph (2).

(C) A description of such consultations.

(D) The recommendations of such veterans, caregivers, and organizations, if any, that were not incorporated into the plan required by paragraph (1)(A).

(E) The reasons the Secretary did not incorporate such recommendations into such plan.

(c) Annual Evaluation Report.—

(1) In General.—Not later than two years after the date described in subsection (a)(5) and annually thereafter, the Secretary shall submit to the Committee on Veterans’ Affairs of the Senate and the Committee on Veterans’ Affairs of the House of Representatives a report on such plan.

(2) Report Contents.—The report required by paragraph (1) shall include such required in such paragraph.

(d) Report on Feasibility and Advisability of Expanding Caregiver Assistance.—

(1) In General.—Not later than two years after the date of the enactment of the CAREGivers and Veterans Omnibus Health Services Act of 2009, the Secretary shall submit to the Committee on Veterans’ Affairs of the Senate and the Committee on Veterans’ Affairs of the House of Representatives a report on the feasibility and advisability of expanding the provision of family caregiver assistance under section 1717A of title 38, United States Code, as added by subsection (a)(1), to family members of veterans (or other individuals designated by such veterans) whom—

(A) have a serious injury described in section (b)(1) of such section 1717A incurred or aggravated before September 11, 2001; and

(B) are described in paragraph (2) of such subsection.

(2) Recommendations.—The report required by paragraph (1) shall include such recommendations as the Secretary considers appropriate with respect to the expansion described in such paragraph.

SEC. 105. LODGING AND SUBSISTENCE FOR ATTENDANTS.

Section 111(e) is amended—

(1) by striking “When any” and inserting “Any time”;

(2) in paragraph (1), as designated by paragraph (1) of such subsection—

(A) by inserting “(including lodging and subsistence)” after expenses of travel”; and

(B) by inserting before the period at the end of the following: “for the period consisting of travel to and from a treatment facility and the duration of the treatment episode at such facility”; and

(3) by adding at the end the following:

“(2) The Secretary may prescribe regulations to carry out this subsection. Such regulations may include provisions—

“(A) to limit the number of individuals that may receive expenses of travel under paragraph (1) for a single treatment episode of a person; and

“(B) to require attendants to use certain travel services.

(3) In this subsection:

“(A) The term ‘attendant’ includes, with respect to a person described in paragraph (1), the following:

(i) A family member of the person.

(ii) An individual approved as a personal care attendant under section 1717A(d)(3) of this title.

(iii) Any other individual whom the Secretary determines—

(I) has a preexisting relationship with the person; and

(II) provides a significant portion of the person’s care.

(B) The term ‘family member’ shall have the meaning as the Secretary shall determine by policy or regulation.”.

SEC. 106. SURVEY OF INFORMAL CAREGIVERS.

(a) In General.—The Secretary of Veterans Affairs shall, in collaboration with the Secretary of Defense, conduct a national survey of family caregivers of seriously disabled veterans and members of the Armed Forces to better understand the size and characteristics of the population of such caregivers and the types of care they provide such veterans and members.

(b) Report.—Not later than 540 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall, in collaboration with the Secretary of Defense,
submit to Congress a report containing the findings of the Secretary with respect to the survey conducted under subsection (a). Results of the survey shall be disaggregated by the following:

1. Veterans and members of the Armed Forces;
2. Veterans and members of the Armed Forces who served in Operation Iraqi Freedom or Operation Enduring Freedom;
3. Veterans and members of the Armed Forces who live in rural areas.

**TITLE II—WOMEN VETERANS HEALTH CARE MATTERS**

SEC. 201. REPORT ON BARRIERS TO RECEIPT OF HEALTH CARE FOR WOMEN VETERANS UNDER THE PROGRAM OF MILITARY SERVICE IN OPERATION IRAQI FREEDOM AND OPERATION ENDURING FREEDOM.

(a) Report.—Not later than June 1, 2010, the Secretary of Veterans Affairs shall submit to the Committee on Veterans’ Affairs of the Senate and the Committee on Veterans’ Affairs of the House of Representatives a report on barriers to receipt of comprehensive health care through the Department of Veterans Affairs that are encountered by women veterans, especially veterans of Operation Iraqi Freedom and Operation Enduring Freedom.

(b) Elements.—The report required by subsection (a) shall include the following:

1. An identification and assessment of the following:
   (A) Any stigma perceived or associated with seeking mental health care services through the Department of Veterans Affairs;
   (B) The ability of women veterans with disabilities to access the Department’s facilities;
   (C) The availability of child care;
   (D) The receipt of health care through women’s health clinics, integrated primary care clinics, or both;
   (E) The extent of comprehension of eligibility requirements for health care through the Department;
   (F) The quality and nature of the reception of women veterans by Department health care providers and other staff;
   (G) The perception of personal safety and comfort of women veterans in inpatient, outpatient, and behavioral health facilities of the Department;
   (H) The sensitivity of Department health care providers and other staff to issues that particularly affect women;
   (I) The Department’s outreach on health care services of the Department that are available to women veterans;
   (J) Such other matters as the Secretary considers appropriate for the purposes of the assessment.

2. Such recommendations for administrative and legislative action as the Secretary considers appropriate in light of the report.

(c) Report.—Not later than 18 months after entering into the agreement for the study required by subsection (a), the entity described in subparagraph (B) of subsection (f) shall submit to the Committee on Veterans’ Affairs of the Senate a study on health care services for women veterans of the Armed Forces in deployment in Operation Iraqi Freedom and Operation Enduring Freedom.

SEC. 203. INDEPENDENT STUDY ON HEALTH CONCERNS FOR WOMEN VETERANS OF MILITARY SERVICE IN OPERATIONAL FREEDOMS.

(a) Study Required.—The Secretary of Veterans Affairs shall enter into an agreement with a non-Department of Veterans Affairs entity for conducting a study on health consequences for women veterans of service on active duty in the Armed Forces in deployment in Operation Iraqi Freedom and Operation Enduring Freedom.

(b) Specific Matters Studied.—The study under subsection (a) shall include the following:

1. A determination of any association of environmental and occupational exposures and combat in Operation Iraqi Freedom or Operation Enduring Freedom with the general health, mental health, or reproductive health of women who served on active duty in the Armed Forces in Operation Iraqi Freedom or Operation Enduring Freedom.

2. A review and analysis of published literature on environmental and occupational exposures of women while serving in the Armed Forces, including combat trauma, military sexual trauma, and exposure to potential teratogens associated with reproductive problems and birth defects.

(c) Report.—Not later than 18 months after entering into the agreement for the study under subsection (a), the entity described in subparagraph (B) of subsection (f) shall submit to the Secretary a report setting forth the findings and determinations of the entity described in subsection (a) in the report under paragraph (1).

SEC. 204. TRAINING AND CERTIFICATION FOR MENTAL HEALTH CARE PROVIDERS ON CARE FOR VETERANS SUFFERING FROM SEXUAL TRAUMA.

(a) Program Required.—Section 1720D is amended—

(1) by redesignating subsection (d) as subsection (f); and

(2) by inserting after subsection (f) the following new subsection:

"(d)(1) The Secretary shall implement a program for the purpose of providing education, training, certification, and continuing medical education for mental health professionals to specialize in the provision of counseling and care to veterans suffering from sexual trauma.

(2) The Secretary shall ensure that all such mental health professionals have been certified under the program to professionals and providers who have been so certified.

SEC. 205. PILOT PROGRAM ON COUNSELING IN RETREAT SETTINGS FOR WOMEN VETERANS NEWLY SEPARATED FROM SERVICE IN THE ARMED FORCES.

(a) Pilot Program Required.—

(1) In general.—Commencing not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall carry out, through the Readjustment Counseling Service of the Veterans Health Administration, a pilot program to provide the feasibility and advisability of providing reintegration and readjustment services described in subsection (b) in group retreat settings to women veterans who have received counseling, care, and services provided to female veterans of Operation Iraqi Freedom and Operation Enduring Freedom.

(2) Covered services.—The services provided to a veteran under the pilot program shall include the following:

(A) In general.—Commencing not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to Congress a report setting forth the responses of the Secretary to the findings and determinations of the entity described in subsection (a) in the report under paragraph (1).

(b) Covered services.—The services provided to a veteran under the pilot program shall include the following:

(1) Information on reintegration into the veteran’s family, employment, and community.

(2) Financial counseling.

(3) Occupational counseling.

(4) Information and counseling on stress reduction.

(5) Information and counseling on conflict resolution.

(6) Such other information and counseling as the Secretary considers appropriate to assist a woman veteran under the pilot program in reintegration into the veteran’s family and community.

(7) Location.—The Secretary shall carry out the pilot program at not fewer than five locations selected by the Secretary for purposes of the pilot program.
(d) DURATION.—The pilot program shall be carried out during the two-year period beginning on the date of the commencement of the pilot program.

(e) REPORT.—Not later than 180 days after the completion of the pilot program, the Secretary shall submit to Congress a report on the pilot program. The report shall contain the findings and conclusions of the Secretary as a result of the pilot program, and shall include such recommendations for the continuation or expansion of the pilot program as the Secretary considers appropriate.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Veterans Affairs for each of fiscal years 2010 and 2011, $2,000,000 to carry out the pilot program.

SEC. 206. REPORT ON FULL-TIME WOMEN VETERANS PROGRAM MANAGERS AT MEDICAL CENTERS.

The Secretary shall, acting through the Under Secretary for Health, submit to Congress a report on employment of full-time women veterans program managers at Department of Veterans Affairs medical centers by insured that health care needs of women veterans are met. Such report should include an assessment of whether there is at least one full-time employee at each Department of Veterans Affairs medical center who is a full-time women veterans program manager.

SEC. 207. SERVICE ON CERTAIN ADVISORY COMMITTEES.—WOMEN RECENTLY SEPARATED FROM SERVICE IN THE ARMED FORCES.

(a) ADVISORY COMMITTEE ON WOMEN VETERANS.—Section 522(a)(2)(A) is amended—

(1) in clause (ii), by striking “and” at the end;

(2) in clause (iii), by striking the period at the end and inserting “; and”; and

(3) by inserting after clause (iii) the following new clause:

“(iv) women veterans who are recently separated from service in the Armed Forces.”;

(b) ADVISORY COMMITTEE ON MINORITY VETERANS.—Section 5H1(a)(2)(A) is amended—

(1) in clause (iii), by striking “and” at the end;

(2) in clause (iv), by striking the period at the end and inserting “; and”; and

(3) by inserting after clause (iv) the following new clause:

“(v) women veterans who are minority group members and are recently separated from service in the Armed Forces.”;

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to appointments made on or after the date of the enactment of this Act.

SEC. 208. PILOT PROGRAM ON SUBSIDIES FOR CHILD CARE FOR CERTAIN VETERANS RECEIVING HEALTH CARE.

(a) PILOT PROGRAM REQUIRED.—The Secretary of Veterans Affairs shall carry out a pilot program to assess the feasibility and advisability of providing, subject to subsection (b), subsidies to qualified veterans described in subsection (c) to obtain child care so that such veterans can receive health care services described in such subsection.

(b) LIMITATION ON PERIOD OF PAYMENTS.—A subsidy may only be provided to a qualified veteran under the pilot program for receipt of child care during the two-year period beginning on the date of the certification by the Secretary as described in section 7683 of this title that an individual is eligible for participation in the Education Debt Reduction Program who—

(1) is a disabled veteran;

(2) is a dependent of a disabled veteran; or

(3) is a dependent of a veteran who died after the date of enactment of this Act.

(c) QUALIFIED VETERANS.—In this section, the term “qualified veteran” means an individual who—

(1) is an individual who has been determined by the Secretary to be a qualified veteran; and

(2) has a dependent child or children who is receiving from the Department of Veterans Affairs financial assistance for the support of such dependent child or children on the basis of such veteran’s service in the Armed Forces.

(d) DURATION.—The pilot program shall be carried out during the two-year period beginning on the date of the commencement of the pilot program.

(e) REPORT.—Not later than six months after the completion of the pilot program, the Secretary shall submit to Congress a report on the pilot program. The report shall include the findings and conclusions of the Secretary as a result of the pilot program, and shall include recommendations for the continuation or expansion of the pilot program as the Secretary considers appropriate.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Veterans Affairs for the two-year period beginning on the date of the enactment of this Act, $2,000,000 to carry out the pilot program.

SEC. 209. CARE FOR NEWBORN CHILDREN OF WOMEN VETERANS RECEIVING MATERNITY CARE.

(a) IN GENERAL.—The Secretary may furnish health care services described in subsection (b) to a newborn child of a woman veteran who is receiving maternity care furnished by the Department for not more than 7 days after the birth of the child if the veteran delivered the child—

(1) in a facility of the Department; or

(2) in another facility pursuant to a Department contract for services relating to such delivery.

(b) COVERED HEALTH CARE SERVICES.—Health care services furnished under this subsection are post-delivery care services, including routine care services, that a newborn requires.

(c) DURATION.—The table of sections at the beginning of chapter 17 is amended by inserting after the item relating to section 1786 the following new item:

“1796. Care for newborn children of women veterans receiving maternity care.”;

TITLE III—RURAL HEALTH IMPROVEMENTS

SEC. 301. ENHANCEMENT OF DEPARTMENT OF VETERANS AFFAIRS EDUCATION DEBT REDUCTION PROGRAM.

(a) ENHANCED MAXIMUM AMOUNT.—Paragraph (1) of section 7683(d) is amended by striking “$44,000” and all that follows through “five years of participation in the Program” and inserting “the total amount of principle and interest owed by the participant on loans referred to in subsection (a),”.

(b) NOTICE TO POTENTIAL EMPLOYERS OF EDUCATION DEBT REDUCTION PROGRAM.—Section 7682 is amended by adding at the end the following new subsection:

“(c) OUTREACH.—The Secretary shall publicize the scholarship program established...
under this chapter to educational institutions throughout the United States, with an emphasis on disseminating information to such institutions with high numbers of Hispanic students under Historically Black Colleges and Universities.

§ 7502. Application and acceptance

(a) Application.—(1) To apply and participate in the scholarship program under this chapter, an individual shall submit to the Secretary an application for such participation together with an agreement described in section 7504 of this chapter under which the participant agrees to serve a period of obligated service in the Department as provided in the agreement in return for payment of educational assistance as provided in the agreement.

(2) In distributing application forms and agreement forms to individuals desiring to participate in the scholarship program, the Secretary shall include with such forms the following:

(A) A fair summary of the rights and responsibilities of an individual whose application is approved (and whose agreement is accepted) by the Secretary.

(B) A full description of the terms and conditions that apply to participation in the scholarship program and service in the Department.

(b) Approval.—(1) Upon the Secretary's approval of an individual's participation in the agreement program, the Secretary shall, in writing, promptly notify the individual of that acceptance.

(2) An individual becomes a participant in the scholarship program upon such approval by the Secretary.

§ 7503. Amount of assistance; duration

(a) Amount of assistance.—The amount of the financial assistance provided for an individual under this chapter shall be the amount determined by the Secretary as being necessary to pay the tuition and fees of the individual. In the case of an individual enrolled in a program of study leading to a dual degree or certification in both the areas of study described in section 7501(a)(1) of this chapter, the tuition and fees shall not exceed the amount of credit hours to achieve such dual certification or degree.

(b) Relationship to other assistance.—Financial assistance may be provided to an individual under this chapter to supplement other educational assistance to the extent that the total amount of educational assistance to which an individual is entitled during an academic year does not exceed the total tuition and fees for such academic year.

(c) Maximum amount of assistance.—(1) In no case may the total amount of assistance provided under this chapter for an academic year to an individual who is a full-time student exceed $15,000.

(2) In the case of an individual who is a part-time student, the total amount of assistance provided under this chapter shall bear the same ratio to the amount that would be paid under paragraph (1) if the participant were a full-time student in the program of study being pursued by the individual as the coursework carried by the individual to full-time coursework in that program of study.

(d) Maximum duration of assistance.—The Secretary may provide financial assistance to an individual under this chapter for not more than six years.

§ 7504. Agreement

An agreement between the Secretary and a participant in the scholarship program under this chapter shall be in writing, shall be signed by the participant, and shall include—

(1) the Secretary's agreement to provide the participant with financial assistance as authorized under this chapter;

(2) the participant's agreement—

(A) to accept such financial assistance;

(B) to attend and attend in the program of study described in section 7501(a)(1) of this chapter;

(C) while enrolled in such program, to maintain an acceptable level of academic standing (as determined by the educational institution offering such program under regulations prescribed by the Secretary), and

(D) after the completion of the program, to serve as a full-time employee in the Department for a period of three years, to be served within the first six years after the participation period, in accordance with the requirements of agreement.

§ 7505. Repayment for failure to satisfy requirements of agreement

(a) In general.—An individual who receives an award under this chapter shall repay to the Secretary an amount equal to the unearned portion of such assistance if the individual fails to satisfy any requirement prescribed by the Secretary or makes any waiver or suspension of any obligation of an individual for service or payment under this chapter (or an agreement under this chapter) whenever noncompliance by the individual is due to circumstances beyond the control of the individual or whenever the Secretary determines that the waiver or suspension of compliance is not in the best interest of the United States.

(b) Obligation as debt to United States.—An obligation to repay the Secretary for any reason described in this section shall be considered to be a debt owed the United States. A discharge in bankruptcy under title 11 does not discharge a person from such debt if the discharge is obtained by the person more than three years after the date of the termination of the agreement or contract on which the debt is based.

(c) Clerical amendments.—The tables of chapters at the beginning of title 38, and part V of title 38, are each amended by inserting after the item relating to chapter 74 the following new item:

"75. Visual Impairment and Orientation and Mobility Professionals Education Assistance Program ... 7501."

(c) Effective date.—The Secretary of Veterans Affairs shall implement chapter 75 in the United States Code, as added by subsection (a), not later than six months after the date of the enactment of this Act.

SEC. 303. INCLUSION OF VETERANS AFFAIRS FACILITIES IN LIST OF FACILITIES ELIGIBLE FOR ASSISTANCE TO PARTICIPANTS IN NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP PROGRAM.

The Secretary of Veterans Affairs shall transfer the use and control of all Veterans Health Administration to the Secretary of Health and Human Services to include facilities of the Department of Veterans Affairs in the list maintained by the Health Resources and Services Administration of facilities eligible for assignment of participants in the National Health Service Corps Scholarship Program.

SEC. 304. TELECONSULTATION AND TELERETINAL IMAGING.

(a) Teleconsultation and teleretinal imaging.—

(1) In general.—Subchapter I of chapter 17 is amended by adding at the end the following new section—

"§ 1709. Teleconsultation and teleretinal imaging.

(a) Teleconsultation.—(1) The Secretary shall carry out a program of teleconsultation under this section for the provision of remote mental health and traumatic brain injury assessments in facilities of the Department that are not otherwise able to provide such assessments without contracting with third party providers or reimbursing providers through a fee-for-service system.

(2) The Secretary shall, in consultation with appropriate professional societies, promulgate technical and clinical care standards for the use of teleconsultation services within facilities of the Department.

(b) Teleretinal imaging.—The Secretary shall carry out a program of teleretinal imaging in each Veterans Integrated Services Network (VISN).

(c) Annual reports.—In each fiscal year beginning with fiscal year 2010 and ending with fiscal year 2015, the Secretary shall submit to Congress a report on the programs required by subsections (a) and (b). Such report shall include the following:

(1) A description of the efforts made by the Secretary to make teleconsultation available in rural areas and to utilize teleconsultation in rural areas.

(2) The rates of utilization of teleconsultation by Veterans Integrated Services Networks disaggregated by each fiscal year for which a report is submitted under this subsection.

(3) Definitions.—In this section:

"(d) Definitions.—In this section:

(1) The term ‘teleconsultation’ means the use by a health care specialist of telecommunications to consult with another health care provider in rendering a diagnosis or treatment.

(2) The term ‘teleretinal imaging’ means the use by a health care specialist of telecommunications to perform diagnostic studies of the eye and image interpretation to provide eye care."

(2) Clerical amendment.—The table of sections at the beginning of chapter 17 is amended by inserting after the item related to title 38 the following new item:

"1709. Teleconsultation and teleretinal imaging."

(b) Training in Telemedicine.—The Secretary of Veterans Affairs shall require each Department of Veterans Affairs facility that is involved in the training of medical residents to work with each university concerned to develop and expand its rotation in telemedicine for such residents.

(c) Enhancement of VERA.—

(1) Incentives for provision of teleconsultation, teleretinal imaging, telemedicine, and telehealth coordination services.—The Secretary of Veterans Affairs shall modify the Veterans Equitable Resource Allocation system to provide Veterans Integrated Services Networks with incentives to utilize teleconsultation, teleretinal imaging, telemedicine, and telehealth coordination services.

(2) Inclusion of Telemedicine Visits in Workload Reporting.—The Secretary shall modify the Veterans Equitable Resource Allocation system to count teleretinal imaging and all telemedicine visits in the calculation of facility workload.
(d) DEFINITIONS.—In this section:

(1) The terms ‘‘teleconsultation’’ and ‘‘teleretention imaging’’ have the meanings given such terms in section 1709 of title 38, United States Code, as added by subsection (a).

(2) The term ‘‘telemedicine’’ means the use by a health care provider of telecommunications to assist in the diagnosis or treatment of a patient’s medical condition.

(3) The term ‘‘telehealth’’ means the use of telecommunications to collect patient data remotely and send data to a monitoring station for interpretation.

SEC. 305. DEMONSTRATION PROJECTS ON ALTERNATIVE HEALTH CARE FOR VETERANS IN RURAL AREAS.

(a) IN GENERAL.—The Secretary of Veterans Affairs, through the Director of the Office of Rural Health, may carry out demonstration projects to examine the feasibility and advisability of alternatives for expanding care for veterans in rural areas, which may include the following:

(1) Establishing a partnership between the Department of Veterans Affairs and the Centers for Medicare and Medicaid Services of the Department of Health and Human Services to coordinate care for veterans in rural areas at critical access hospitals (as defined under section 608 of the Social Security Act (42 U.S.C. 1395s)).

(2) Establishing a partnership between the Department of Veterans Affairs and the Department of Health and Human Services to coordinate care for veterans in rural areas at community health centers.

(3) Expanding coordination between the Department of Veterans Affairs and the Indian Health Service to expand care for Indian veterans.

(b) GEOGRAPHIC DISTRIBUTION.—The Secretary shall ensure that the demonstration projects carried out under subsection (a) are located at facilities that are geographically distributed throughout the United States.

(c) REPORT.—Not later than two years after the date of the enactment of this Act, the Secretary shall submit a report on the results of the demonstration projects conducted under subsection (a) to—

(1) the Committee on Veterans’ Affairs and the Committee on Appropriations of the Senate; and

(2) the Committee on Veterans’ Affairs and the Committee on Appropriations of the House of Representatives.

(d) VETERANS HEALTH CARE COORDINATORS.—There is authorized to be appropriated to carry out this section $5,000,000 for fiscal year 2010 and each fiscal year thereafter.

SEC. 306. PROGRAM ON PROVISION OF READJUSTMENT AND MENTAL HEALTH CARE SERVICES TO VETERANS WHO SERVED IN OPERATION IRAQI FREEDOM AND OPERATION ENDURING FREEDOM.

(a) PROGRAM REQUIRED.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall establish and provide—

(1) to veterans of Operation Iraqi Freedom and Operation Enduring Freedom, particularly veterans who served in such operations while in the National Guard and the Reserves—

(A) peer outreach services;

(B) peer support services;

(C) counseling and services described in section 1721A of title 38, United States Code; and

(D) mental health services; and

(2) to the immediate family of such a veteran, during the three-year period beginning on the date of the return of such veteran from deployment in Operation Iraqi Freedom or Operation Enduring Freedom—

(A) education, support, counseling, and mental health services to assist in—

(A) the readjustment of such veteran to civilian life;

(B) in the case such veteran has an injury or illness incurred during such deployment, the recovery of such veteran; and

(C) the readjustment of the family following the return of such veteran.

(b) CONTRACTING MENTAL HEALTH CENTERS AND QUALIFIED ENTITIES FOR PROVISION OF SERVICES.—In carrying out the program required by subsection (a), the Secretary shall contract with community mental health centers and other qualified entities to provide the services required by such subsection only in areas the Secretary determines are not adequately served by other health care facilities or vet centers of the Department of Veterans Affairs. Such contracts shall require each contracting community mental health center or entity—

(1) to the extent practicable, to use telehealth services for the delivery of services required by subsection (a);

(2) to the extent practicable, to employ veterans trained under subsection (c);

(3) to participate in the training program conducted in accordance with subsection (d);

(4) to comply with applicable protocols of the Department before incurring any liability on behalf of the Department for the provision of the services required by subsection (a);

(5) for each veteran for whom a community mental health center or other qualified entity provides care under such contract, to provide the Department with such clinical summary information as the Secretary shall require;

(6) to submit annual reports to the Secretary containing, with respect to the program required by subsection (a) and for the last full calendar year ending before the submission of such report—

(A) the number of the veterans served, veterans diagnosed, and courses of treatment provided for such veterans required by paragraph (1);

(B) demographic information for such services, diagnoses, and courses of treatment; and

(7) to meet such other requirements as the Secretary shall require.

(c) TRAINING OF VETERANS FOR THE PROVISION OF TELEHEALTH AND PEER-SUPPORT SERVICES.—In carrying out the program required by subsection (a), the Secretary shall—

(1) conduct a training program for veterans of community mental health centers or entities that have contracts with the Secretary under subsection (b) to ensure that such veterans can provide the services required by subsection (a) in a manner that—

(A) recognizes factors that are unique to the experience served on active duty in Operation Iraqi Freedom or Operation Enduring Freedom (including their combat and military training experiences); and

(B) utilizes best practices and technologies.

(d) REPORTS REQUIRED.—

(1) INITIAL PLAN FOR IMPLEMENTATION.—Not later than 45 days after the date of the enactment of this Act, the Secretary shall submit to the Committee on Veterans’ Affairs of the Senate and the Committee on Veterans’ Affairs of the House of Representatives a report containing the plans of the Secretary to implement the program required by subsection (a).

(2) STATUS REPORT.—Not later than one year after the date of the enactment of this Act, the Secretary shall submit to the Committee on Veterans’ Affairs of the Senate and the Committee on Veterans’ Affairs of the House of Representatives a report on the implementation of the program. Such report shall include the following:

(A) Information on the number of veterans who received services as part of the program implementation of the program; and

(B) A recommendation as to whether the period described in such paragraph should be extended to a five-year period.

SEC. 307. IMPROVEMENTS IN CARE OF AMERICAN INDIAN VETERANS.

(a) INDIAN HEALTH CoORDINATORS.—

(1) IN GENERAL.—Subchapter II of chapter 73 of title 38, United States Code, is amended by inserting after the item relating to Operational Stress Injury Prevention and Recovery Program the following new item:

7330B. Indian Veterans Health Care Coordinators.

(2) The Secretary shall—

(A) survey the Department Medical Centers for purposes of identifying the 10 Department Medical Centers that currently serve communities with the greatest number of Indian veterans per capita; and

(B) utilizing the results of the most recent survey conducted under subparagraph (A), assign to each of the Department Medical Centers the greatest number of Indian veterans per capita.

(b) DUTIES.—The duties of an Indian Veterans Health Care Coordinator shall include the following:

(1) Improving outreach to tribal communities.

(2) Coordinating the medical needs of Indian veterans on Indian reservations with the Indian Health Service Administration and the Indian Health Service.

(3) Expanding the access and participation of the Department of Veterans Affairs, the Indian Health Service, and tribal members in the Department of Veterans Affairs Tribal Veterans Representative program.

(4) Acting as an ombudsman for Indian veterans enrolled in the health care system of the Veterans Health Administration.

(5) Advocating for the incorporation of traditional medicine and healing in Department treatment plans for Indian veterans in need of care and services provided by the Department.

(c) INDIAN DEFINED.—In this section, the term ‘‘Indian’’ has the meaning given the term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 460j)."

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 is amended by inserting after the item relating to 7328A the following:

7328B. Indian Veterans Health Care Coordinators.

(b) INTEGRATION OF ELECTRONIC HEALTH RECORDS WITH INDIAN HEALTH SERVICE.—Not later than one year after the date of the enactment of this Act, the Secretary of Veterans Affairs and the Secretary of Health

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and Human Services shall enter into a memorandum of understanding to ensure that the health records of Indian veterans may be transferred electronically between facilities of the Indian Health Service and the Department of Veterans Affairs.

(c) Transfer of Medical Equipment to the Department of Veterans Affairs—(1) In General.—The Secretary of Veterans Affairs may transfer to the Indian Health Service such surplus Department of Veterans Affairs medical equipment as necessary to carry out the purposes of this section.

(2) Transportation and Installation.—In transferring medical or information technology equipment under this subsection, the Secretary of Veterans Affairs may transport and install such equipment in facilities of the Indian Health Service.

(d) Report on Joint Health Clinics With Indian Tribes—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs and the Secretary of Health and Human Services shall provide to Congress a report on the feasibility and advisability of the joint establishment and operation by the Veterans Health Administration and the Indian Health Service of Indian health clinics on reservations to serve the populations of such reservations, including Indian veterans.

SEC. 308. THE REIMBURSEMENT FOR VETERANS RECEIVING TREATMENT AT FACILITIES OF THE DEPARTMENT OF VETERANS AFFAIRS.

(a) Enhancement of Allowance Based Upon Mileage Traveled.—Section 111 is amended—

(1) in subsection (a), by striking “travel,” and inserting “(at a rate of 41.5 cents per mile),”; and

(2) by amending subsection (g) to read as follows:

“(g)(1) Beginning one year after the date of the enactment of the Caregivers and Veterans Omnibus Health Services Act of 2009, the Secretary may adjust the mileage rate described in subsection (a) to be equal to the mileage reimbursement rate for the use of privately owned vehicles by Government employees (when a Government-owned vehicle is available), as prescribed by the Administrator of General Services under section 5(b) of the Federal Property and Administrative Services Act of 1949 (41 U.S.C. 651).

“(2) If an adjustment in the mileage rate under paragraph (1) results in a lower mileage rate than the mileage rate otherwise specified in subsection (a), the Secretary shall not later than 60 days before the date of the implementation of the mileage rate as so adjusted, submit to Congress a written report setting forth the adjustment in the mileage rate under this subsection, together with a justification for the decision to make the adjustment in the mileage rate under this subsection.”

(b) Coverage of Cost of Transportation by Air.—Subsection (a) of section 111, as amended by subsection (a)(1), is further amended by inserting after the first sentence the following new sentence: “Actual necessary expense of travel includes the reasonable cost of transportation by air and is the only practical way to reach a Department facility.”

(c) Elimination of Limitation Based on Maximum Annual Rate of Pension.—Subsection (b)(1)(D)(i) of section 111 is amended by inserting “who is not traveling by air and” before “whose annual.”

(d) Consideration of Practicality.—Subsection (b) of such section is amended by adding at the end the following new paragraph:

“(4) In determining for purposes of subsection (a) whether travel by air is the only practical way for a veteran to reach a Department facility, the Secretary shall consider the medical condition of the veteran and any other impediments to the use of ground transportation the veteran.”

(e) No Expansion of Eligibility for Beneficiary Travel.—(1) The amendments made by subsection (a) of this section may not be construed as expanding or otherwise modifying eligibility for payments or allowances for beneficiary travel under section 111 of title 38, United States Code, as in effect on the day before the date of the enactment of this Act.

(2) Clarification of Relation to Public Travel Rates.—Section 111 of title 38, United States Code, as revised by the Secretary to encourage participation in the voluntary peer review under subsection (d), as inserted by such section, shall be read as follows:

“(1) The Secretary shall provide for coordinating care and collaborating with such clinic reside in a highly rural area. The Secretary shall designate a rural outreach coordinator for each facility. The Secretary may adjust the mileage rate so that the health records of Indian veterans and their spouses may be shared among hospitals, clinics, and medical facilities of the Indian Health Service and the Department of Veterans Affairs. The Secretary of Health and Human Services shall enter into a Memorandum of Understanding to share health records of Indian veterans and their spouses with the Department of Veterans Affairs. The Secretary may adjust the mileage rate so that the health records of Indian veterans and their spouses may be shared among hospitals, clinics, and medical facilities of the Indian Health Service and the Department of Veterans Affairs. The Secretary, the Secretary of Veterans Affairs, and the Secretary of Health and Human Services jointly consider appropriate for purposes of transportation and installation. In transiting medical information technology equipment under this subsection, the Secretary of Veterans Affairs may transport and install such equipment in facilities of the Indian Health Service. The Secretary of Veterans Affairs may purchase equipment to repair or maintain such equipment in facilities of the Indian Health Service.

SEC. 309. OFFICE OF RURAL HEALTH FIVE-YEAR STRATEGIC PLAN.

(a) Strategic Plan.—Not later than 180 days after the date of the enactment of this Act, the Director of the Office of Rural Health of the Department of Veterans Affairs shall develop a five-year strategic plan for the Office of Rural Health.

(b) Contents.—The plan required by subsection (a) shall include—

(1) Specific goals for the recruitment and retention of health care personnel in rural areas, developed in conjunction with the Director of the Office of Rural Health Administration Handbook to clarify that an allowance for travel based on mileage paid under section 111(a) of title 38, United States Code, may exceed the cost of such travel by public transportation regardless of medical necessity.

(2) Each year, beginning with the first fiscal year following the date of the enactment of this section, the Secretary shall provide the Secretary of Veterans Affairs with a report on the implementation of the five-year strategic plan required by subsection (a) of this section.

(3) The Chief Quality and Performance Officer of each Veterans Integrated Services Network shall designate Department facilities in such network for the peer review of patient records submitted under this subsection.

(4) Each year, beginning with the first fiscal year following the date of the enactment of this section, the Secretary shall submit to the Secretary of Veterans Affairs a report on the implementation of the five-year strategic plan required by subsection (a) of this section.

(5) Each Department facility designated under paragraph (3) that receives patient records under paragraph (4) shall—

(A) peer review such records in accordance with policies and procedures established by the Secretary;

(B) ensure that peer reviews are evaluated by the Peer Review Subcommittee; and

(C) develop a mechanism for notifying the Secretary of Veterans Affairs when quality of care concerns are identified through such peer review.

(6) The Secretary of Veterans Affairs shall develop a mechanism for notifying the Secretary of Health and Human Services when quality of care concerns are identified through such peer review.

(7) The Chief Quality and Performance Officer of each Veterans Integrated Services Network shall be responsible for the oversight of the program of peer review under this subsection in that network.”

SEC. 310. OVERSIGHT OF CONTRACT AND FEE-BASIS CARE.

(a) In General.—Subchapter I of chapter 17 is amended by inserting after section 1703 the following new section:

“§ 1703A. Oversight of contract and fee-basis care

“(a) Rural Outreach Coordinators.—The Secretary shall designate a rural outreach coordinator at each Department community based outpatient clinic which not less than 50 percent of the veterans enrolled at such clinic reside in a highly rural area. The coordinator at a clinic shall be responsible for carrying out the functions specified in paragraph (1) and the duties specified in paragraph (2) to a facility selected under paragraph (3) to be peer reviewed by such facility.

“(b) Incentives to Obtain Accreditation of Medical Providers.—The Secretary shall adjust the fee-basis compensation of providers of health care services under the Department to encourage such providers to obtain accreditation through a recognized accrediting entity.

“(c) Incentives for Participation in Peer Review.—(1) The Secretary shall adjust the fee-basis compensation of providers of health care services under the Department that do not provide such services as part of a medical practice accredited by a recognized accrediting entity to encourage such providers to participate in peer review under subsection (d).

“(2) The Secretary shall provide incentives for participating providers of health care services under the Department who participate in peer review under subsection (d).”

SEC. 311. ENHANCEMENT OF VET CENTERS TO MEET NEEDS OF VETERANS OF OPERATION IRAQI FREEDOM AND OPERATION ENDURING FREEDOM.

(a) Volunteer Care Coordination—(1) In General.—Subsection (c) of section 1712A is amended—

(A) by striking “The Under Secretary” and inserting “(1) The Secretary”;

(B) in paragraph (1), as designated by paragraph (1), by striking “and, in carrying” and inserting “and, in carrying out the following new paragraphs;”;

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

“(2) In carrying out this section, the Under Secretary may utilize the services of the following:

[Preceding text]

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services to veterans in rural areas.

clinical activities and systems of care for the furnishing of health services to veterans in rural areas;

on the furnishing of health services to veterans in rural areas;

1 and not more than five centers of excellence for rural health research, education, and clinical activities, which shall—

Secretary, through the Director of the Office of Veterans Integrated Services Networks (VISNs).

452c. Centers of excellence for rural health research, education, and clinical activities.

section 1712a(c)(4), as added by paragraph (1).

activities.”

is named in a tort claim arising from professional activities; and

has never had, and has no pending, disciplinary action taken with respect to any license or certification qualifying that individual to provide counseling services; or

is who is otherwise credentialed and privileged to perform counseling services by the Secretary.

(ii) provides counseling services without compensation;

(ii) is a licensed psychologist or social worker;

never have been named in a tort claim arising from professional activities; and

has never had, and has no pending, disciplinary action taken with respect to any license or certification qualifying that individual to provide counseling services; or

(A) the hospital is located in a health professional shortage area;

result of the survey) is sufficient for purposes of the pilot program.

(c) GEOGRAPHIC DISPERSION.—The Secretary shall ensure that the centers established under this section are located at health care facilities that are geographically dispersed throughout the United States.

(d) FUNDING.—(1) There are authorized to be appropriated to the Medical Care Account and the Medical and Prosthetics Research Account of the Department of Veterans Affairs such sums as may be necessary for the support of the research and education activities of the centers operated under this section.

(2) There shall be allocated to the centers operated under this subsection from amounts authorized to be appropriated to the Medical Care Account and the Medical and Prosthetics Research Account by paragraph (1), such amounts as the Secretary of health considers appropriate for such centers. Such amounts shall be allocated through the Director of the Office of Rural Health.

(3) Activities of clinical and scientific investigation at each center operated under this section—

(A) shall be eligible to compete for the award of funding from funds appropriated for the Medical and Prosthetics Research Account; and

(B) shall receive priority in the award of funding from such account to the extent that funds are awarded to projects for research in the care of veterans who are receiving care at such centers.

1(1) in paragraph:

“(i) The Secretary”; and

“(ii) has never been named in a tort claim arising from professional activities; and

which—

who—

not later than 60 days after receipt of the application.

(1) ESTABLISHMENT OF CENTERS.—The Secretary of Veterans Affairs shall establish the procedures described in section 1712a(c)(4), as added by paragraph (1).

(2) COMMUNITY HOSPITALS.—Any community hospital may be selected by the Secretary as a location for the pilot program or the commencement of the pilot program.

(3) TREATMENT OF COMPENSATION.—The Secretary shall carry out a pilot program to assess the feasibility and advisability of each of the following:

(1) The provision of financial incentives to eligible physicians who obtain and maintain inpatient privileges at community hospitals in health professional shortage areas in order to facilitate the discharge of eligible physicians of primary care and mental health services to veterans at such hospitals.

(2) The collection of payments from third-party providers for care provided by eligible physicians to nonveterans while discharging inpatient responsibilities at community hospitals in the course of exercising the privileges described in paragraph (1).

(3) ELIGIBLE PHYSICIANS.—For purposes of this section, an eligible physician is a primary care or mental health physician employed by the Department of Veterans Affairs on a full-time basis.

LOCATION.—The pilot program shall be carried out during the three-year period beginning on the date of the commencement of the pilot program.

(b) ELIGIBLE PHYSICIANS.—For purposes of this section, an eligible physician is a primary care or mental health physician employed by the Department of Veterans Affairs.

The Secretary shall conduct a survey of eligible physicians who—

(A) express interest in participating in the pilot program;

(B) are in good standing with the Department; and

(C) primarily have clinical responsibilities with the Department.

(2) VOLUNTARY PARTICIPATION.—Participation in the pilot program is voluntary.

Nothing in this section shall be construed to require a physician working for the Department to assume inpatient responsibilities at a hospital.

(3) PROCEDURES FOR ISSUING CREDENTIALS AND PRIVILEGES TO VOLUNTEER COUNSELORS.—Not later than one year after the date of the enactment of this Act, the Secretary of Veterans Affairs shall establish the procedures for the issuance of credentials and privileges for the provision of counseling and related mental health services.

(iii) has never been named in a tort claim arising from professional activities; and

(iv) has never had, and has no pending, disciplinary action taken with respect to any license or certification qualifying that individual to provide counseling services; or

(3) activities.

(4) Eligible volunteer counselors shall be issued credentials and privileges for the provision of counseling and related mental health services under this section on an expedited basis in accordance with such procedures as the Secretary shall establish. Such procedures shall provide for the completion of such credentials and privileges not later than 60 days after receipt of the application.

(2) PROCEDURES FOR ISSUING CREDENTIALS AND PRIVILEGES TO VOLUNTEER COUNSELORS.—Not later than one year after the date of the enactment of this Act, the Secretary of Veterans Affairs shall establish the procedures for the issuance of credentials and privileges for the provision of counseling and related mental health services.

(1) The Secretary shall provide for the completion of such credentials and privileges not later than 60 days after receipt of the application.

(2) After the establishment of such procedures, the Secretary shall conduct a survey of eligible physicians who—

(A) who—

(1) in paragraph:

“(iii) has never been named in a tort claim arising from professional activities; and

(2) in paragraph:

(A) in paragraph:

(1) The Secretary shall provide for the completion of such credentials and privileges not later than 60 days after receipt of the application.

(2) After the establishment of such procedures, the Secretary shall conduct a survey of eligible physicians who—

(A) who—

(1) in paragraph:

“(iii) has never been named in a tort claim arising from professional activities; and

(2) in paragraph:

(A) in paragraph:

(1) The Secretary shall provide for the completion of such credentials and privileges not later than 60 days after receipt of the application.

(2) After the establishment of such procedures, the Secretary shall conduct a survey of eligible physicians who—

(A) who—

(1) in paragraph:

“(iii) has never been named in a tort claim arising from professional activities; and

(2) in paragraph:

(A) in paragraph:

(1) The Secretary shall provide for the completion of such credentials and privileges not later than 60 days after receipt of the application.

(2) After the establishment of such procedures, the Secretary shall conduct a survey of eligible physicians who—

(A) who—

(1) in paragraph:

“(iii) has never been named in a tort claim arising from professional activities; and

(2) in paragraph:

(A) The Secretary shall develop the outreach plan to ensure that the community served by the center is aware of the services offered by the center.

(2) Each center shall develop an outreach plan to ensure that the community served by the center is aware of the services offered by the center.

SEC. 312. CENTERS OF EXCELLENCE FOR RURAL HEALTH RESEARCH, EDUCATION, AND CLINICAL ACTIVITIES.

(a) In General.—In chapter II of chapter 73, as amended by section 307 of this Act, is further amended by adding at the end the following new section:

“(G) Services to veterans at such hospitals.

(1) The Secretary shall in the course of exercising the privileges to practice at such hospital are conditioned upon the provision of services to individuals who are not veterans while the physician is on call for such hospital, the provision of such services by the physician shall be considered an action within the scope of the physician’s office or employment purposes of section 26, United States Code (commonly referred to as the “Federall Tort Claims Act”).

(h) COMPENSATION.—(1) In General.—The Secretary shall provide each eligible physician participating in the pilot program with such compensation (including pay and other appropriate compensation) as the Secretary determines to be appropriate to compensate such physician for the discharge of any inpatient responsibilities by such physician at a community hospital for which the compensation would not otherwise be compensated by the Department as a full-time employee of the Department.

(2) WRITTEN AGREEMENT.—The amount of any compensation to be provided a physician under the pilot program shall be specified in a written agreement entered into by the Secretary and the physician for purposes of the pilot program.

(3) TREATMENT OF COMPENSATION.—The Secretary shall consult with the Director of the Office of Personnel Management on the inclusion of a provision in the written agreement required under paragraph (2) that describes the treatment under Federal law of any compensation provided a physician under the pilot program, including treatment for purposes of retirement under the civil service laws.
SEC. 316. MODIFICATION OF ELIGIBILITY FOR PARTICIPATION IN PILOT PROGRAM OF IN-PATIENT RESPONSIBILITIES DEFINED.—In this section, the term "in-patient responsibilities" means any responsibilities required of a physician by a community hospital as a condition of granting of (a) chronic care for veterans living in rural areas.

(a) ANNUAL REPORT.—The Secretary of Veterans Affairs shall submit to Congress each year a report, together with documents submitted to Congress in support of the budget for the fiscal year ending in such fiscal year, an assessment, current as of the date of the report, of the activities of the pilot program under this section.

(b) USE OF FUNDS TRANSFERRED.—Funds transferred to the Secretary of Veterans Affairs under subsection (a) shall be subject to the availability of appropriations for such transfer.

(c) AUTHORIZATION OF APPROPRIATIONS.—The Secretary shall submit to Congress a report on the progress of the pilot program under this section.

(d) REGULATIONS.—The Secretary shall, by regulation, establish the eligibility criteria for participation in the pilot program under this section.

SEC. 401. ELIGIBILITY OF MEMBERS OF THE ARMED FORCES NOT AUTHORIZED COUNSELING PROGRAM.

(a) STUDY REQUIRED.—The Secretary of Veterans Affairs shall submit to Congress a study of the number of veterans who died by suicide between January 1, 1999, and the date of the enactment of this Act, and the findings of the Secretary.

(b) USE OF FUNDS TRANSFERRED.—Funds transferred under subsection (a) shall be subject to the availability of appropriations for such transfer.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $50,000 for each of fiscal years 2010 through 2014 to carry out this section.

(d) CONGRESSIONAL REPORT.—The Secretary of Veterans Affairs shall submit to Congress a report on the progress of the pilot program under this section.

(e) REGULATIONS.—The eligibility of members of the Armed Forces who serve in Operation Iraqi Freedom or Operation Enduring Freedom to participate in the pilot program under this section shall be subject to the availability of appropriations for such transfer.

(f) REPORT TO CONGRESS.—The Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the progress of the pilot program under this section.

TITLED—MENTAL HEALTH CARE MATTERS

SEC. 401. ELIGIBILITY OF MEMBERS OF THE ARMED FORCES WHO SERVE IN OPERATION IRAQI FREEDOM OR OPERATION ENDURING FREEDOM FOR READING AND WRITING SERVICES THROUGH READJUSTMENT COUNSELING SERVICE.

(a) IN GENERAL.—Any member of the Armed Forces, including a member of the National Guard or Reserve, who serves on active duty in the Armed Forces in Operation Iraqi Freedom or Operation Enduring Freedom is eligible for readjustment counseling and related mental health services under this section.

(b) REQUIREMENT FOR CURRENT ACTIVE DUTY.—A member of the Armed Forces who is on active duty is eligible for counseling and services under subsection (a) is entitled to counseling and services under this section.
to award grants to support the training of psychologists in the treatment of veterans with post-traumatic stress disorder, traumatic brain injury, and other combat-related disorders.

(c) Preference for Department of Veterans Affairs Health Care Facilities.—In the award of contracts under subchapter II of chapter 73 of this title, the Secretary shall give preference to health care facilities of the Department of Veterans Affairs and graduate medical centers of education that are affiliated with such facilities.

TITLE V—OTHER HEALTH CARE MATTERS

SEC. 501. REPEAL OF CERTAIN ANNUAL REPORT REQUIREMENTS.

(a) Nurse Pay Report.—Section 7451 is amended by—

(1) by striking subsection (f); and

(2) by redesignating subsection (g) as subsection (f).

(b) Long-Term Planning Report.—

(1) In General.—Section 807 is repealed.

(2) Conforming Amendment.—The table of sections at the beginning of chapter 81 is amended by striking the item relating to section 807.

SEC. 502. MODIFICATIONS TO ANNUAL GULF WARS RESEARCH REPORT.

Section 707(c)(1) of the Persian Gulf War Veterans Disability Compensation Act (title VII of Public Law 102-585; 38 U.S.C. 527 note) is amended by striking “Not later than March 1 of each year” and inserting “Not later than July 1 of each of the five following years”.

SEC. 503. PAYMENT FOR CARE FurnISHED TO CHAMPVA BENEFICIARIES.

Section 1709 is amended by inserting after the item relating to section (f).

“(a) Required Disclosure of Social Security Number.—(1) Any individual who applies for or is in receipt of care described in this paragraph shall, at the time of such application, or otherwise when requested by the Secretary, submit to the Secretary—

(A) the individual’s social security number; and

(B) the social security number of any dependent or Department beneficiary on whose behalf, or based upon whom, such individual applies for or is in receipt of such care.

(2) The care described in this paragraph includes—

(A) hospital, nursing home, or domiciliary care;

(B) medical, rehabilitative, or preventive health services;

(C) other medical care under laws administered by the Secretary.

(b) Required Disclosure of Social Security Number.—(1) Any individual who applies for or is in receipt of care described in this paragraph (2) shall, at the time of such application, or otherwise when requested by the Secretary, submit to the Secretary—

(A) the individual’s social security number; and

(B) the social security number of any dependent or Department beneficiary on whose behalf, or based upon whom, such individual applies for or is in receipt of such care.

(2) The care described in this paragraph includes—

(A) hospital, nursing home, or domiciliary care;

(B) medical, rehabilitative, or preventive health services;

(C) other medical care under laws administered by the Secretary.

(c) Failure to Disclose Social Security Number.—(1) The Secretary shall deny an individual’s application for, or may terminate an individual’s enrollment in, the system of patient enrollment established by the Secretary under section 1705 of this title, if such individual does not provide the social security number required or requested to be submitted pursuant to paragraph (2).

(2) Following a denial or termination under paragraph (1) with respect to an individual, the Secretary may, upon receipt of the information required or requested under subsection (b), approve such individual’s application or reinstate such individual’s enrollment (if otherwise in order), for such medical care and services provided on and after the date of such receipt of information.

(d) Construction.—Nothing in this section shall be construed as authorizing the Secretary to deny medical care and treatment to an individual in a medical emergency.

(2) Clerical Amendment.—The table of sections at the beginning of chapter 17 is amended by inserting after the item relating to section 1708 the following new item:

“1709. Disclosure to Secretary of health-plan contract information and social security number of certain veterans receiving care.”.

SEC. 504. DISCLOSURES FROM CERTAIN MEDICAL RECORDS.

Section 7321(b)(2) is amended by adding at the end the following new subparagraph:

“(F)(ii) To a representative of a patient who lacks decision-making capacity, when a practitioner deems the content of the given record necessary for that representative to make an informed decision regarding the patient’s treatment.

(ii) In this subparagraph, the term ‘representative’ means an individual, organization, or other body authorized under section 7301 of this title and its implementing regulations to give informed consent on behalf of a patient who lacks decision-making capacity.”.

SEC. 505. DISCLOSURE TO SECRETARY OF HEALTH-PLAN CONTRACT INFORMATION AND SOCIAL SECURITY NUMBER OF CERTAIN VETERANS RECEIVING CARE.

(a) In General.—Subchapter I of chapter 17 is amended by adding at the end the following new section:

“§ 1709. Disclose to Secretary of health-plan contract information and social security number of certain veterans receiving care—

(a) Required Disclosure of Health-Plan Contracts.—(1) Any individual who applies for or is in receipt of care described in paragraph (2) shall, at the time of such application, or otherwise when requested by the Secretary, submit to the Secretary such contract information and social security number as the Secretary may require to identify any health-plan contract (as defined in section 1729(i) of this title) under which such individual is covered, to include, as applicable—

(A) the name, address, and telephone number of such health-plan contract;

(B) the name of the individual’s spouse, if the individual’s coverage is under the spouse’s health-plan contract;

“(C) the plan number; and

“(D) the plan’s group code.

(2) The care described in this paragraph includes—

(A) hospital, nursing home, or domiciliary care;

(B) medical, rehabilitative, or preventive health services;

(C) other medical care under laws administered by the Secretary.

(b) Required Disclosure of Social Security Number.—(1) Any individual who applies for or is in receipt of care described in this paragraph (2) shall, at the time of such application, or otherwise when requested by the Secretary, submit to the Secretary—

(A) the individual’s social security number; and

(B) the social security number of any dependent or Department beneficiary on whose behalf, or based upon whom, such individual applies for or is in receipt of such care.

(2) The care described in this paragraph includes—

(A) hospital, nursing home, or domiciliary care;

(B) medical, rehabilitative, or preventive health services;

(C) other medical care under laws administered by the Secretary.

(c) Failure to Disclose Social Security Number.—(1) The Secretary shall deny an individual’s application for, or may terminate an individual’s enrollment in, the system of patient enrollment established by the Secretary under section 1705 of this title, if such individual does not provide the social security number required or requested to be submitted pursuant to paragraph (2).

(2) Following a denial or termination under paragraph (1) with respect to an individual, the Secretary may, upon receipt of the information required or requested under subsection (b), approve such individual’s application or reinstate such individual’s enrollment (if otherwise in order), for such medical care and services provided on and after the date of such receipt of information.

(d) Construction.—Nothing in this section shall be construed as authorizing the Secretary to deny medical care and treatment to an individual in a medical emergency.

(2) Clerical Amendment.—The table of sections at the beginning of chapter 17 is amended by inserting after the item relating to section 1708 the following new item:

“1709. Disclosure to Secretary of health-plan contract information and social security number of certain veterans receiving care.”.

SEC. 506. ENHANCEMENT OF QUALITY MANAGEMENT.

(a) Enhancement of Quality Management Through Quality Management Officers.—

(1) In General.—Subchapter II of chapter 73 is amended by inserting after section 7311 the following new section:

“§ 7311A. Quality management officers—

(a) National Quality Management Officer.—(1) The Under Secretary for Health shall designate an official of the Veterans Health Administration to act as the principal quality management officer for the quality-assurance program required by section 7311 of this title. The official so designated shall be the ‘National Quality Management Officer of the Veterans Health Administration’ (in this section referred to as the ‘National Quality Management Officer’).

(2) The National Quality Management Officer shall report directly to the Under Secretary for Health in the discharge of responsibilities and duties of the Officer under this section.

(b) The National Quality Management Officer shall be the official within the Veterans Health Administration who is principally responsible for the quality-assurance program referred to in paragraph (1).

(2) Developing an aggregate quality metric from existing data sources, such as the Inpatient Evaluation Center, the National Surgical Quality Improvement Program, the External Peer Review Program of the Veterans Health Administration, that could be used to assess reliably the quality of care provided at individual Department medical centers and associated community based outpatient clinics.

(3) Ensuring that existing measures of quality, including measures from the Inpatient Evaluation Center, the National Surgical Quality Improvement Program, System-Wide Ongoing Assessment and Review reports of the Department, and Combined Assessment Program reviews of the Office of Inspector General, are monitored routinely and analyzed in a manner that ensures the timely detection of quality of care issues.

(4) Encouraging research and development in the area of quality metrics for the purposes of improving how the Department measures quality in individual facilities.

(5) Carrying out such responsibilities and duties relating to quality management in the Veterans Health Administration as the Under Secretary for Health shall specify.

(6) The requirements under paragraph (3) shall include requirements regarding the following:

(A) A confidential system for the submittal of reports by Veterans Health Administration personnel regarding quality management at Department facilities.

(B) Mechanisms for the peer review of the actions of individuals appointed in the Veterans Health Administration in the position of physician.

(c) Quality Management Officers for VISNs.—(1) The Regional Director of each Veterans Integrated Service Network (VISN) shall appoint an individual of the Network to act as the quality management officer of the VISN.

(2) The quality management officer for a Veterans Integrated Service Network shall report to the Regional Director of the Veterans Integrated Service Network, and to the National Quality Management Officer, regarding the discharge of the responsibilities and duties of the officer under this section.

(3) The quality management officer for a Veterans Integrated Service Network shall—

(A) direct the quality management office in the Network; and

(B) coordinate, monitor, and oversee the quality management programs and activities of the Department’s medical facilities in the Network in order to ensure the thorough and uniform discharge of quality management requirements under such programs and activities throughout the VISN.

(c) Quality Management Officers for Medical Facilities.—(1) The director of each Veterans Health Administration medical facility shall appoint a quality management officer for that facility.

(2) The quality management officer for a facility shall report directly to the Director of the facility, and to the quality management officer of the Veterans Integrated Service Network.
Services Network in which the facility is located, regarding the discharge of the responsibilities and duties of the quality management officer under this section.

(3) The quality management officer for a facility shall be responsible for designing, disseminating, and implementing quality management programs and activities for the facility that meet the requirements established by the National Quality Management Officer under subsection (a).

(d) AUTHORIZATION OF APPROPRIATIONS.—
(1) In addition to the funds appropriated to the Veterans Health Administration for the fiscal years 2010, 2011, and 2012, there are authorized to be appropriated such sums as may be necessary to carry out this section.

(2) There are authorized to be appropriated to carry out the provisions of subsection (a) such sums as may be necessary to carry out this section.

(2) Clerical Amendment.—The table of sections at the beginning of chapter 3 is amended by inserting after the item relating to section 3711 the following new item:

"3711A. Quality management officers."

(b) REPORTS ON QUALITY CONCERNS UNDER QUALITY-ASSURANCE PROGRAM.—Section 7311(b) is amended by inserting after the following new paragraph:

"(4) As part of the quality-assurance program, the Under Secretary for Health shall establish mechanisms through which employees of Veterans Health Administration facilities may submit reports, on a confidential basis, on matters relating to quality of care in Veterans Health Administration facilities to the quality management officers of such facilities under section 3711(a) of this title. The mechanisms shall provide for the prompt and thorough review of any reports so submitted by the receiving officials.

(c) REVIEW OF CURRENT HEALTH CARE QUALITY SAFEGUARDS.—
(1) In general.—The Secretary of Veterans Affairs shall conduct a comprehensive review of all current policies and protocols of the Department of Veterans Affairs for maintaining health care quality and patient safety at Department medical facilities. The review shall include a review and assessment of the National Surgical Quality Improvement Program (NSQIP), including an assessment of—

(A) the efficacy of the quality indicators under the program;

(B) the efficacy of the data collection methods under the program;

(C) the frequency with which regular data analyses are performed under the program; and

(D) the extent to which the resources allocated for the quality indicators are adequate to fulfill the stated function of the program.

(2) Report.—Not later than 60 days after the date of enactment of this section, the Secretary shall submit to Congress a report on the review conducted under paragraph (1), including the findings of the Secretary as a result of the review and such recommendations as the Secretary considers appropriate in light of the review.

SEC. 508. PILOT PROGRAM ON USE OF COMMUNITY-BASED ORGANIZATIONS AND LOCAL AND STATE GOVERNMENT ENTITIES TO ENSURE THAT VETERANS RECEIVE CARE AND BENEFITS FOR WHICH THEY ARE ELIGIBLE.

(a) PILOT PROGRAM REQUIRED.—The Secretary of Veterans Affairs shall carry out a pilot program to assess the feasibility and advisability of placing community-based organizations and local and State government entities—

(1) to increase the coordination of community, local, and State health care and benefits for veterans to assist veterans who are transitioning from military service to civilian life in such transition;

(2) to increase the availability of high quality medical and mental health services to veterans transitioning from military service to civilian life;

(3) to provide assistance to families of veterans who are transitioning from military service to civilian life to help such families adjust to such transition; and

(4) to provide outreach to veterans and their families to inform them about the availability of benefits and connect them with appropriate care and benefit programs.

(b) DURATION OF PROGRAM.—The pilot program shall be carried out during the two-year period beginning on the date of the enactment of this Act.

(c) PROGRAM LOCATIONS.—
(1) In general.—The pilot program shall be carried out at five locations selected by the Secretary for purposes of the pilot program.

(2) Considerations.—In selecting locations for the pilot program, the Secretary shall consider the advisability of selecting locations in—

(A) rural areas;

(B) areas with populations that have a high proportion of minority group representation;

(C) areas with populations that have a high proportion of individuals who have limited access to health care; and

(D) areas that are not in close proximity to an active duty military installation.

(d) GRANTS.—The Secretary shall carry out the pilot program through the award of grants to community-based organizations and local and State government entities.

(e) SELECTION OF GRANTEES.

(1) In general.—A community-based organization or local or State government entity seeking a grant under the pilot program shall submit to the Secretary of Veterans Affairs an application therefor in such form and in such manner as the Secretary considers appropriate.

(2) ELIGIBILITY.—Each application submitted under paragraph (1) shall include the following:

(A) A description of the proposal was developed in consultation with the Department of Veterans Affairs; and

(B) A plan to coordinate activities under the pilot program, to the extent possible, with the local, State, and Federal providers of services for veterans to reduce duplication of services and to increase the effectiveness of such services.

(f) USE OF GRANT FUNDS.—The Secretary shall prescribe appropriate uses of grant funds received under the pilot program.

(g) CONGRESSIONAL VETERANS AFFAIRS COMMITTEES DEFINED.—In this section, the term "congressional veterans affairs committees" means—

(1) the Committees on Veterans' Affairs and Appropriations of the Senate; and

(2) the Committees on Veterans' Affairs and Appropriations of the House of Representatives.

SEC. 509. SPECIALIZED RESIDENTIAL CARE AND REHABILITATION FOR CERTAIN VETERANS.

Section 1720 is amended by adding at the end the following new subsection:

"(e) STUDY.—The Secretary shall submit to Congress a report on the implementation of—

(A) the funding and use of specialized residential care and rehabilitation services to veterans of Operation Enduring Freedom and Operation Iraqi Freedom;

(B) the extent to which the resources allocated to specialized residential care and rehabilitation services to veterans of Operation Enduring Freedom and Operation Iraqi Freedom under section 1710E of this title were made available to veterans transition services; and

(C) the extent to which the resources allocated to specialized residential care and rehabilitation services to veterans of Operation Enduring Freedom and Operation Iraqi Freedom under section 1710E of this title were made available to veterans of Operation Iraqi Freedom.

SEC. 510. EXPANDED STUDY ON THE HEALTH IMPACT OF PROJECT SHIPBOARD HAZARD AND DEFENSE.

(a) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall enter into a contract with the Institute of Medicine of the National Academies entitled "Long-Term Health Effects of Participation in Project SHAD II" or "Long-Term Health Effects of Participation in Project SHAD II" of the Institute of Medicine of the National Academies.

(b) COVERED VETERANS.—The study required by subsection (a) shall include, to the extent practicable, all veterans who participated in Project Shipboard Hazard and Defense (Project SHAD).

(c) UTILIZATION OF EXISTING STUDIES.—The study required by subsection (a) may use results from the study covered in the report entitled "Long-Term Health Effects of Participation in Project SHAD II" of the Institute of Medicine of the National Academies.

SEC. 511. USE OF NON-INDIGENT FACILITIES FOR REHABILITATION OF INDIVIDUALS WITH TRAUMATIC BRAIN INJURY.

Section 1710E is amended—

(1) by redesignating subsection (b) as subsection (c);

(2) by inserting after subsection (a) the following new subsection:

"(b) COVERED INDIVIDUALS.—The care and services provided under subsection (a) shall be available to all covered individuals.

(2) SUMMARY.—This section imposes no substantive requirements on the Secretary or any other Federal agency or entity.

(3) NO REPEAL.—Nothing in this section shall be construed to repeal or otherwise modify any provision of law relating to the recovery and rehabilitation for such individual."; and
§ 8133A. Tribal organizations following new section:

(A) Authority to award grants.—The Secretary may award a grant to a tribal organization under this subchapter in order to carry out the purposes of this subchapter.

(B) Condition of grant awards.—(1) Grants to tribal organizations under this section shall be awarded in the same manner, and under the same conditions, as grants awarded to the several States under the provisions of this subchapter, subject to such exceptions as the Secretary shall prescribe for purposes of this subchapter.

(2) For purposes of Title I of the Act, payments under this section shall in each case be considered as payments under Title I of the Act, made in furtherance of the Act, and shall be credited to such Act without accounting to the several States.

(3) Nothing herein contained shall be construed to require the Secretary to make grants to any tribe for any reason other than those set forth in paragraph (1). The Secretary shall prescribe for purposes of this section

(2) Any survivor or dependent of a veteran who is eligible for medical care under section 1701 of this title.

(c) Duration of program.—The pilot program shall be carried out during the three-year period beginning on the date of enactment.

(d) Pilot program locations.—The pilot program shall be carried out in not less than two and not more than four Veterans Integrated Services Networks (VISNs) selected by the Secretary of Veterans Affairs for purposes of the pilot program.

(e) Administration.—The Secretary of Veterans Affairs shall contract with a dental insurance company to provide dental care and treatment as described in this section to any veteran who is enrolled in the dental insurance plan provided under the pilot program.

(f) Benefits.—The dental insurance plan under the pilot program shall provide such benefits for dental care and treatment as the Secretary considers appropriate for the dental insurance plan, including diagnostic services, preventative services, endodontics and other restorative services, surgical services, and emergency services.

(g) Enrollment.—(1) Voluntary.—Enrollment in the dental insurance plan under this section shall be voluntary.

(2) Minimum period.—Enrollment in the dental insurance plan shall be for such minimum period as the Secretary shall prescribe for purposes of this section.

(h) Premiums.—(1) In general.—Premiums for coverage under the dental insurance plan under this section shall be in such amount or amounts as the Secretary of Veterans Affairs shall prescribe to cover all costs associated with the pilot program.

(2) Annual adjustment.—The Secretary shall adjust the premiums payable under the pilot program for coverage under the dental insurance plan for each individual covered by the dental insurance plan at the time of such an adjustment shall be notified of the amount and effective date of such adjustment.

(i) Responsibility for payment.—Each individual covered by the dental insurance plan shall pay the entire premium for coverage under the dental insurance plan, in addition to the full cost of any copayments.

(j) Voluntary disenrollment.—(1) In general.—With respect to the inclusion of such insurance plan in the dental insurance plan under the pilot program, the Secretary shall—

(A) permit the voluntary disenrollment of an individual in the dental insurance plan if the disenrollment occurs during the thirty-month period beginning on the date of the enrollment of the individual in the dental insurance plan; and

(B) permit the voluntary disenrollment of an individual in the dental insurance plan for such circumstances as the Secretary shall prescribe for purposes of this section, including the Secretary of Health and Human Services with respect to the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and the Medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.).

(2) Allowable circumstances.—The circumstances prescribed under paragraph (1) shall include the following:

(A) If an individual enrolled in the dental insurance plan refuses to comply with the conditions of the dental insurance plan that prevents utilization of the benefits under the dental insurance plan.

(B) If the inclusion of the dental insurance plan is prevented by a serious medical condition from being able to obtain benefits under the dental insurance plan.

(C) Such other circumstances as the Secretary shall prescribe for purposes of this section.

(3) Establishment of procedures.—The Secretary shall establish procedures for determinations on the permissibility of voluntary disenrollments under paragraph (1)(B). Such procedures shall ensure timely determinations on the permissibility of such disenrollments.

(k) Relationship to dental care provided by Secretary.—Nothing in this section shall affect the responsibility of the Secretary to provide dental care under section 1712 of title 38, United States Code, and the participation of an individual in the dental insurance plan under the pilot program shall not affect the individual's entitlement to outpatient dental services and treatment, and related dental appliances, under that section, regulations and procedures of the Secretary.
(B) In paragraph (b), by inserting before the period at the end the following: ‘‘, including a State Medicaid agency with respect to payments made under a State plan for medical assistance approved under title XIX of such Act (42 U.S.C. 1396 et seq.)’’.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsections (a) and (b) shall take effect on the date of the enactment of this Act, and shall apply with respect to emergency treatment furnished on or after that date.

(2) RENUMBERING FOR TREATMENT BEFORE EFFECTIVE DATE.—The Secretary of Veterans Affairs may provide reimbursement under section 1729 of title 38, United States Code, as a result of an appointment, for emergency treatment furnished before the date of the enactment of this Act if the Secretary determines that, under the circumstances applicable with respect to the veteran, it is appropriate to do so.

SEC. 515. PROHIBITION ON COLLECTION OF CO-PAYMENTS FROM VETERANS WHO ARE CATASTROPHICALLY DISABLED.

(a) IN GENERAL.—Subchapter III of chapter 17 is amended by adding at the end the following new section:

‘‘§1730A. Prohibition on collection of copayments from catastrophically disabled veterans.

‘‘Notwithstanding subsections (f) and (g) of section 1722(a) of title 38, United States Code, or any other provision of law, the Secretary may not require a veteran who is catastrophically disabled to make any copayment for the receipt of hospital care or medical services under the laws administered by the Secretary.’’.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of this chapter is amended by inserting after the item relating to section 1730 the following new item:

‘‘1730A. Prohibition on collection of copayments from catastrophically disabled veterans.’’.

TITLE VI—DEPARTMENT PERSONNEL MATTERS

SEC. 601. ENHANCEMENT OF AUTHORITIES FOR RETENTION OF MEDICAL PROFESSIONALS.

(a) SECRETARIAL AUTHORITY TO EXTEND TITLE 38 STATUS TO ADDITIONAL POSITIONS.—

(1) IN GENERAL.—Paragraph (3) of section 7401 is amended by striking ‘‘and blind rehabilitation outpatient specialists,’’ and inserting ‘‘blind rehabilitation outpatient specialists, and such other classes of health care occupations as the Secretary considers necessary for the recruitment and retention of such personnel on a case-by-case basis.’’

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on the date of the enactment of this Act, and shall apply to pay periods beginning on or after such effective date.

(b) SPECIAL INCENTIVE PAY FOR DEPARTMENT PHARMACIST EXECUTIVES.—

(1) IN GENERAL.—Section 7401(a) is amended—

(A) by striking ‘‘The annual’’ and inserting ‘‘(1) The annual’’;

(B) by striking ‘‘The pay’’ and inserting ‘‘(2) The pay’’;

(C) by striking ‘‘under the preceding sentence’’ and inserting ‘‘under paragraph (1)’’; and

(D) by adding at the end the following new paragraph:

‘‘(3) The rate of basic pay for a position to which an Executive Order applies under paragraph (1) is not described by paragraph (2) of subsection (a) of section 5307(d) of title 5, the rate of basic pay payable for level II of the Executive Schedule.’’.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on the first day of the first pay period beginning after the day that is 180 days after the date of the enactment of this Act.

(c) NOTWITHSTANDING THE PROVISIONS OF SECTION 5307(d) OF TITLE 5, THE SECRETARY MAY MAKE ANY CERTIFICATION UNDER THE PROVISIONS OF SUBSECTION (A) OF THAT SECTION IN ORDER TO RECRUIT AND RETAIN HIGHLY QUALIFIED DEPARTMENT PHARMACIST EXECUTIVES.—

(1) IN GENERAL.—Section 5307(d) of title 5, the rate of basic pay payable for level II of the Executive Schedule shall apply to positions described in section 7403(b) of this title as if such positions were a Senior Executive Service position as such term is defined in section 3301 of title 5.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on the date of the enactment of this Act.

(d) NOTWITHSTANDING THE PROVISIONS OF SECTION 5307(d) OF TITLE 5, THE SECRETARY MAY MAKE ANY CERTIFICATION UNDER THE PROVISIONS OF SUBSECTION (A) OF THAT SECTION IN ORDER TO RECRUIT AND RETAIN HIGHLY QUALIFIED DEPARTMENT PHARMACY EXEMPT STAFF.—

(1) IN GENERAL.—Section 5307(d) of title 5, the rate of basic pay payable for level II of the Executive Schedule shall apply to positions described in section 7403(b) of this title as if such positions were a Senior Executive Service position as such term is defined in section 3301 of title 5.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on the date of the enactment of this Act.
“(C) The personal qualifications of the individual.

“(D) The characteristics of the labor market concerned.

“(E) Other factors as the Secretary considers appropriate.

“(3) Special incentive pay under paragraph (1) for an individual shall not be considered basic pay for purposes of adverse actions under chapter V of this chapter.

“(4) Except as provided in paragraph (5), special incentive pay under paragraph (1) for an individual shall be considered basic pay for all purposes, including retirement benefits under chapters 83 and 84 of title 5, and other benefits.

“(5) Special incentive pay under paragraph (1) may not be awarded to an individual in an amount that would result in an aggregate amount of pay (including bonuses and awards) received by such individual in a year under this title that is greater than the annual pay of the President.

“(2) PAY FOR PHYSICIANS AND DENTISTS.—

“(1) NON-FOREIGN COST OF LIVING ADJUSTMENT ALLOWANCE.—Section 7431(b) is amended by adding at the end the following new paragraph:

“(i) The non-foreign cost of living adjustment allowance authorized under section 5941 of title 5 for physicians and dentists whose service under this section shall be determined as a percentage of base pay only.

“(2) MARKET PAY DETERMINATIONS FOR PHYSICIANS AND DENTISTS IN ADMINISTRATIVE OR EXECUTIVE LEADERSHIP POSITIONS.—Section 7431(c)(4)(I)(i) is amended by adding at the end the following: ‘‘The Secretary may exempt physicians and dentists occupying administrative or executive leadership positions from the requirements of the previous sentence.’’

“(3) EXCEPTION TO PROHIBITION ON REDUCTION OF MARKET PAY.—Section 7431(c)(7) is amended by striking ‘‘concerned.’’ and inserting ‘‘concerned, unless there is a change in board certification or reduction of privileges.’’

“(h) ADJUSTMENT OF PAY CAP FOR NURSES.—Section 7451(c)(2) is amended by striking ‘‘low’’ and inserting ‘‘level IV’’.

“(i) EXEMPTION FOR CERTIFIED REGISTERED NURSE ANESTHETISTS FROM LIMITATION ON AUTHORIZED COMPETITIVE PAY.—Section 7451(c)(4)(B)(i) is amended by adding at the end the following new sentence: ‘‘The maximum rate of basic pay for a grade for the position of certified registered nurse anesthetist pursuant to an adjustment under subsection (d) may exceed the maximum rate otherwise provided in the preceding sentence.’’

“(j) INCREASED LIMITATION ON SPECIAL PAY FOR NURSE EXECUTIVES.—Section 7452(g)(2) is amended by striking ‘‘$25,000’’ and inserting ‘‘$100,000’’.

“(k) LOCALITY PAY SCALE COMPUTATIONS.—

“(1) EDUCATION, TRAINING, AND SUPPORT FOR FACILITY DIRECTORS IN WAGE SURVEYS.—Section 7451(d)(3) is amended by adding at the end the following new subparagraph:

“(F) The Under Secretary for Health shall provide appropriate education, training, and support to directors of Department health care facilities in the conduct and use of surveys, including the use of third-party surveys, under this paragraph.

“(2) USE OF METHODOLOGY USED IN WAGE SURVEYS.—Section 7451(e)(4) is amended—

“(A) by redesignating subparagraph (D) as subparagraph (E)

“(B) by inserting after subparagraph (C) the following new subparagraph (D):

“(D) In any case in which the director conducts such a wage survey during the period covered by the report and makes adjustment in rates of basic pay applicable to one or more covered positions, facility information on the methodology used in making such adjustment or adjustments.’’;

“(3) DISCLOSURE OF INFORMATION TO PERSONS IN COVERED SURVEYS.—Section 7451(d)(3) is amended by adding at the end the following new paragraph:

“(E) The Under Secretary for Health or the director of such facility shall provide to the individual the most current report for such facility provided under such paragraph.

“(B) An individual described in this subparagraph—

“(i) an individual in a covered position at a Department health-care facility; or

“(ii) a representative of the labor organization representing that individual who is designated by that individual to make the request.’’;

“(1) ELIGIBILITY OF PART-TIME NURSES FOR ADDITIONAL PAY.—Section 7452(g)(2) is amended—

“(1) IN GENERAL.—Section 7453 is amended—

“(A) by redesignating subparagraph (D) as subparagraph (E)

“(B) in subsection (b)—

“(I) by striking ‘‘on a tour of duty’’ and inserting ‘‘such service’’; and

“(II) by striking ‘‘of such service’’ and inserting ‘‘such service’’;

“(C) in subsection (c)—

“(I) by striking ‘‘on a tour of duty’’ and inserting ‘‘such service’’;

“(II) by striking ‘‘on such tour’’ and inserting ‘‘such service’’;

“(D) in subsection (e)—

“(I) by striking ‘‘eight hours in a day’’ and inserting ‘‘eight consecutive hours’’; and

“(II) by striking ‘‘eight hours in a day’’ and inserting ‘‘eight consecutive hours’’;

“(m) ENHANCED AUTHORITY TO INCREASE RATES OF BASIC PAY TO OBTAIN OR RETAIN SERVICES OF CERTAIN PERSONS.—Section 7456(c) is amended by adding at the end the following new subparagraph:

“(c)(1) Subject to paragraph (2), the amount of any increase under subsection (a) in the minimum rate for any grade may not exceed the following:

“(A) the rate of basic pay of the highest grade at the time of the increase;

“(B) the rate of basic pay provided under section 7456 or 7456A of this title; or

“(C) the minimum rate for any grade provided under paragraph (4) with respect to such grade.

“(2) The Under Secretary for Health shall—

“(A) the work is a consequence of an emergency that could not have been reasonably anticipated;

“(B) the emergency is non-recurring and is not caused by or aggravated by the inattention of the Secretary or lack of reasonable contingency planning by the Secretary;

“(C) the Secretary has exhausted all good faith, reasonable attempts to obtain voluntary workers;

“(D) the nurse staff have critical skills and expertise that are required for the work; and

“(E) the work involves work for which the standard of care for a patient assignment requires continuity of care through completion of a case, treatment, or procedure.

“(n) NURSING STAFF: SPECIAL RULES FOR OVERTIME DUTY.—

“(1) VOLUNTARY OVERTIME.—(1) Nursing staff prohibited to work hours otherwise prohibited by subsection (a).

“(2) The refusal of nursing staff to work hours prohibited by subsection (a) shall not be grounds to discriminate (within the meaning of section 704(a) of the Civil Rights Act of 1964 (42 U.S.C. 2000e-3(a))) against the staff, dismissal or discharge of the staff, or any other adverse personnel action against the staff.

“(c) OVERTIME UNDER EMERGENCY CIRCUMSTANCES.—(1) Subsection (b) of section 7453 of this title is amended—

“(A) by redesignating paragraph (3) as paragraph (4);

“(B) in paragraph (4), by striking ‘‘such service’’; and

“(C) by inserting ‘‘of such service’’ after ‘‘the work involves work for which the standard of care for a patient assignment requires continuity of care through completion of a case, treatment, or procedure.’’

“(d) NURSING STAFF DEFINED.—In this section, the term ‘nursing staff’ includes the following:

“(1) a registered nurse.

“(2) A licensed practical or vocational nurse.

“(3) A nurse assistant appointed under this chapter or title 5.

“(4) Any other nurse position designated by the Secretary for purposes of this section.

“(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 74 is amended by inserting after the item relating to section 7458 the following new item:

“7459. Nursing staff: special rules for overtime duty.”;

“(b) WEEKEND DUTY.—Section 7456 is amended by adding at the end the following new subsection:

“(1) by striking subsection (c); and

“(2) by redesignating subsection (d) as subsection (c).

“(c) SCHEDULED WORK SCHEDULES FOR NURSES.—

“(1) IN GENERAL.—Section 7456(b)(1)(A) is amended by striking ‘‘three regularly scheduled and all that follows through the period at the end and adding at the end the following new subparagraph:

“(A) the work involves work for which the standard of care for a patient assignment requires continuity of care through completion of a case, treatment, or procedure.”;

“(2) CONFORMING AMENDMENTS.—Section 7456(a)(b) is amended—

”
SEC. 603. IMPROVEMENTS TO CERTAIN EDUCATION DEBT REIMBURSEMENT PROGRAMS.

(a) RHINSTATTMENT OF HEALTH PROFESSIONALS EDUCATIONAL ASSISTANCE SCHOLARSHIP PROGRAM.—

(i) General.—Section 7616 is amended by striking “December 31, 1998” and inserting “December 31, 2019”.

(ii) Expansion of Eligibility Requirements.—Section 7612(b)(2) is amended by striking “under section” and all that follows through “vocational nurse.” and inserting the following: “as an appointee under paragraph (1) or (3) of section 7401 of this title.”.

(b) IMPROVEMENTS TO EDUCATION DEBT REDUCTION PROGRAM.—

(i) Administration—Employer Retention as Purpose of Program.—Section 7681(a)(2) is amended by inserting “and retention” after “recruitment” the first time it appears.

(ii) Eligibility.—Section 7682 is amended—

(A) in subsection (a)(1), by striking “a recently appointed” and inserting “an”;

(B) in subsection (c),

(c) PROGRAM FOR CLINICAL RESEARCHERS FROM DISADVANTAGED BACKGROUNDS.—

(i) General.—The Secretary of Veterans Affairs may enter into an agreement with the Secretary of Health and Human Services, utilize the authorities available in section 487E of the Public Health Service Act (42 U.S.C. 288–5) for the administration of the principal and interest of educational loans of appropriately qualified health professionals who are from disadvantaged backgrounds in order to secure clinical research by such professionals for the Veterans Health Administration.

(ii) Limitations.—The exercise by the Secretary of Veterans Affairs of the authorities referred to in paragraph (i) shall be subject to the conditions and limitations specified in paragraphs (2) and (3) of section 487E(a) of the Public Health Service Act (42 U.S.C. 288–5(a)(2) and (3)).

(iii) Funding.—Amounts for the repayment of principal and interest of educational loans under this subsection shall be derived from amounts available to the Secretary of Veterans Affairs for the Veterans Health Administration for Medical Services.

SEC. 604. STANDARDS FOR APPOINTMENT AND PRACTICE OF PHYSICIANS IN DEPARTMENT OF VETERANS AFFAIRS MEDICAL FACILITIES.

(a) Standards.—

(i) General.—Subchapter I of chapter 74 of this title is amended by inserting after section 7492 the following new section:

87402A. Appointment and practice of physicians: standards

(‘‘(a) In General.—The Secretary shall, acting through the Under Secretary for Health, prescribe standards to be met by individuals in order to obtain appointment in the Veterans Health Administration in the position of physician and to practice as a physician in medical facilities of the Administration. The Secretary shall incorporate the requirements of this section.

(b) Disclosure of Certain Information Required.—If an individual seeking appointment in the Veterans Health Administration in the position of physician shall do the following:

(1) Provide the Secretary a full and complete explanation of the following:

(A) Each lawsuit, civil action, or other claim (whether open or closed) brought against the individual for medical malpractice or negligence;

(B) Each payment made by or on behalf of the individual to settle any lawsuit, action, or claim covered by subparagraph (A);

(2) each medical malpractice judgment rendered against the individual by the courts or administrative agencies or bodies of such State;

(3) each disciplinary action taken or under consideration against the individual by an administrative agency or body of such State;

(4) Each change in the status of the license to practice medicine issued the individual by the courts or administrative agencies or bodies of such State, or any outstanding allegation against the individual before such an administrative agency or body of such State;

(5) Each written notification by the State to the individual of potential termination of a license for cause or otherwise;

(6) Each filing of a claim for medical malpractice or negligence;

(7) Each payment made by or on behalf of the individual to settle any lawsuit, action, or claim covered by subparagraph (A); and

(8) Each lawsuit, civil action, or other claim (whether open or closed) brought against the individual for medical malpractice or negligence.

(2) Approval of Appointments by Director.—(A) Each lawsuit, civil action, or other claim brought against the individual for medical malpractice or negligence covered by paragraph (1)(A) that occurred in such State;

(B) Each payment made by or on behalf of the individual to settle any lawsuit, action, or claim covered by subparagraph (A);

(c) Each medical malpractice judgment rendered against the individual by the courts or administrative agencies or bodies of such State;

(d) Each disciplinary action taken or under consideration against the individual by an administrative agency or body of such State;

(e) Each change in the status of the license to practice medicine issued the individual by the courts or administrative agencies or bodies of such State, or any outstanding allegation against the individual before such an administrative agency or body of such State;

(f) Each filing of a claim for medical malpractice or negligence;

(g) Each written notification by the State to the individual of potential termination of a license for cause or otherwise;

(h) Each disciplinary action taken or under consideration against the individual by an administrative agency or body of such State;

(i) Each change in the status of the license to practice medicine issued the individual by the courts or administrative agencies or bodies of such State, or any outstanding allegation against the individual before such an administrative agency or body of such State;

(j) Each payment made by or on behalf of the individual to settle any lawsuit, action, or claim covered by subparagraph (A);

(k) Each lawsuit, civil action, or other claim (whether open or closed) brought against the individual for medical malpractice or negligence; and

(l) Each payment made by or on behalf of the individual to settle any lawsuit, action, or claim covered by subparagraph (A).

(3) Any disposition of a matter disclosed pursuant to subparagraph (A) or under this subparagraph.

(3) Each individual appointed in the Veterans Health Administration in the position of physician shall, as part of the biennial review of the performance of the physician under the appointment, submit the request and authorization described in subsection (b) for the requirements of this paragraph is in addition to the requirements of paragraph (1) or (2), as applicable.

(4) Investigation of Disclosed Matters.—(1) The Director of the Veterans Integrated Services Network (VISN) in which an individual is seeking appointment in the Veterans Health Administration in the position of physician shall perform an investigation (in a manner so specified) of each matter disclosed under subsection (b) with respect to the individual.

(2) The Director of the Veterans Integrated Services Network in which an individual is appointed in the Veterans Health Administration in the position of physician shall perform an investigation (in a manner so specified) of each matter disclosed under subsection (c) with respect to the individual.

(5) Approval of Appointments by Director.—(A) The entries in the Proactive Disclosures Service of the National Practitioner Data Bank for each physician extended such privileges in the Public Health Service Act (42 U.S.C. 288–3) of each matter disclosed under this subsection shall be fully documented.

(6) Approval of Appointments by Director.—(B) An investigatory disclosure does not disqualify the individual from appointment.

(7) Enrollment of Physicians with Proactive Disclosures Service.—(A) Each medical facility of the Department at which physicians are extended the privileges of practice shall enroll each physician extended such privileges in the Proactive Disclosure Service of the National Practitioner Data Bank.
(g) Encouraging Hiring of Physicians with Board Certification.—(1) The Secretary shall, for each performance contract with a Director of a Veterans Integrated Services Network (VISN), include in the terms of contract a provision that encourages such director to hire physicians who are board eligible or board certified in the specialty in which they intend to still practice.

(2) The Secretary may determine the nature and manner of the provision described in paragraph (1).

(b) Effective Date and Applicability.—

(1) EFFECTIVE DATE.—Except as provided in paragraphs (2) and (3), the amendments made by subsection (a) shall take effect on the date of the enactment of this Act.

(2) APPLICABILITY OF CERTAIN REQUIREMENTS TO PHYSICIANS PRACTICING ON EFFECTIVE DATE.—In the case of an individual appointed to the Veterans Health Administration in the position of physician as of the date of the enactment of this Act, the requirements of section 7402A of title 38, United States Code, as added by subsection (a) of this section, shall take effect on the date that is 60 days after the date of the enactment of this Act.

(3) APPLICABILITY OF REQUIREMENTS RELATED TO HIRING OF PHYSICIANS WITH BOARD CERTIFICATION.—The requirement of section 7402A(g) of such title, as added by subsection (a) of this section, shall begin with the first cycle of performance contracts for directors of Veterans Integrated Services Networks beginning after the date of the enactment of this Act.

TITLe VII—HOMELESS VETERANS MATTERS

SEC. 701. PILOT PROGRAM ON FINANCIAL SUPPORT FOR ENTITIES THAT COORDINATE THE PROVISION OF SUPPORTIVE SERVICES TO FORMERLY HOMELESS VETERANS RESIDING ON CERTAIN MILITARY PROPERTY.

(a) Establishment.—

(1) IN GENERAL.—Subject to the availability of appropriations for such purpose, the Secretary of Veterans Affairs may carry out a pilot program to make grants to public and nonprofit organizations (including faith-based and community organizations) to coordinate the provision of supportive services available in the local community to very low income, formerly homeless veterans residing in permanent housing.

(2) NUMBER OF GRANTS.—The Secretary may make grants at up to 10 qualifying properties under the pilot program.

(b) Qualifying Property.—Qualifying property under the pilot program is any property in the United States on which permanent housing is provided or afforded to formerly homeless veterans, as determined by the Secretary.

(c) Criteria for Grants.—The Secretary shall prescribe criteria and requirements for grants under this section and shall publish such criteria and requirements in the Federal Register.

(d) Duration of Program.—The authority of the Secretary to make grants under a pilot program under this section shall cease on the date that is five years after the date of the commencement of the pilot program.

(e) Very Low Income Defined.—In this section, the term "very low income" has the meaning given that term in the Resident Characteristics Report issued annually by the Department of Housing and Urban Development.

(f) Authorization of Appropriations.—There is authorized to be appropriated from amounts made available under the heading "General Operating Expenses", not more than $3,000,000 in each of fiscal years 2010 through 2014 to carry out the purposes of this section.

SEC. 702. PILOT PROGRAM ON FINANCIAL SUPPORT FOR ENTITIES THAT COORDINATE THE PROVISION OF SUPPORTIVE SERVICES TO FORMERLY HOMELESS VETERANS IN PERMANENT HOUSING.

(a) Establishment of Pilot Program.—

(1) IN GENERAL.—Subject to the availability of appropriations for such purpose, the Secretary of Veterans Affairs may carry out a pilot program to make grants to public and nonprofit organizations (including faith-based and community organizations) to coordinate the provision of supportive services available in the local community to very low income, formerly homeless veterans residing in permanent housing.

(2) NUMBER OF GRANTS.—The Secretary may make grants at up to 10 qualifying properties under the pilot program.

(b) Qualifying Property.—Qualifying property under the pilot program is any property in the United States on which permanent housing is provided or afforded to formerly homeless veterans, as determined by the Secretary.

(c) Criteria for Grants.—The Secretary shall prescribe criteria and requirements for grants under this section and shall publish such criteria and requirements in the Federal Register.

(d) Duration of Program.—The authority of the Secretary to make grants under a pilot program under this section shall cease on the date that is five years after the date of the commencement of the pilot program.

(e) Very Low Income Defined.—In this section, the term "very low income" has the meaning given that term in the Resident Characteristics Report issued annually by the Department of Housing and Urban Development.

(f) Authorization of Appropriations.—There is authorized to be appropriated from amounts made available under the heading "General Operating Expenses", not more than $3,000,000 in each of fiscal years 2010 through 2014 to carry out the purposes of this section.

SEC. 703. PILOT PROGRAM ON FINANCIAL SUPPORT FOR ENTITIES THAT PROVIDE OUTREACH TO INFORM CERTAIN HOMELESS VETERANS ABOUT PENSION BENEFITS.

(a) Authority to Make Grants.—In addition to the amounts available under the heading "General Operating Expenses", not more than $3,000,000 in each of fiscal years 2010 through 2014 to carry out the purposes of this section.

(b) Criteria for Grants.—The Secretary shall prescribe criteria and requirements for grants under this section and shall publish such criteria and requirements in the Federal Register.

(c) Duration of Program.—The authority of the Secretary to make grants under a pilot program under this section shall cease on the date that is five years after the date of the commencement of the pilot program.

(d) Authorization of Appropriations.—There is authorized to be appropriated from amounts made available under the heading "General Operating Expenses", not more than $1,275,000 in each of fiscal years 2010 through 2014 to carry out the purposes of this section.

SEC. 704. ASSESSMENT OF PILOT PROGRAMS.

(a) Progress Reports.—Not less than one year before the expiration of the authority to carry out a pilot program authorized by sections 501 through 503, the Secretary of Veterans Affairs shall submit to Congress a progress report on such pilot program.

(b) Contents.—(1) The progress report submitted for a pilot program under subsection (a) shall include the following:

(1) The list of lessons learned by the Secretary of Veterans Affairs with respect to such pilot program.

(2) The recommendations of the Secretary on whether to continue such pilot program.

(3) The number of veterans and dependents served by such pilot program.

(4) An assessment of the quality of service provided to veterans and dependents under such pilot program.

(5) The amount of funds provided to grant recipients under such pilot program.

(6) The names of organizations that have received grants under such pilot program.

TITLe VIII—NONPROFIT RESEARCH AND EDUCATION CORPORATIONS

SEC. 801. GENERAL AUTHORITIES ON ESTABLISHMENT OF CORPORATIONS.

(a) Authorization of Multi-Medical Center Research Corporations.—

(1) IN GENERAL.—Section 7801 is amended—

(A) by redesigning subsection (b) as subsection (e); and

(B) by inserting after subsection (a) the following new subsection (b):—

(b)(1) Subject to paragraph (2), a corporation established under this subchapter may facilitate the conduct of research, education, or both at more than one medical center.

Such a corporation shall be known as a ‘multi-medical center research corporation’. Such a corporation established under this subchapter may act as a multi-medical center research corporation under this subchapter and may adminster receipts and expenditures relating to such research, education, or both, as applicable, performed at the Department medical centers concerned with the activities of such a corporation.

Such a corporation shall be known as a ‘multi-medical center research corporation’. Such a corporation established under this subchapter may act as a multi-medical center research corporation under this subchapter and may adminster receipts and expenditures relating to such research, education, or both, as applicable, performed at the Department medical centers concerned with the activities of such a corporation.

(c) MULTIPLE MEDICAL CENTER RESEARCH CORPORATION.—Such section is further amended by adding at the end the following new subsection:

(1) A corporation established under this subchapter may act as a multi-medical center research corporation under this subchapter in accordance with subsection (b) if—

(1) the board of directors of the corporation approves a resolution permitting facilitation by the corporation of the conduct of...
research, education, or both at the other Department medical center or medical centers concerned; and

(2) the Secretary approves the resolution of the multi-medical center research corporation that is consistent with the purpose of such corporation as the flexible funding mechanism for the conduct of research or education at the other Department medical center or medical centers concerned.

(b) MODIFICATION OF DEFINED TERM RELATING TO EDUCATION AND TRAINING.—Subsection (b) of such section is amended by striking “the term ‘education’ includes education and training” and inserting “the term ‘education’ includes education and training and

(c) EFFECT OF ROLE OF CORPORATIONS WITH RESPECT TO FELLOWSHIPS.—Paragraph (1) of subsection (b) of such section is amended by striking the flush matter following subparagraph (C).

(d) AVAILABILITY OF EDUCATION FOR FAMILIES OF VETERAN PATIENTS.—Paragraph (2) of subsection (b) of such section is amended by striking “to patients and to the families” and inserting “and includes education and training for patients and families”.

SEC. 803. MODIFICATION OF REQUIREMENTS FOR NON-DEPARTMENT BOARD MEMBERS.—(1) In general.—Section 7366, as amended by section 805 of this Act, is amended by inserting “not less than two” before “members”.

(2) By striking “and who” and all that follows through “to the conduct of” and inserting “to the conduct of such corporation, the associate chief of staff for research and the associate chief of staff for education and training for patients and families”.

SEC. 804. CLARIFICATION OF POWERS OF CORPORATIONS.—(a) IN GENERAL.—Section 7364 is amended to read as follows: (b) TRANSFER AND ADMINISTRATION OF FUNDS.—(1) Except as provided in paragraph (2), any funds received by the Secretary for the conduct of research or education at a Department medical center or medical centers other than funds appropriated to the Department, may be transferred to and administered by a corporation established under this subchapter for such purpose.

(2) A Department medical center may retitle the corporation for all or a portion of the pay, benefits, or both of an employee of the corporation who is assigned to the Department medical center if the assignment is carried out pursuant to subchapter VI of chapter 33 of title 10.

(3) A Department medical center may retain and use funds provided to it by a corporation established under this subchapter. Such funds shall be credited to the applicable appropriation account of the Department and shall be available, without fiscal year limitation, for the purposes of that account.

(4) For reasonable and usual preliminary costs for project planning before its approval, a corporation established under this subchapter may not spend funds for a research project unless the project is approved in accordance with procedures prescribed by the Under Secretary for Health for research carried out within the Department and shall include a scientific review process.

(5) For reasonable and usual preliminary costs for project planning before its approval, a corporation established under this subchapter may not spend funds for an education activity unless the activity is approved in accordance with procedures prescribed by the Under Secretary for Health.

SEC. 805. REDESIGNATION OF SECTION 7364A OF TITLE 38, UNITED STATES CODE.—(a) REDESIGNATION.—Section 7364A is redesignated as section 7365.

(b) CLERICAL AMENDMENTS.—The table of sections at the beginning of chapter 73 is amended— (1) by striking the item relating to section 7364A; and

(2) by inserting “section 7365” in the place prescribed by the item relating to section 7364.

SEC. 806. IMPROVED ACCOUNTABILITY AND OVERSIGHT OF CORPORATIONS.—(a) ADDITIONAL INFORMATION IN ANNUAL REPORTS.—Subsection (c) of section 7366 is amended to read as follows: (b) TRANSFER AND ADMINISTRATION OF FUNDS.—(1) Except as provided in paragraph (2), any funds received by the Secretary for the conduct of research or education at a Department medical center or medical centers other than funds appropriated to the Department, may be transferred to and administered by a corporation established under this subchapter for such purpose.

(2) A Department medical center may retitle the corporation for all or a portion of the pay, benefits, or both of an employee of the corporation who is assigned to the Department medical center if the assignment is carried out pursuant to subchapter VI of chapter 33 of title 10.

(3) A Department medical center may retain and use funds provided to it by a corporation established under this subchapter. Such funds shall be credited to the applicable appropriation account of the Department and shall be available, without fiscal year limitation, for the purposes of that account.
"(C) Any audit under this paragraph shall be performed by an independent auditor."

"(3) The corporation shall include in each report to the Secretary under paragraph (1) the following:

"(A) The most recent audit of the corporation under paragraph (2)."

"(B) The most recent Internal Revenue Service examination of Organization Exempt from Income Tax' or equivalent and the applicable schedules under such form.'"

"(B) CONFIRMATION OF APPLICATION OF CONFLICT OF INTEREST REGULATIONS TO APPLICABLE CORPORATION POSITIONS.—Subsection (c) of such section is amended—

"(1) by striking 'laws and' each place it appears;

"(2) in paragraph (1)—

"(A) by inserting "each officer and" after "under this subchapter"; and

"(B) by striking "and each employee of the Department" and all that follows through "during any year"; and

"(3) in paragraph (2)—

"(A) by inserting ""officer,"" after "verifying that each director"; and

"(B) by striking "in the same manner" and all that follows before the period at the end.

"(c) REPORTING THRESHOLD.—Subsection (d)(3)(C) of such section is amended by striking "$55,430,000" and inserting "$50,000".

TITLE IX—CONSTRUCTION AND NAMING MATTERS

SEC. 901. AUTHORIZATION OF MEDICAL FACILITY PROJECTS.

(a) AUTHORIZATION OF FISCAL YEAR 2010 MAJOR MEDICAL FACILITY PROJECTS.—The Secretary of Veterans Affairs may carry out the following major medical facility projects in fiscal year 2010, with each project to be carried out in the amount specified for each project: (1) Construction (including acquisition of land) for the realignment of services and closure of the Department of Veterans Affairs Medical Center in Livermore, California, in an amount not to exceed $5,430,000.

(2) Construction of a Multi-Specialty Care Facility in Walla Walla, Washington, in an amount not to exceed $71,400,000.

(3) Construction (including acquisition of land) for a new medical facility at the Department of Veterans Affairs Medical Center in Louisville, Kentucky, in an amount not to exceed $75,000,000.

(4) Construction (including acquisition of land) for a clinical expansion for a Mental Health Facility at the Department of Veterans Affairs Medical Center in Dallas, Texas, in an amount not to exceed $15,646,000.

(5) Construction (including acquisition of land) for a replacement bed tower and clinical expansion at the Department of Veterans Affairs Medical Center in St. Louis, Missouri, in an amount not to exceed $31,900,000.

(b) EXPANSION OF AUTHORIZATION FOR MAJOR MEDICAL FACILITY CONSTRUCTION PROJECTS PREVIOUSLY AUTHORIZED.—The Secretary of Veterans Affairs may carry out the following major medical facility projects described in subparagraph (a) of this subsection that were authorized by an act of Congress prior to September 30, 2009, in an amount not to exceed $800,000,000.

(c) AUTHORIZATION OF APPROPRIATIONS.—

(1) AUTHORIZATION OF APPROPRIATIONS FOR CONSTRUCTION.—There is authorized to be appropriated to the Secretary of Veterans Affairs for fiscal year 2010, or the year in which funds are appropriated, for the Construction, Major Projects account—

"(A) $290,610,000 for the projects authorized in subsection (a)(1);

"(B) $994,400,000 for the projects authorized in subsection (b); and

"(C) LIMITATION.—The projects authorized in subsections (a) and (b) may only be carried out using—

"(A) funds appropriated for fiscal year 2010 pursuant to the authorization of appropriations in paragraph (1) of this section;

"(B) funds available for Construction, Major Projects for a fiscal year before fiscal year 2010 that remain available for obligation; and

"(C) funds appropriated for Construction, Major Projects for fiscal year 2010 for a category of activity not specific to a project; and

"(D) funds appropriated for Construction, Major Projects for a fiscal year before 2010 for a category of activity not specific to a project; and

"(E) funds appropriated for Construction, Major Projects for a fiscal year after 2010 for a category of activity not specific to a project; and

"(F) funds appropriated for Construction, Major Projects for a fiscal year after 2010 for a category of activity not specific to a project; and

"(G) The powers granted to Department police officers designated under this section shall be exercised in accordance with guidelines approved by the Secretary and the Attorney General."
MORNING BUSINESS

Mrs. MURRAY. Madam President, I ask unanimous consent that the Senate proceed to a period of morning business with Senators permitted to speak for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mrs. MURRAY. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

HEALTH CARE REFORM

Mr. GRASSLEY. Madam President, we have been waiting for many weeks while the Democratic leadership worked behind closed doors to write a new health care reform bill. Rather than trying to build consensus for a bill that could get broad-based support, they went out of their way to avoid it. But long last this new health care reform plan is finally public. They have come forward to at last reveal the legislative language for a health care reform bill that the Democrats intend to bring to the floor.

We know where they started. We know the changes they made along the way. Those in this Chamber will recall that we worked for months in the Senate Finance Committee on health reform. Senator Baucus and I worked very carefully in committee to try to develop a bipartisan reform plan.

Health care, as everybody knows, is one-sixth of the economy. If that economic fact is obscure to people, $1 out of every 6 dollars in the United States is spent on health care.

We are, of course, to spend upward of $33 trillion on health care in this country over the next decade—$33 trillion. Already our health care system is on an unsustainable path. Our current health care entitlement programs, at least the two, Medicare and Medicaid, are both on very unsound financial footing. Not only are both programs in jeopardy financially, but the magnitude of the problem is a real threat to the Federal budget.

Starting in 2008, the Medicare Program began spending more out of the hospital insurance trust fund than it is taking in. That deficit spending at the trust fund is the beginning of the end of Medicare unless Congress steps in and does something to maintain that trust fund. The Medicare trustees have been warning us for years that the hospital insurance fund—the trust fund, that is—is going to go broke. They now predict that year of going broke is 2017. As a result, the Democratic leaders pulled the plug on that bipartisan process, and the hopes that we get broad-based support ended at that point. Ultimately, the Finance Committee reported out a bill that did not have that broad bipartisan support, the support we had hoped for earlier in the year. The bigger and far more liberal agenda driven by the White House and the Democratic leadership went beyond where the true consensus on reform exists.

Now the next step in this process has begun to merge together the bill from the HELP Committee and the Finance Committee. That job fell to the Democratic leader and the chairmen of the two committees. But, ultimately, their support was something Senator Baucus and I focused on in our work on the Finance Committee, as we were trying to bring forth a bill that would be bipartisan.

In the Finance Committee, we believed strongly that the significant changes should be done with broad-based support; in other words, health care is a life-or-death issue for every American, and it affects $1 out of every $6 spent in America. Because it is so big, that is the basis for that statement about broad-based support.

Under the leadership of Senator Baucus, chairman of the Finance Committee, we started last year with a bipartisan health care reform summit. We held 20 hearings. We held three public forums this year on options for financing, coverage, and delivery system reform. We invited experts from across the country. We invited anyone to submit input to the committee on those options, and we received over 600 sets of comments on the option papers.

Senator Baucus and I developed the broad outlines of what we believed would be a good reform package. That broad outline reflected the input we had from that very open and public process. We took those inputs and we sat down with four other leaders on the issue of health care in this very Chamber. That group soon became known as the group of six. That group began meeting in June to take that framework and finish those details. We met for untold hours. We consulted with experts at the Congressional Budget Office and the Joint Committee on Taxation. We invested a tremendous amount of time and effort to develop a bipartisan package.

Then what happens around here too often? People get impatient. In this case, the Democratic leaders got impatient. They wanted the reform bill to be finished faster. They were more concerned with health care reform getting done right now rather than getting done right. We said we needed to give the process the time it needed. We said we were not going to be bound by arbitrary deadlines. We wanted to get the job done right. But when the first of September rolled around, they were not willing to give the group of six any more time.

As a result, the Democratic leaders pulled the plug on that bipartisan process and the hopes for broad support ended. It was an unfortunate outcome.
leader even excluded the chairmen from the process. That process began on October 2. So the rest of the Senate has been waiting ever since that time to see what would emerge from behind closed doors just across the hall.

But it started to complain about how long it was taking to develop the merged bill. When that happened, lo and behold, we started to hear from the Democratic leader what the group of six had been saying. That leader, too, was saying he was getting close to having something, but when was it going to be bound by some kind of artificial timeline. He, too, started saying he was going to take whatever time he needed. Imagine our shock and dismay when we heard this. All the impatience we heard about how long our bipartisan process was taking, the criticism we took.

So they pulled the plug on that effort out of impatience. My suspicion is that now only is there a realization of how hard it is to assemble a comprehensive healing reform plan. Now at long last, that merged bill is before us. Now we know what is in it. The bill has undergone many changes since the Democrats decided to do a partisan bill. They are not positive. They have moved more to not only the extreme agenda. It is an agenda so extreme, they are having difficulty finding votes among Democratic Members. They have 60-vote control of this body. They have an overwhelming majority in the House. Yet they are trying to blame Republicans for slowing down the process.

Surely they don’t expect 100 Senators to get this done faster than it took a leader behind closed doors to get the bill done, to put together the two bills between the Finance Committee and the HELP Committee, what we have before us or will eventually have before us. But it is not Republicans who are slowing the process. They are not positive. They have moved more to not only the partisan agenda, they have moved to an extreme agenda. It is an agenda so extreme, they are having difficulty finding votes among Democratic Members. They have 60-vote control of this body. They have an overwhelming majority in the House. Yet they are trying to blame Republicans for slowing down the process.

The reason for the difficulties is that their leftwing is driving the health care reform plan. It is not Republicans that it took so long to get this done. It still gives the Secretary of Health and Human Services the power to set prices and define benefits for private health plans. That is a lot of government power in Washington over what we would do to cause health care premiums for millions to go up.

As I said when this process started, the bill released by the Finance Committee was an incomplete but comprehensive, good-faith attempt to reach bipartisan agreement. But ever since that moment, the bill has moved further and further away from that approach on several key issues. Now we can see clearly that the bill continues to take shape into an extreme agenda driven by the far left. This far left partisan change is precisely what my party feared would occur at later stages in the legislative process.

Today we see there were legitimate and justified. Nevertheless, I still hold out hope that at some point the door is open. I hope at some point the White House and leadership will want to consider that they have made mistakes they made mistakes. We have to get our collaboration work of 3 months during the summer. I hope at some point they will want to let bipartisan work begin again. Then they need to back that effort and give it the time needed to get it right rather than getting it done right now. It is clear that today is not the day that is going to happen. I yield the floor.

The PRESIDING OFFICER (Mrs. McCaskill). The Senator from Colorado.

MR. BENNET. Madam President, I am pleased to be here today with my colleagues from New Hampshire to talk about fiscal accountability in the context of the health care reform discussion we have been having.

Back in Colorado, people are not talking about far-left or far-right or Democratic or Republican. That is not what concerns them. What concerns them is that for the last 10 years they have seen double-digit increases in the cost of their health insurance, year-in and year-out, at a time, by the way, when their incomes actually declined.

Even before we were in the worst recession since World War II—which we are in today—during the last recovery, the Bush recovery, it was the first recovery in the history of the United States when median family income actually declined. It was, in effect, for a working family a recession. And they are not going to recover not just from the greatest recession since the Great Depression but from a 10-year period when they actually fell behind in terms of their income. What was happening at the same time their income was going down? The cost of health insurance was going up, by 97 percent in my State. By the way, higher education was going up by 50 percent during that same period.

What we have seen is working families before this recession and now in the depths of this recession is that they are expected to do more with less. They are threatened by politics in Washington that it is already or will eventually have before us. But it is not Republicans who are before us or will eventually have before us. But it is not Republicans who are driving the far left. This far left partisan change is precisely what my party feared would occur at later stages in the legislative process.

Today we see these fears were legitimate and justified. Nevertheless, I still hold out hope that at some point the door is open. I hope at some point the White House and leadership will want to consider that they have made mistakes they made mistakes. We have to get our collaboration work of 3 months during the summer. I hope at some point they will want to let bipartisan work begin again. Then they need to back that effort and give it the time needed to get it right rather than getting it done right now. It is clear that today is not the day that is going to happen. I yield the floor.

The PRESIDING OFFICER (Mrs. McCaskill). The Senator from Colorado.

MR. BENNET. Madam President, I am pleased to be here today with my colleagues from New Hampshire to talk about fiscal accountability in the context of the health care reform discussion we have been having.

We must pass effective reform that will rein in skyrocketing costs in both the public and private sectors and help to solve the fiscal problems that threaten our economy and our kids’ futures. Without reform, if we just hold on to the status quo, if we listen to the sirens of special interests, out-of-control health care costs will place an even higher burden on government expenditure. That is why our Federal budget deficits are enormous and our debt is staggering. Health care reform, as I said, must help solve that problem, not make it worse.

I, for one, have said from the very beginning of this debate that I would not support a health care reform bill that added a dollar to our deficit. I am very clear that the leader of my party feared would occur at later stages in the legislative process.

We must pass effective reform that will rein in skyrocketing costs in both the public and private sectors and help to solve the fiscal problems that threaten our economy and our kids’ futures. Without reform, if we just hold on to the status quo, if we listen to the sirens of special interests, out-of-control health care costs will place an even higher burden on government expenditure. That is why our Federal budget deficits are enormous and our debt is staggering. Health care reform, as I said, must help solve that problem, not make it worse.

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health care. It is like having two small businesses, one across the street from the other, and one is spending a fifth of their revenue on their light bill and the one across the street is spending less than half that. You do not need an MBA to know which of those small businesses is going to be able to continue in their business plan and grow. If we expect to be able to compete in the global economy, we need to devote a smaller percentage of our GDP to health care.

Since 1970, every year for almost 40 years—year-in and year-out—Medicare spending per person has risen by over 8 percent a year and private insurance spending per person has risen by over 9 percent a year. We cannot expect reform to begin at the private or employer-based level. We must drive these costs down at the Federal level by re-orienting our Medicare incentive structure.

The Congressional Budget Office Director, Doug Elmendorf, has said that the "rising costs for health care represent the single greatest challenge to balancing the federal budget." If you are embracing the status quo, you are embracing skyrocketing deficits.

The White House Budget Director, Peter Orszag, agrees, saying:

"The single most important thing—"the single most important thing"—we can do to put the nation on a sounder long-term fiscal footing is to reduce the rate of growth of health care costs."

Meanwhile, the cost of health insurance is eating into family budgets faster and faster. About 20 years ago, the cost of an average family health care policy was $9,700 in Colorado, representing 12 percent of the average family’s income. Today, an average family’s health care policy costs roughly $12,000, amounting to 20 percent of the family’s income, going by 2016, if we do nothing, to 40 percent of their income.

Middle-class wages are not even close to keeping up with these rising insurance costs. In fact, median family income in this country fell by $300 as health care costs increased by 80 percent just while the last administration was in office.

Looking outside the confines of the budget context, health care reform will contribute significantly to economic growth. Health care reform will rein in skyrocketing costs by doing a more cost-effective job of providing health care, the bill is projected to reduce the deficit by almost $130 billion over the next 10 years. That is what I want to talk about this afternoon—some of those ways in which we can provide health care more cost-effectively and also improve health outcomes for people.

Research shows us that spending on health care does not necessarily translate into better health care. I am proud of the Dartmouth Institute for Health Policy, which is in my home State of New Hampshire, because it has been leading the way on some of this important research. What Dartmouth’s research shows us is that when patients are engaged in their treatment decisions, they will choose the less invasive and less costly procedures 40 percent of the time. So almost half of the time, we know patients, when they are involved, are going to choose the less costly procedures—likely they are going to be happier about those treatment decisions. We know, based on this research, that the health care system can do better in so many cases for less and that we can recoup savings in our system.

One example of that, which I have worked hard on, along with Senator COLLINS from Maine, is something we call the Medicare Transitional Care Act. Experts estimate that we can save $5,000 per Medicare beneficiary if we can reduce costly readmissions. That is what our work shows. Medicare costs can be reduced and we can offer better support and coordination of care to Medicare patients if we keep seniors who are discharged from the hospital unnecessarily returning. We know that reducing costs for those seniors who are discharged from the hospital, who are on Medicaid, are going to get readmitted within 90 days because we do not do a
good job of providing for that transition. If we add a benefit through Medicare that helps with that transition, we have a commonsense solution that will improve the quality of health care for our seniors and save taxpayers money. I am very pleased that this provision is included in the health care reform bill that is before us now or that we hope will be before us soon.

We can also contain health care costs by improving access to lower cost generic drugs. Again, that is something that we have experienced before. The sheer memorials as a day of horror unlike any we have experienced before. The sheer.

The legislation we hope to be able to work on will help Americans access lower cost medications. It will save taxpayers money. This is our opportunity to improve the quality of care available to Americans and to control costs at the same time. It is critical we achieve this for the citizens of New Hampshire and for all Americans. The Patient Protection and Affordable Care Act is a very important step forward. I hope all my colleagues will, as we debate this bill, look at the important changes we are making and decide this is our opportunity to get real, meaningful health care reform done.

Thank you, and I yield the floor. The PRESIDING OFFICER. The Senator from Missouri is recognized.

SEPTEMBER 11 TERRORISTS’ TRIALS

Mr. BOND. Madam President, faith has written many painful chapters in America’s history. Each is sharply engraved in our memories. Many involve military conflict: the British burning of Washington, the Civil War, Pearl Harbor, Iwo Jima, Pork Chop Hill.

Others were singular acts of aggression, such as the bombing of the Oklahoma City Federal Building, the assassinations of Martin Luther King and Presidents Lincoln, McKinley, and Kennedy.

September 11, 2001, is the latest painful chapter in American history, one that forever will be burned into our memories as a day of horror unlike any we have experienced before. The sheer magnitude and deliberate evil of the attacks that day defy comprehension. Who among us will soon forget the wrenching images of passenger planes used as missiles aimed at the World Trade Center Towers and the Pentagon or the people diving out of 70-story windows to avoid being burned again, and whose heroic actions saved passengers aboard Flight 93 as it headed toward the Nation’s Capital? Who among us will forget the pictures and the hopeful messages that sprang up around the area where the World Trade Center once proudly stood as relatives searched in vain for loved ones?

Three thousand men and women perished that day at the hands of terrorists who cared nothing for the innocent lives they stole. As the towers fell, their comrades and sympathizers, including Khalid Shaikh Mohammed, diabolically cheered the devastation.

It is the hope of 9/11 that last week’s decision by the Obama Justice Department to give the mastermind of these attacks and his associates all the rights and benefits of a civilian trial in New York City unexplainable and compel me to rise to voice my strong objection to that decision.

It is an insult to the memories of those who were brutally murdered on September 11 that the perpetrator of these cowardly acts will sit in a courtroom blocks away from Ground Zero and reap the full benefits and protections of the U.S. Constitution. Even worse than the insult to the victims and their families is the dangerous precipice the Obama Justice Department has now crossed with this foolhardy decision. Earlier this year, the Homeland Security Secretary signaled an alarming change of perspective about the nature of the enemy we face. No longer would we call the acts of terrorism what they are: acts of war. Instead, according to Secretary Napolitano, the accepted terminology for an attack such as 9/11 would now be a "man-caused forest fire." Apparently, 9/11 was no different than a forest fire started by an arsonist.

This initial change in terminology was troubling enough, but trying Khalid Shaikh Mohammed and his 9/11 associates in civilian Federal court sends a loud and clear signal that this administration is now comfortable recasting certain acts of terrorism as simply what the Attorney General calls a red herring. Well, unfortunately, the Attorney General’s decision as a way to showcase an extraordinary crime, justifying trial in a civilian court. Yet killing 17 servicemen abroad the USS Cole is an extraordinary crime, justifying trial in a civilian court. Yet killing 17 servicemen aboard the USS Cole is an act of war or the murder of 13 service members at Fort Hood justifies continued proceedings before the military commission.

Mr. BOND. I must wonder if the Attorney General thinks that the decision to bring 9/11 coconspirators into the Federal justice system would preclude the possibility of community interrogation of Osama bin Laden if he were captured. The Attorney General refused to say whether bin Laden would be given Miranda warnings upon capture and claimed "the case against him is so overwhelming" that there would be no need to rely on any statements he might make after capture. Mr. Holder called the concerns about not being able to interrogate bin Laden a "red herring." Well, unfortunately, the Attorney General’s testimony shows a complete lack of understanding that the purpose of intelligence interrogations is to stop planned attacks and to take down terrorist networks, not to elicit confessions for use in a criminal trial.

It is beyond troubling that the Attorney General, as the head of the Department of Justice, the Justice Department’s FBI National Security Division—the very people charged with preventing terrorist attacks whose disrupted in New York, Illinois, and North Carolina, seem to have no interest in obtaining valuable intelligence from bin Laden. As the leader of al-Qaeda, bin Laden clearly has considerable knowledge of its network, its members, its methods, and its potential to kill more Americans. So what the Attorney General calls a red herring, I call a red flag.

Some have hailed the administration’s decision as an intelligence victory over the judicial system for the world, but the Attorney General has confirmed that in the event KSM or one of his associates is acquitted, he will still be

Words are simply words, but the mentality that these words represent is dangerously naive. Whether it is called a man-caused disaster or extraordinary crime, refusing to treat the September 11 perpetrators as terrorists, deserving no less than the full protections of our court system, is a dangerous throwback to the pre-9/11 mentality that resulted in the attack on the USS Cole, the bombings of our embassies, and the first World Trade Center bombing.

I vigorously object to this concept of prosecutorial discretion and the right of the executive branch to bring criminal actions against perpetrators as supported by the facts. But in this instance, this discretion must give way to the larger national security interests of our country. In spite of the stated intention of KSM to plead guilty in the military commission, the Attorney General has asserted he believes there is a greater chance of success against these 9/11 coconspirators in civilian court. This belief—does not justify the enhanced risks to our security and the dangerous precedent for the treatment of future terrorists this trial will bring.

That this case will establish a very bad precedent was made clear by the Attorney General in his testimony before the Senate Judiciary Committee, when he summarily dismissed concerns that the decision to bring 9/11 coconspirators into the Federal justice system would preclude the possibility of community interrogation of Osama bin Laden if he were captured. The Attorney General refused to say whether bin Laden would be given Miranda warnings upon capture and claimed "the case against him is so overwhelming" that there would be no need to rely on any statements he might make after capture. Mr. Holder called the concerns about not being able to interrogate bin Laden a "red herring."
This begs the question: Why should we incur the time, expense, and risk our national security on a show trial if we are not detaining to detain these terrorists forever anyway? Rather than showcasing our judicial system, this strange logic seems to make a mockery of the civilian judicial system. While the Attorney General has declared that failure is not an option, he does not continue businesses, nor the facts and perceptions that may sway any one of 12 jurors who will decide KSM’s fate. A conviction will be expected, but there can be no guarantees.

Make no mistake, America is still at war. The war on terror is real. It will not go away just by calling it another name. We cannot afford to bury our heads in the sand. While Khalid Shaikh Mohammed may ultimately be convicted, our success in the war against terrorism will not be final when we hunted these terrorists into extinction. We need look no further than the terror plots disrupted earlier this fall in New York, Colorado, Illinois, and at Quantico, to name a few, to understand the threat we now face. Bin Laden and his lieutenants will not go quietly, and we will only increase the likelihood of more attacks to keep our Nation safe.

The Obama administration is standing at a crossroads of history. It can either persist in downplaying the reality that we are at war with terrorists or it can affirm that its top priority is to keep Americans safe by winning this war on terror.

Madam President, success in this war on terror cannot simply be defined as getting a guilty verdict against KSM in a civilian federal court. If the Department of Justice jeopardizes our intelligence sources and methods, incurs unnecessary security risks, and makes the trial of Zacarias Moussaoui as part of the government’s pretrial discovery response. In ordering the U.S. Marshals to seize the documents from Moussaoui’s cell, the judge noted that “significant national security interests of the United States could be compromised if the defendant were to retain copies of this classified information.”

I believe these examples provide ample evidence that public trials of these types of terrorism cases are a clear win for terrorists seeking to learn more about our intelligence sources and methods.

We were there no alternatives, we would proceed with this type of trial, despite the risk, because our Nation values due process. Congress has approved in favor of circuses that will promise in favor of circuses that will.

The concept of military commissions is one our Nation has relied upon before. When Congress created the military commissions process after September 11, it established a framework to ensure that intelligence sources and methods would not be jeopardized. While changes have been made over the years to the process itself in light of Supreme Court decisions, the general framework and principles remain solid.

This process isn’t new to this administration either. The administration is not only using this process, the Attorney General announced that the USS Cole bomber will still be tried under the commission. They worked with Congress to make the changes to it themselves.

Yet in the case of the 9/11 conspirators, the administration has chosen to reject the tried and true method of prosecuting enemy combatants in a venue where intelligence sources and methods are unlikely to be compromised in favor of circuses that will make the trial of Zacarias Moussaoui, with its endless motions and Moussaoui’s challenge of a duel to former Attorney General Ashcroft, seem like a mundane proceeding.

This is an unnecessarily dangerous gamble. While the decision to take this gamble with our national security is clearly a matter of the executive branch, the administration has found a willing ally in many of my colleagues in Congress. Earlier this month, I joined 44 other Senators, from both sides of the aisle, in supporting an amendment to prohibit taxpayer funds from being used to prosecute in a civilian court the 9/11 perpetrators. Unfortunately, we were outvoted. The amendment didn’t pass.

I encourage my colleagues to rethink their opposition. When the appropriate time comes, I hope they will reaffirm that our national security interests must have priority over politically correct prosecutions.

America is rightfully a different nation today than it was before September 11. We were attacked in a way and at a magnitude that we hope never to experience again. But we simply cannot rely on hope alone. Following these terrorist attacks, we took critical steps to try to ensure we are never attacked like this again. We made sure that we gave our intelligence professionals the tools they needed to fight terrorists, not just criminals. We gave them the tools they needed to fight a war on terror.

We must always remember the lessons of September 11. We owe it to the victims of these and other terrorist attacks to keep our Nation safe. I call on the President from this floor to reverse the disastrous decision of the Attorney General and reaffirm his commitment to our national security and to winning this war against terrorism.

I yield the floor.

The PRESIDENT OF THE UNITED STATES

Mr. REID. Madam President, I apologize to the Republican leader. I was detained in my office talking to another Senator, so I apologize for not being here and his having to wait.

UNANIMOUS CONSENT AGREEMENT—H.R. 3590

Mr. REID. Madam President, I ask unanimous consent that on November 20, at 10 a.m., the Senate proceed to a period of debate on the motion to proceed to H.R. 3590, until 11 p.m., with the time controlled in alternating 1-hour blocks, with the majority controlling the first hour; and at 10 p.m., Friday, there be 30-minute blocks until 11 p.m., with the majority controlling the first 30 minutes; further, that on Saturday, November 21, at 10 a.m., the Senate continue with controlled debate in alternating blocks until 6 p.m., with the majority controlling the first hour block; that at 6 p.m., the majority control the time until 6:30 p.m., the Republicans then control 6:30 to 7:10 p.m., the majority control 7:10 p.m. to 7:30 p.m., the Republican leader controls 7:30 to 7:45, and the majority leader controls 7:45 to 8 p.m.; that at 8 p.m., the Senate proceed to vote on the motion to invoke cloture on the motion to proceed to H.R. 3590; that if cloture is invoked on the motion, then all post cloture time be yielded back, the time be set aside, and the motion to reconsider be laid upon the table; that after the bill is reported, the majority leader be recognized to
Mr. REID. Madam President, I move to proceed to Calendar No. 175, H.R. 3590, and I send a cloture motion to the desk.

The PRESIDING OFFICER. The cloture motion having been presented under rule XXII, the Chair directs the clerk to read the motion. The bill clerk read as follows:

CLOTURE MOTION

We, the undersigned Senators, in accordance with the provisions of rule XXII of the Standing Rules of the Senate, hereby move to bring to a close the debate on the motion to proceed to Calendar No. 175, H.R. 3590, Harry Reid, Tom Harkin, Jack Reed, Edward E. Kaufman, Jeff Merkley, Roland W. Burris, Daniel K. Akaka, Patty Murray, Richard Durbin, Sherrod Brown, Barack Obama, F. Bennett, Jeanne Shaheen, Sheldon Whitehouse, Bill Nelson, Mark Udall, Benjamin L. Cardin, Christopher J. Dodd, Patty Murray.

Mr. REID. I ask that the mandatory quorum required under rule XXII be waived.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. I thank the Chair.

The PRESIDING OFFICER. The Senator from Minnesota is recognized.

Mr. FRANKEN. Madam President, I move unanimous consent that I be allowed to speak in morning business for up to 5 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

COBRA SUBSIDY EXTENSION AND ENHANCEMENT ACT

Mr. FRANKEN. Madam President, I rise today to urge my colleagues to swiftly enact the COBRA Subsidy Extension and Enhancement Act and allow more families to maintain health care insurance coverage as they look for work.

I urge my colleagues to support S. 2730, the COBRA Subsidy Extension and Enhancement Act. As you may know, COBRA allows jobless workers to keep their health care as they look for new work. The Recovery Act included a COBRA subsidy of 65 percent for 18 months for this year, but if we fail to act, millions of Americans currently looking for work will be faced with a further unbearable burden—the tripling of their COBRA payments.

I am very pleased with the Senate Patient Protection and Affordable Care Act that was released yesterday. This bill will help bring down health care costs for families and the Federal Government. We will invest in prevention and provide incentives to doctors to provide high-quality health care. I commend Leader Reid, Chairman Harkin, Chairman Baucus, and Chairman Dodd for moving us one critical step closer to secure, affordable health care for all Americans. But while health care reform will bring long-term relief, the proposed COBRA extension will help us bridge the gap before health care reform is fully implemented.

Take the situation of one of my constituents, Gregory, from Lakeville, MN, southeast of the Twin Cities. Gregory has built a professional career in the printing industry, the same industry my dad was in. He was a printing salesman for 30 years. The printing industry has been especially hard hit by our current recession. Gregory’s wife depends on him for health insurance. She has rheumatoid arthritis. My mom had rheumatoid arthritis. Gregory also has two daughters in school.

Gregory was laid off this March and has been tirelessly looking for a job ever since. But there aren’t any jobs to be found. Now he has accepted that he may have to change fields, but he is 57 years old and at Sars of 77. At 57 it isn’t easy. Unless Congress passes a COBRA extension, his premiums will nearly triple, going from $350 a month to $940 a month. In today’s dismal economy, who has $940 each month to spend on health care assistance, especially if you don’t have a job?

Gregory has explored the option of a private insurance plan, but his wife’s preexisting rheumatoid arthritis makes private plans an impossibility. Gregory and I have been hearing from families who are struggling to maintain coverage as they look for work.

Mr. COCHRAN. Madam President, in the coming weeks and months, the Senate is scheduled to complete action on bills that will have a profound impact on Federal spending for many years to come. I rise to express my concern about the manner in which new spending is being proposed in that legislation.

Congress has sent 5 of the 12 annual appropriations bills to the President for marking up. We have tried to get the bills to the floor individually so all Senators have an opportunity to offer amendments, and so we can avoid the necessity of grouping the bills into an omnibus bill.

The chairman, who is the distinguished Senator from Hawaii, Mr. Inouye, deserves the credit for these improvements. All Senators on the committee have cooperated, though. Despite the many difficulties associated with enacting the appropriations bills, the process compels us to hear testimony, analyze programs, and consider funding needs and priorities on an annual basis. It is not always a smooth process, but it has the benefit of compelling us to continually re-evaluate the level of Federal spending. That is not the case when we create long-term or permanent mandatory spending programs.

I don’t mean to criticize the oversight of the authorizing committees. Many of them do excellent work in this regard, holding agencies and funding recipients accountable for their management decisions. But once a funding stream is made mandatory, it is difficult to reduce spending or to use the leverage of future funding to motivate more efficient management of Federal programs or activities.

I urge my colleagues to swiftly enact the COBRA Subsidy Extension and Enhancement Act and allow more families to maintain health care insurance coverage as they look for work.

I yield the floor.

The PRESIDING OFFICER. The Senator from Mississippi is recognized.

APPROPRIATIONS BILLS

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I don’t mean to criticize the oversight of the authorizing committees. Many of them do excellent work in this regard, holding agencies and funding recipients accountable for their management decisions. But once a funding stream is made mandatory, it is difficult to reduce spending or to use the leverage of future funding to motivate more efficient management of Federal programs or activities.
One of the justifications often cited for creating mandatory spending programs is that the funding recipients need predictability to properly and efficiently manage programs. While there may be some truth to this, in itself it is not a sufficient reason to make a program mandatory or to change an existing program from discretionary to mandatory.

If increased predictability is the goal, Congress should make greater efforts to get the annual appropriations bills to the finish line on time and in order. An 'expanded and sustained national investment in prevention and health care' will require an investment in prevention and existing programs. There may be some truth to the idea that the programs be mandatory or to change an existing program from discretionary to mandatory.

Failure to process the appropriations bills in this manner has the effect of driving interest groups to seek the predictability of long-term mandatory funding streams. In effect, we create a situation whereby Congress must take proactive steps to reduce or eliminate spending as opposed to proactive steps to create new spending.

As a general matter, we should be very careful about moving programs in that direction, in my opinion. As I look at the major legislation that Congress is slated to consider over the coming months, the one thing I’m most immediately concerned about is the health care bill on which we will soon begin debate.

The bill reported by the Senate Finance Committee creates new programs for the prevention and control of diseases and a demonstration program for emergency psychiatric treatment. There are grants for school-based health centers, a demonstration program for emergency psychiatric care, and a demonstration program to address the health profession’s workforce needs.

A previously authorized childhood obesity program is directly funded with a mandatory appropriation. Many of these programs are funded for only a few years, just enough time to get funding recipients invested in the program, after which expectations will be overwhelming that the programs be continued with annual appropriations. As ranking member on the Labor, Health and Human Services Subcommittee, I might be inclined to support funding some of them, but beginning new programs with short-term, mandatory funding is a recipe for trouble. It results in hiding the long-term costs of these programs and provides no opportunity upfront to consider tradeoffs between the new programs and existing programs.

The health care bill reported by the HELP Committee includes a new prevention and public health fund to support an expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs." That is a quote from the bill. The bill appropriates $2 billion for this purpose in fiscal year 2010 alone and increases that amount to $10 billion by fiscal year 2014 and thereafter.

This has long been a priority of the Senator from Iowa, Mr. HARKIN. To the committee's credit, the bill provides some latitude for the Appropriations Committee to allocate funds among various prevention and wellness programs in the outyears. At its current form, this provision implies that we know today what the appropriate Federal investment for wellness programs will be 10 or 20 years from now. I just don't think that is plausible. If prevention and wellness programs are that important, let's call up the Labor, Health and Human Services appropriations bill and either increase the size of the bill or reallocate money in the bill to support wellness programs. When the fiscal year 2011 appropriations process begins, let's analyze how those programs are working and consider, once again, the appropriate funding levels for the coming year.

Beyond the health care bill, there is legislation to address global climate change. Here, again, we face the prospect of massive new annual Federal expenditures being established on a mandatory basis, effectively being put on autopilot right from the beginning. While there is value in the carbon allowances that would be auctioned under some climate bills, it is clear that tens of billions of dollars from such auctions would be plowed directly back into an array of programs administered by Federal, State, and local government agencies.

Some of the programs have a more obvious relationship to climate change than others. Just to list a few, the Senate-reported bill directly funds clean energy research, worker training, coastal preservation, and Federal land acquisition.

Many programs that would be funded by this bill are identical or similar to programs already funded in annual appropriations bills. Others are entirely new.

Are we truly confident in the year 2016 it will be prudent to spend 4.3 percent of an unknowable amount of auction revenues on international deforestation efforts? Are we sure that in the year 2030 we should be spending 74 percent of auction proceeds on worker assistance programs?

Congress should protect its ability to reconsider support or opposition to such spending annually, or at least periodically, based on program performance and our current national interests.

What about funding of Federal land acquisition? I have supported some Federal land acquisitions in my State of Mississippi, sometimes to incorporate important resources into our National Park System, sometimes to preserve sensitive habitats by including them in our national wildlife refuge system or in our national forests. I have had other Senators request specifically that we not approve the Federal acquisition of a particular piece of property. This is a clearly sensitive issue for our western colleagues, particularly in whose States Federal land ownership is already extensive. Yet in the climate bill, we are being asked to allocate funding to the executive branch only on the basis for unspecified Federal land acquisition projects, all with no apparent mechanism for congressional oversight.

Are any Senators really comfortable with that arrangement? This is just one example of why Congress should consider programs on an annual basis through an open process rather than putting programs on autopilot and funding them, including the basis for unspecified Federal land acquisition projects, all with no apparent mechanism for congressional oversight.

In July, the House passed an education bill, the Student Aid and Fiscal Responsibility Act. The bill terminates the programs that private lenders make federally guaranteed loans to students and provides that future student loans will be provided only through direct Federal loans from the U.S. Department of Education. Concerns have been raised that the House-passed bill establishes a number of new mandatory education programs and expands several existing programs with mandatory funding streams. The Congressional Budget Office estimates the House-passed bill would reduce mandatory spending by $87 billion over the next decade. But the House bill directly spends all but $3 billion of that amount on new and expanded programs. It directly funds a new college access and completion innovation fund. It establishes mandatory funding streams for school modernization, renovation, and repair, including a program of supplemental grants for States and the Gulf Coast that establishes mandatory programs for early childhood education and for reforming community colleges and improving training for workforce development.

In many cases, these are new programs. In some cases, the mandatory amounts are meant to supplement funding currently provided through annual appropriations.

Regardless of the merits of these programs, it is important to recognize that we are faced with a debt problem of huge proportions. We have now closed the books on fiscal year 2009, finishing the year with a budget deficit of $1.4 trillion. We began fiscal year 2010 with a deficit of $1.4 trillion. Our national debt has hit $12 trillion, and soon Congress will have to act to raise the Federal debt ceiling again.

President Obama’s own budget, optimistic in many respects, forecasts that our national debt will be rising to 66 percent of the gross domestic product by 2013. The Congressional Budget Office forecasts debt reaching 77 percent.
of GDP in 2020 and increasing thereafter to even more alarming levels. Given this set of facts, is it responsible to enact a bill that is expected to produce—not guaranteed to produce but expected to produce—a savings of $37 billion in mandatory spending but then in the same legislation spends all but $8 billion of that anticipated savings on new programs or expansions of existing programs that could just as well be achieved through the annual appropriations process?

Is it responsible to advance a climate bill that spends tens of billions of dollars on new mandatory programs and to allocate funding among those programs for decades into the future when we have no ability to judge whether those programs are needed or effective or what different programs might be necessary depending on how climate legislation would affect our economy, our workforce, and our environment?

Can we afford to enact a health care bill that expands costly mandatory programs but short on cost savings that we all know must be found within our health care system?

Certainly, there are situations where mandatory funding is an appropriate mechanism to ensure government services. In cases where our goal is to provide a service to a certain group of eligible people, regardless of how many people may be eligible in a given year, a mandatory appropriation may be the most efficient means of achieving that goal.

Given our Nation's fiscal situation, however, it seems to me we should strongly favor a procedure that requires Congress to consider programmatic spending every year. This is the very principle stated in paragraph 13 of rule XXVI of the Standing Rules of the Senate. This is not a question of which committee has the power over the purse. It is a question of whether Congress retains the power over the purse and deliberately exercise it.

Every year in appropriations bills, programs are terminated, reduced, or expanded based on performance and the availability of resources, pursuant to the budget resolution. Interest groups and program beneficiaries are required to give us their views annually. The competition for available dollars is intense. But so what? Whether it is health care, climate change, education, or other legislation, Congress should be very careful about establishing very, long-term, mandatory funding streams because it fundamentally weakens our ability to control Federal spending at a time when we greatly need to exercise that control.

I hope my colleagues will keep this in mind as we proceed with the business before us.

The PRESIDING OFFICER (Mr. WHITEHOUSE). The Senator from Maryland is recognized.

Mr. CARDIN. Mr. President, shortly we will have an opportunity to vote on moving forward and considering health care reform in this country. I thank the majority leader, Senator REID, for putting together the bill that came out of our two committees that accomplishes what I think are the three goals we need to accomplish in health care reform. I have been asked by the people of Maryland whether I would support a particular bill, and I am a voter for me to vote for a bill, it has to do three things: First, it needs to bring down the cost of health care in America; second, it needs to provide an affordable quality insurance option to every American; and third, it must be done in a fiscally responsible way.

The bill Senator REID is bringing forward accomplishes those three goals. First, it brings down the cost of health care in America by about $1 trillion. It does it by investing in prevention and healthy lifestyles; by cracking down on fraud, waste, and abuse; and by eliminating unnecessary administrative costs in our health care system. That is the way we should bring down health care costs that will improve quality but bring down costs.

Second, this bill allows every American to have access to affordable health insurance and health care. The Congressional Budget Office estimates the new bill will insure uninsured America by 31 million. We will be able to get 98 percent of Americans who are in this country legally, citizens, covered by health insurance as a result of this legislation.

This is the type of progress that is possible in a fiscally responsible way by not only staying within our budget but by actually reducing our budget deficit by $127 billion with no new tax burdens on middle-income families.

I am particularly pleased this bill will help middle-income families in America. Mr. President, I know you have received letters from your constituents. I have received letters from my constituents that tell us the status quo is unacceptable for any of us. Under the status quo everyone gets sick, everyone gets covered, everyone is sick, and they cannot get an insurance plan to cover the family. They have to pay two separate deductibles because they couldn't get an insurance policy to cover the family. The amount of money they are paying for health insurance is prohibitively expensive.

The status quo is not acceptable for the Cathcarts and should not be acceptable for any of us. Under the health care bill the leader is bringing forward, though, discriminatory practices by private insurance companies would be prohibited, and the Cathcarts would have the option of a lot of different plans they could choose from to cover their entire family without separate deductibles for different members of their family.

That is the type of health care reform we need that will help middle-income families in America. It will help middle-income families by bringing down the cost of health care. The cost of health care in America is growing at way too fast a rate. Ten years ago in Maryland it cost an average family about $6,000 for health insurance. Maybe their employer paid part; maybe they paid part. Today that is $12,000 a family. By 2016 it will be $24,000 a family if we do not take action. We need to help middle-income families. We need to move forward with health care reform.

The average family in Maryland today is paying $1,100 per family for the cost of the health care premiums for those who do not have health insurance. Those who have health insurance are paying for those who do not have health insurance.
That is why the bill the leader is bringing forward, that will cover 98 percent of Americans, is going to help middle-income families by eliminating that hidden tax of $1,100 per family in Maryland and around the country.

Health care costs are growing three times faster than the wages are growing in America. Inaction should not be an option.

For small businesses the situation is very dire. They are spending 20 percent more to provide health care than does the same business that is larger. Just as stressful, they cannot predict what the annual premium increase is going to be. How can you run a business without knowing what your costs are going to be from 1 year to another? For the sake of small businesses we need to move forward with health care reform.

A lot of families in Maryland depend upon Medicare; a lot of middle-income families in Maryland depend upon Medicare. This bill will strengthen Medicare by dealing with the underlying costs of health care, by getting that under control. At the same time we protect Medicare for the future, we provide additional benefits for our seniors by starting to close the doughnut hole, getting prescription drug costs under control, and providing preventive care for our seniors. This legislation will help middle-income families by dealing with insurance reform and eliminating preexisting conditions. It will allow those pools to offer more choice for middle-income families.

This legislation will help workers who work for small companies. It will help those people in our community who have preexisting conditions. It will help those people in our community who are changing jobs. It will help those in our community who depend upon Medicare. This legislation that is critically important for middle-income families in America.

That is unacceptable. We need to act, and we are going to have a chance to do that when we vote Saturday on proceeding with health care reform. I urge my colleagues to move forward on this vital legislation for America.

I yield the floor.

The PRESIDING OFFICER. The distinguished Senator from Utah is recognized.

Mr. BENNETT. Mr. President, I enjoyed listening to my colleague from Maryland. He says to us repeatedly the status quo is not acceptable. I agree with that. I would point out to him that the bill that has been presented to us by the majority leader guarantees the status will remain “quo” until 2014. This bill delays implementation until 2014. For 4 years the status will remain “quo” on key provisions.

Mr. CARDIN. Will my colleague yield on that point?

Mr. BENNETT. I am happy to yield.

Mr. CARDIN. Let me point out that much of the insurance reform takes effect immediately. The preexisting conditions are dealt with immediately. The larger pools for those who can’t find health coverage, that is done and implemented immediately.

Mr. BENNETT. I understand, but the key provisions of the bill that cost significant are postponed until 2014. Why? Because unless you make that postponement you cannot get the score down to the point where it is in the majority leader’s bill.

The challenge is that the real cost of health care is substantially more than this bill demonstrates as it comes out of the Congressional Budget Office. Why? Because the Congressional Budget Office is required by law to give costs over a 10-year period. If this whole thing started at the time the bill was passed and ran for the whole 10 years, the cost would be so high that it could not be offset with the programs that have been put in the bill. So the easy way to save costs and bring it down below the level that is acceptable is to delay the implementation until 2014.

We saw that in the Finance Committee. The Baucus bill moved the date of implementation from January 1, 2013, to July 1, 2013, to save money. Now we are looking at July 1, 2013, to January 1, 2014, an entire year of additional “savings.”

These are not savings at all. These are simply a delay in the implementation and therefore a delay in the expenditures. I want to move to the point the Senator from Mississippi was making with respect to the impact of this on the national debt and the national deficit. The last time we had a budget from President Bush, the last Bush budget said the total expenditures would be $3.1 trillion.

President Obama’s budget called for expenditures of $3.6 trillion or ½ trillion more. OK, ½ trillion more, you would assume, therefore, that the deficit that would occur would be roughly ½ trillion more than the Bush deficit. But the last deficit of the Bush administration, before the financial crisis hit us, was $116 billion. That is ½ trillion of the $3.1 trillion. And the first deficit of the Obama administration is $1.4 trillion.

You say: Wait a minute. Those numbers do not add up. The reason they do not add up is, we can control how much we spend, but we cannot control how much we take in. How much we take in is a function of the economy.

Let’s go back to the budget that was submitted and passed by the Obama administration and passed on the floor of the Senate by the Democratic majority. It projected $2.2 trillion in revenue, and it projected $2.2 trillion in entitlement spending, mandatory spending. That meant that everything else in government had to be borrowed. Money for the Department of Defense had to be borrowed, the State Department, all of our embassies overseas, all of that money had to be borrowed. The money for transportation, for the Federal Aviation Administration had to be borrowed. The money for national parks had to be borrowed. The money for education had to be borrowed.

It wasn’t that the expenditures went up an extra $1½ trillion to get a $1.4 trillion deficit. It was that the revenues went down. Yes, the expenditures did go up. The expenditures under the Obama budget went up roughly $½ trillion from the expenditures under the Bush budget. But the big problem was, the revenues went down at the same time.

The cautionary tale that comes out of this is, again, we can control how much we spend, but we cannot control how much we get in. That is a function of the economy. Money does not come from the budget; money comes from the economy. When the economy is weak, as it is now, we are going to have deficits, no matter how big an effort we make to try to avoid them, because the math simply does not work.

The reason I make that point is because, back again to the numbers that we realized when we were debating the budget, the money coming in was $2.2 trillion and the money already committed or committed within the entitlement of the Federal Government was $1.4 trillion. What Congress did not deal with in the appropriations process was $2.2 trillion. What we will do, if we pass the bill the majority leader has introduced or will introduce, is to increase the amount of mandatory spending, increase the commitments of the Federal Government to make expenditures in the health care area that will be beyond the reach of the Appropriations Committee, that will be going out whether or not we have the money coming in to pay for them.

I know the score out of CBO says this will save money for the Federal Government, but let’s get into the details of what the CBO had to say to see how much it would save and see why it would save.

The CBO says, about the longer term calculations with respect to this bill:

These longer-term calculations assume that the provisions are enacted and remain unchanged throughout the next two decades, which is often not the case for major legislation.

I think that is one of the understatement of the year. Major legislation does not often go unchanged for two decades. Congress will add goodies. Congress will delay some of the tax provisions. We see that every year with respect to the legislation known around here as the doc fix. It is in the law right now that every year we cut reimbursements to doctors under Medicare, and every year the Congress comes in and says: We won’t do it this year. The doc fix comes in and says: We will change this earlier situation. That means any score that depends on our not passing a doc fix is going to be worthless. CBO says that. Again:

These longer-term calculations assume that the provisions are enacted and remain unchanged throughout the next two decades,
We cannot produce that kind of money on the revenue side because we cannot really control the amount of revenue that comes in. The amount of revenue that comes in is a function of the economy.

Once again, where are we this year? Mr. President, $2.2 trillion in revenue, substantially below the amount of revenue that came in in the Bush administration. It is not Bush’s fault that there was more or less. It was the economy. CBO could estimate their costs when that legislation was being considered by the Congress.

In other words: We will make no attempt to guess what is going to happen in the future, but we can tell you that any kind of tinkering with this in the future is going to make all of our predictions wrong. That is the logical thing for them to say, it is the prudent thing for them to say, and it is the accurate thing for them to say.

There are a lot of things about this bill that I don’t like. I am convinced it will increase premiums for those who currently have health insurance. There is no way it can produce the kinds of results my friend from Maryland talked about of covering 30 million more people and cutting costs for everybody in Middle America without costing a lot more money someplace else. One of those places is going to be either in your tax responsibilities or in increased premiums or in state expenditures. We all know how the Governors feel about this proposal. The Governors have said this proposal will bankrupt us by the rolling of Medicaid costs onto the States—nay, Republican Governors, it is Democratic Governors who have come forward and said: We can’t handle this. So there are lots of things about this bill I don’t like.

But I believe the score that has been put on this by the prominent publication noted that rates for small business were being dramatically increased. Senator HARKIN scheduled a hearing in the Health, Education, Labor, and Pensions Committee. One of my constituents from Lancaster came in to testify that his premiums were rising by 128 percent. So I believe that inaction is not an option; that there are too many people not covered by health insurance or who are underinsured. The cost of health care was escalating at such a tremendous rate. It is having a great impact especially on small businesses. A trade association has scheduled a hearing for Saturday at 8 p.m. It is my hope and, candidly, my expectation that we will have the 60 votes to proceed for the consideration of this bill.

It is my view that inaction is not an option; that there are too many people not covered by health insurance or who are underinsured. The cost of health care is escalating at such a tremendous rate. It is having a great impact especially on small businesses. A trade association has scheduled a hearing for Saturday at 8 p.m. It is my hope and, candidly, my expectation that we will have the 60 votes to proceed for the consideration of this bill.
FORECLOSURES

Mr. SPECTER. Mr. President, while I have the floor, I wish to briefly address one other subject. I know my colleague is on the floor waiting for an opportunity to speak. This relates to a plan which is being carried on in the city of Philadelphia to stop foreclosures. We have seen a tremendous problem across America with the housing bubble, with so many people being in houses they could not afford and so many foreclosures. The Philadelphia program received front-page attention in the New York Times just yesterday as a model program. I call the Philadelphia program to the attention of my colleagues and to anyone who may be watching C-SPAN2, a program which is a model and which ought to be followed in other jurisdictions.

In March of 2008, the Philadelphia City Council approved a resolution called the Residential Mortgage Foreclosure Diversion Pilot Program. Following the council resolution, Philadelphia’s civil court adopted rules that no owner-occupied house could be foreclosed on or sold at sheriff’s sale before a mandatory conciliation conference between the borrower and lender aimed at finding a workable compromise. This Philadelphia program has emerged as a model, enabling hundreds of troubled home buyers to retain their homes.

In October of last year, a little more than a year ago, Senator CASEY and I held field hearings in Philadelphia and Pittsburgh to explore ways to keep borrowers in their homes using the successful Philadelphia program. I ask unanimous consent that at the conclusion of these remarks, a copy of the New York Times article be printed in full in the Record which details the Philadelphia program and is a suggestion for other cities as to how to follow that.

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

[From the New York Times, Nov. 18, 2009]

PHILADELPHIA GIVES HOMEOWNERS A WAY TO STAY PUT

(By Peter S. Goodman)

PHILADELPHIA—Christopher Hall stepped tentatively through the entranceway of City Hall Courthouse, one of dozens of others confronting foreclosure purgatory. His hopes all but extinguished, he fully expected the morning to end with a final indignity and would sign over the deed to his house—his grandfather’s two-story row house; the only house in which he had ever lived; the house where he had raised three children.

“This is devastating,” he said last month as he sat in the gallery awaiting his hearing. “This is my childhood home. I grew up there. My mother passed away there. My grandfather passed away there. All of my memories are there.”

A union roofer, Mr. Hall, 42, had not worked since August 2008, when the contractor employed him as a foreman went broke and laid off more than 40 people. He had not made a mortgage payment in more than a year, and his lender, Bank of America, was threatening to auction off his house through the sheriffs office.

In most American towns that probably would have been the end of the story: another home turned into distressed bank inventory by the national foreclosure crisis. But in Philadelphia, one of the first cities to face the crisis last year to try to keep people in their homes, Mr. Hall entered the courtroom with a reasonable chance of hanging on.

Under the rules adopted by Philadelphia’s primary civil court, no owner-occupied house may be foreclosed on and sold by the sheriffs office before a “conciliation conference,” a face-to-face meeting between the homeowner and the lender aimed at striking a workable compromise. Every homeowner facing a default filing is furnished with counseling, and sometimes legal representation.

So, as Mr. Hall stepped into the ornate courtroom just after 9 o’clock, he was swiftly provided with a volunteer lawyer, Kristine A. Phillips. She conferred briefly with a lawyer for Bank of America and returned with a useful promise. The bank would leave him alone for six more weeks while his housing counselor pursued solutions in an attempt to lower his payments permanently.

“You’ve got more time,” Ms. Phillips told him. “We’ll get this all worked out.”

“Thank you so much,” Mr. Hall said softly, his body shaking with pent-up anxiety now tinged with relief. “It’s a lot of weight off my shoulders.”

In a nation confronting a still-gathering crisis of foreclosure, Philadelphia’s program has emerged as a model that has enabled hundreds of troubled borrowers to retain their homes. Other cities, from Pittsburgh to Chicago to Louisville, have examined the program and adopted similar efforts.

“It brings the mortgage holder and the lender to the table,” said City Councilman John M. Tobin Jr. of Boston, who is planning to introduce legislation to enact a program in his city modeled on Philadelphia’s. “When people are face to face, it can be pretty disarming.”

When homeowners in Philadelphia receive legal default notices from their mortgage companies, the court system schedules a conciliation hearing. Canvassers working for local nonprofit agencies visit foreclosed homeowners, distributing fliers that inform them of their rights to a conference, and urging them to call a hot line that can direct them to free legal help.

“You can feel a certain sense of relief from their just being able to speak to someone about the program,” said Anna Hargrove, who works as a canvasser in West Philadelphia.

Every Thursday morning, the sixth floor of the City Hall Courthouse, where the conciliation hearings are held, is given over to the conciliation conferences. It fills up with volunteer lawyers in jogging shoes, who are representing homeowners; lawyers for mortgage companies; and all variety of delinquent borrowers—elderly citizens leaning on canes, construction workers in coveralls, parents with bored children in tow. Sometimes lawyers exchange preliminary settlement terms, while the homeowners fill out papers and wait.

In some cases, deals are struck that lower monthly payments for borrowers and allow them to retain their homes. When a homeowner cannot afford the home even at modified terms, the program helps to precipitate a graceful exit, in which the borrower accepts cash for vacating the property or signs over the deed in lieu of further payment.

RIGHT TO MEDIATION

The Philadelphia program forces an outcome by bringing homeowners to precipitate in one room. If the mortgage company proves intractable, the homeowner has the right to request mediation in front of a volunteer lawyer serving as a provisional judge, who relays recommendations to the program’s supervising judge. If the judge finds that the mortgage company is not acting in good faith, she can bend the legs of the lender by denying permission for a sheriff’s sale.

While data is scant, a legal aid group, Philadelphia’s Volunteer Defender Program, has complete information on 61 of the 397 cases it has resolved since October 2008 through the anti-foreclosure program. Fifty five resulted in sheriff’s sales, while 35 ended with loan modifications that lowered payments, the group says. The remaining 21 cases were divided among bankrupcy, loan forbearance and repayment arrangements, graceful exits and straightforward sales.

Some suggest the city’s program is plagued by the same basic defect as the Obama rescue plan: Nearly all the loans that have been modified have been altered on a trial basis, requiring homeowners to reapply for an extension of the terms after only a few months—a process that appears rife with obstacles, according to participants.

“There’s no teeth to the conciliation program,” said Matthew B. Weisburg, a Philadelphia lawyer who represents homeowners in cases involving alleged mortgage fraud. “It’s a largely ineffective stopgap prolonging what appears to be the inevitable, which is the loss of homes.”

Still, Mr. Weisburg grudgingly praised the plan.

“You can’t legislate arbitrary and unpredictable,” he said, “but it’s better than what anybody else is doing.”
Philadelphia's Residential Mortgage Foreclosure Diversion Pilot Program began with a resolution passed by the City Council in March 2006. Sheriff John D. Hall decided to scrap the sheriff's sale scheduled for April. Low-income neighborhoods were already experiencing a surge of foreclosures involving subprime borrowers. In early 2008, nearly 200 homes a month were being auctioned by the sheriff's office, about one-third more than in 2006.

In West Philadelphia, Councilman Curtis Jones Jr., one of the sponsors of the resolution, watched his childhood neighborhood consume, as the homes of working families—their porches once lined with flower pots—were boarded up with plywood.

"It becomes a blight on your entire community," Mr. Jones said. "It creates an environment that fosters everything bad, from prostitution to drug dealing to wildlife."

raccoons. A whole house, the one becomes 10, and 10 becomes the whole block.

Response to the resolution. Sheriff Green canceled the April sale. Meanwhile, Judge Annette M. Rizzo, who oversaw a local task force on stemming foreclosures, joined with the president judge of Philadelphia's Court of Common Pleas to develop the program.

For Judge Rizzo, a high-energy woman who has long taken an interest in housing policy, the moratorium presented both a crisis and an opportunity. The sheriff was effectively refusing to fulfill his mandated responsibilities, leaving his office unable to legal challenges. Mortgage companies could be persuaded to participate in an alternative way of addressing foreclosures, more people could stay in their homes.

"I realized we're either going to go down in flames or we're going to be a national model," Judge Rizzo said. "We're going to look at these cases and see what we can work out."

Mr. Hall knew none of this. What he knew was that his life seemed to be unraveling.

HOME TO FOUR GENERATIONS

Ever a teenager, he had earned a middle-class living with his hands. He had been raised by his grandfather in his three-bedroom house on Akron Street, in a predominantly black neighborhood in Northeast Philadelphia.

He had attended St. Martin's, the Catholic school around the corner, married his childhood sweetheart and still remained in his grandfather's house, sending his children—two boys (now in their 20s) and a 12-year-old girl—to the same school.

Mr. Hall, a soft-spoken yet intense man with a silver-tinted goatee, had worked seven days a week for much of this decade, bringing home weekly pay of about $1,000 enough to get him through in his early 20s; enough to obtain a fixed-rate mortgage and buy the house for $44,000 when his grandfather succumbed to Alzheimer's disease in the mid-1980s; enough for a motorcycle and a boat.

But three years ago, Mr. Hall committed the sort of mistake that has upended millions of households. At the recommendation of a for-profit credit counselor, he took out a new mortgage—a variable-rate loan from Countrywide Financial, which is now owned by Bank of America. He paid off some credit card debt, and he borrowed an extra $15,000 to renovate his home, expanding his mortgage balance to $63,000.

The loan began with manageable payments of about $500 a month. But Mr. Hall's interest rate soon soared—something he says was never explained to him—lifting his payments to $350 a month.

"When I got the mortgage, I didn't really understand it," he said. "They told me this would improve my credit and that was it. It was just, 'sign here,' and 'initial here.'"

He paid off some credit. With unemployment growing, lost credit. He might still have managed had construction not come to a halt. By 2007, Mr. Hall's employer was cutting work hours. In August 2008, it shut down, turning his $1,000 weekly paycheck into an $800 monthly unemployment check.

Every day, he set the alarm clock and headed to the union hall at 5 a.m., waiting and hoping. One day he went home, still jobless and discouraged, now confronting the displeasure of his wife, who worked as a nurse, and who he said never came to terms with the reality that he would not see the actual spending in the bill start to kick in until January 1 of 2014.

However, many of the revenue components in the bill begin to kick in next year, on January 1, 2010. So the tax increases, which are multiple and many of the revenue components in the bill begin to kick in next year, on January 1, 2010. So the tax increases, which are multiple and hundreds of billions of dollars, would be seen to take effect immediately, starting January 1, 2010, while much of the spending in the bill would be deferred until much later in the budget window—not taking effect until January 1, 2011.

What distort the true picture of what this legislation would cost and distorts it substantially.

The other point I will make is that there are a couple other provisions in the bill that, by its terms, has been under state law as it is now in the bill, and its inclusion in the other, understate the cost of the bill. One is the absence of the sustainable growth rate formula, or the so-called physician fee fix, the reimbursement form, that is a $247 billion hole—$247 billion in additional spending that is not included in the bill. That, of course, understates the overall cost.

There is also a $72 billion assumption in there for a program called the CLASS Act. I wish to read for you something that one of my colleagues on the Democratic side said about the CLASS Act. This was the Senator from North Dakota, chairman of the Budget

HEALTH CARE REFORM

Mr. THUNE. Mr. President, we now have a draft of the Senate majority's health care reform bill, after spending several weeks behind closed doors producing that bill. Some of the details are starting to emerge.

I believe it is critical that all Members in the Senate have an opportunity to look very closely at what is in the bill. It should come as no surprise that it is a 2,000-plus page bill. Much was made of the bill in the House of Representa-

tives being a 2,300-page bill when it was all said and done. This is 2,074 pages. It hasn't been amended yet, so that will probably expand it as this bill comes to the floor.

I think we at least now have something we can look at and review. There was a lot made last night by the majority when they rolled this bill out—how fiscally responsible this bill is and how much of an improvement it is over recent drafts of this legislation. I wish to point out a couple things that I think, perhaps, put into perspective what this bill would do, what it entails, and how, with all the rhetoric about how it differs and improves upon previous drafts of the bill, it comes down to basically the same elements that have been in all the bills we have seen.

First is with respect to the costs. It is very clear the cost of this bill— which was stated last night as $849 billion—is dramatically understated relative to its true cost when fully implemented, by its terms, and in its reasons.

One, they push back the effective implementation date to 2014 for many of the provisions to take effect. So you will not see the actual spending in the bill start to kick in until January 1 of 2014.

However, many of the revenue components in the bill begin to kick in next year, on January 1, 2010. So the tax increases, which are multiple and hundreds of billions of dollars, would be seen to take effect immediately, starting January 1, 2010, while much of the spending in the bill would be deferred until much later in the budget window—not taking effect until January 1, 2011.

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There is also a $72 billion assumption in there for a program called the CLASS Act. I wish to read for you something that one of my colleagues on the Democratic side said about the CLASS Act. This was the Senator from North Dakota, chairman of the Budget
Committee in the Senate. He called the CLASS Act "a ponzi scheme of the first order, the kind of thing that Bernie Madoff would be proud of." That is how he refers to this CLASS Act included in the bill and the savings that are associated with it. In fact, the 10-year, $727 billion shows in the first 10 years turns into a deficit in the second 10 years. So when you back out the $72 billion that it is, it is assumed, would add to the revenues in the bill and you add to the cost of the bill the $225 billion that would be required to fund the physician fee formula over a 10-year period, the so-called surplus that this bill generates actually turns into a deficit. It goes from a surplus of $130 billion to a deficit of $189 billion.

Again, a lot of gimmicks are being used to understate the true cost of the bill to the American people. All that being said, if you look at the overall cost, when fully implemented over 10 years, you come up with this: Remember, when the Finance Committee passed its version of this bill out of committee, the 10-year, fully-implemented cost was $2.2 trillion.

When the Finance Committee passed its version of the health care reform bill out of the Finance Committee, they have fully-implemented cost of that bill was $1.8 trillion. So that is $1.8 trillion for the Finance Committee bill and $2.2 trillion for the Health, Education, Labor, and Pensions Committee bill. Guess what? We got one bill that was merged together and has now been unveiled for all the world to see. It is $2.5 trillion in overall cost—10-year, fully-implemented cost. That is a $2.5 trillion expansion of the Federal Government in Washington, DC, associated with the fully- implemented cost of the bill.

The point I am trying to make is this: The cost of the bill is being dramatically understated by the authors of the bill. It looks like it comes in under $1 trillion, when, in fact, when you back out the two components I mentioned, it is over $1 trillion in the first 10 years, and that is because they delay implementation of many provisions until January 1, 2014—a budgetary gimmick designed to understate the true cost of the bill.

When you look at the fully implemented, 10-year cost of the legislation, without the gimmick of the delayed implementation, and the other gimmicks in here, it is $2.5 trillion in additional costs to the taxpayers of this country. Of course, that $2.5 trillion has to be paid for somehow. The way it is paid for isn't any different than in any of the other bills we have seen so far. It is paid for with higher taxes on small businesses and higher taxes on individuals. It is paid for with cuts to Medicare Programs that would impact senior citizens in this country, as well as medical providers, from hospitals to physician—name it—and medical device manufacturers get hit hard in this legis- lation. Everybody gets hit when it comes to the reimbursement side to pay for this.

Of course, the American taxpayer gets hit hard when it comes to the tax increases included in there—$2 trillion in tax increases and $1 trillion in Medicare. The $2.5 trillion expansion of the Federal Govern- ment to create a new entitlement program to make many of these decisions based on what is cost-effective, and some of these deci- sions that have traditionally been made between patients and doctors are converted into government contractors. What are now merely recommendations will become de facto rules, and under national health care these kinds of cost analyses will inevitably become more common as govern- ment decides what patients can afford.

I will read you something that was in an editorial in the Wall Street Journal today. It gets at the very heart of what I am talking about. It says:

More important for the future, every Democratic version of ObamaCare makes this task force an arbitrage of the benefit that private insurers are required to cover as they are converted into government contractors. What are now merely recommendations will become de facto rules, and under national health care these kinds of cost analyses will inevitably become more common as government decides what patients can afford.

I fear that we are entering an era of deliberate decisions where we choose to trade people's lives for money.

What is important about that observation is that he is pointing out what a lot of people will be very concerned about. If you are a woman in my home State of South Dakota, and let's say you are 42 years old, the recommenda- tion made by this task force, which everybody is now dismissing and saying that there is no evidence that this is the right way to go under legislation such as this, where you create a board that actually does have statutory powers and is enabled to make many of these decisions based on what is cost-effective, you could have someone in a State such as mine, or any woman in any State in this country who is in their forties—be- cause they said 50 should be the base- line now, the age at which you get mammograms or breast cancer screening— that you could actually have somebody in this country who would be denied the opportunity to do that.

Of course, we all know and everybody can relate to people in this country
who, by virtue of that screening process and that test, have been detected early and able to beat breast cancer, which is something that afflicts a great number of women across this country.

That is one example. I use that as an example of how this new type of government-run program might work. But there are countless other examples of the very same thing.

As we head into this debate, again I remind my colleagues this type of underwriting—referring to health care—ought to be about driving down costs, it ought to be about providing more access to Americans, it ought to be about maintaining that important relationship between a physician and their patient and not getting to where we have the government making those decisions, where we are actually bending the cost curve up rather than driving it down.

By the way, the CBO said in response to the majority’s bill that was unveiled yesterday that it actually increases costs by $160 billion. To me, the fundamental goal of health care reform for most Americans, the key concern they have about health care today, is its costs. Everything we have seen so far, including the most recent version which we are going to have at some point on the floor of the Senate, probably sometime after the Thanksgiving holiday, increases costs, drives the cost curve up.

How can you be for something that cuts Medicare to providers and seniors across this country, that raises taxes on small businesses, the economic engine that creates jobs in this country, raises taxes on middle-income Americans and which also, ironically, raises the cost of health care, increases the cost of health care? I am not saying this is the CBO. That has been consistent through all the bills that have been produced. It is consistent with this country, with the précis that has included all the new provisions that will be included—again, $2.5 trillion, 10-year fully implemented costs paid for by Medicare cuts, $3 trillion in Medicare cuts, $1 trillion in tax increases, and obviously much more than that when you get into the fully implemented time period, all that—all that—to raise health care costs for people in this country. How can we label that reform?

I hope the American people, as they listen to this debate, will engage, will participate, and certainly I think most government too much money, even if it saves lives.

Mr. THUNE. Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan.

Ms. STABENOW. Mr. President, I ask unanimous consent to speak for up to 20 minutes in morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

HEALTH CARE REFORM

Ms. STABENOW. Mr. President, first, it is a good thing our health care reform doesn’t do the kinds of things the President is talking about. I wouldn’t support it either if the Chair would either. It is a good thing that is not what we are doing. With respect to my friend from South Dakota, we have a different view of this bill. Let me first start by saying, as the Chair knows and as this bill saves lives and saves money, and particularly protects Medicare and stops insurance abuses. That is what we are about.

Before going through the specifics of the bill, I wish to read from a very interesting column today in the New York Times. We can have competing papers, and that the Chair would either. It is a good thing that is not what we are doing. With respect to my friend from South Dakota, we have a different view of this bill.

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that Washington bureaucrats will invade “the privacy of the examination room,” that we are on the road to rationed care and that patients will lose the freedom to choose their own doctor.

All dire—but also wrong. Those forecasts date not from this year, but from the battle over Medicare in the early 1960s. The heirs of those brave women who protected the insurance industry at that time are conjuring the same bogeymen [today].

Indeed, these same arguments we hear today against health reform were used even earlier, to attack President Franklin Roosevelt’s call for Social Security.

I appreciate the concerns that have been raised, but this is a replay of a time in the sixties when there was a debate about whether seniors who couldn’t find affordable insurance in America should have access to the health care they need and the insurance they need.

Thank goodness, Democrats at that time, the President, and the Democratic majorities in the House and the Senate, chose to stand up for seniors and to override the objections coming from the insurance companies and the insurance lobby and those making money off the system at that time.

Let me be clear about what is at stake if we do nothing, because that is the first question. Why should we be doing something? Every single day—in fact, today—14,000 Americans got up with health insurance and by the time they go to bed tonight they will not have it because they have lost their job, because their business had to drop them because the costs went up too much, because they couldn’t afford the explosion in premiums and copays.

Insurance rates will almost double by 2016 for families, up to $24,000 for a family of four. Businesses will see their costs double in the next 10 years. What is extremely concerning to me as a Senator of the great State of Michigan, where we have a lot of employer-based care, employers doing the right thing, working hard to try to continue to provide health care coverage, those increased costs, doubling the costs over the next 10 years will, in fact, cost us 3.5 million jobs. Health care reform is about saving jobs.

Family incomes will be reduced by $10,000. Every single day—right now—5,000 homes are foreclosed. About half the homes that are foreclosed every day are foreclosed because of a medical crisis—because they are paying for that medical care or they are uninsured—but they could get a better rate, such as a big business. That is what this is about.

Amazingly, this big government takeover we hear so much about is for less than 20 percent of the people in the country right now. Eighty percent of the people in the country get their insurance through their employer—about 60 percent. The rest through a public program of some kind—Medicare, VA for veterans, our military, Medicaid.

We agreed on ways that we changed the gap for small businesses and individuals, providing them tax cuts so that health insurance is more affordable and pooling them together. That is what this is about.

We are going to stop the insurance company bad practices as I talked about before. We are going to focus on prevention and quality which saves us money over time. In fact, one of the biggest ways we will save money is by focusing on keeping people healthy, focusing on ways that we change a system so we are not paying for individual procedures, but paying for those things the doctor needs to do and wants to do in total to help you recover from an operation or have the treatment you need.

We are going to, importantly, reduce long-term costs, lower the deficit and reduce long-term spending. If we do nothing, costs will continue to go up and down and down. Unfortunately, because of family costs and business costs, we are likely to see care go down and down as they struggle to keep their heads above water.

We are going to talk a little bit more about Medicare. This is so important, as we know. We are going to strengthen Medicare. We know, again, if we do nothing, it is predicted the Medicare trust fund will be insolvent in 2017. We need to act.

We are doing a number of things both to bring down costs by focusing on prevention, to say to seniors and people with disabilities that if you go in for that annual checkup, if you go in for preventive work and, yes, mammograms or the dread colonoscopy, then you will be able to do that without costs. There will be no deductible and no copay.

We are going to lower the gap in the prescription drug program under Medicare. Right now we have a gap in coverage, and we are going to begin to close that and hopefully close that all the way over time.

We are going to prevent payment cuts to doctors. This is something about which I care very deeply. We are going to make sure the cut for next year of 21 percent does not take place for doctors. But we need to solve long-term the formula problems that are putting at risk doctors’ and patients’ ability to see their doctor. We are committed to doing that, to working with physicians.

It is incredibly important that seniors right now who can, in fact, see the doctor they want—for example, you can choose your own doctor—we want to make sure they can continue to do that.

We are going to reduce the deficit and protect Medicare for the future. This is very important. In fact, the payroll tax that was talked about by the Senator from South Dakota would go into the Medicare trust fund to help make sure we are doing that.

It is important we recognize that AARP, which has endorsed the House bill and supports health care reform moving forward—they have not specifically at this point endorsed what Senator Reid has brought before us today, but we are hopeful they will. We know they are supporting health care reform.

There is no question that AARP, a champion for seniors in this country, would not be supporting moving forward on health care reform, they wouldn’t be supporting what the House did if, in fact, it did what our colleagues are saying on the other side of this Hill, they would not.

Unfortunately, we have had too many seniors who have been scared. I, frankly, think that is shameful, the
kind of misinformation that is being given out to seniors. I know my mom, at 83, was initially concerned about what she was hearing until I walked through what we are doing. By the way, I think you would have to wrestle her to the ground to take away her Medicare card. I am very pleased about two other provisions that I think are so important for families. One is to allow young people to be able to stay on their parents’ insurance if they wish. I wish that had been in place a couple of years ago, actually. I know from experience that the first job a young person may get out of college may not have health insurance or they may come out of college, graduate, and early retirees are finding it extremely difficult, as they put together their numbers, to pay for care. Going forward, when this bill passes we will be a partner with those businesses or entities providing early retiree insurance by providing coverage for catastrophic care. We will take the costs off the backs of the seniors. It also means other entities as well should be able to more accurately plan based on this partnership between businesses, employer-based care, and the Federal Government. This is very significant.

As I close, it is very important to stress what this is all about. There are many pieces to this. I invite anyone from Michigan, as we have done all year, to go to my Web site. We have the entire bill posted. We have done this at every step of the way. We will continue to do that as the debate moves forward, with amendments and so on. We welcome people to get engaged.

I have a Health Care People’s Lobby that folks can sign up for e-mail, and we will keep you posted on what is happening, and you can share your thoughts, your feelings, and your stories about what health care reform would mean to you or what has happened to you as someone needing health care or not getting the health care help from your insurance company that you believe you should as someone who has been paying for health care.

We are in a position now, we are positioned to do something that I believe should have been done years ago. Many have tried to do it.

I commend this President for making health care, health insurance reform, a top priority; for understanding that we are losing jobs overseas because we are not competitive internationally with other countries, that health insurance reform is about jobs. It is about saving jobs. It is about the cost of losing your insurance. It is about businesses seeing that the costs go up and up and up, and that we have to begin to turn this ship so we can get these costs under control. Saving lives, saving money, protecting Medicare for the future, and stopping the insurance abuses that occur every day for too many families—that is what health insurance reform is all about.
It is worth the time, whatever it takes, to do this and get it right. Saving lives and saving money for American families and businesses, protecting Medicare, stopping insurance abuses—this is worth fighting for. I am very proud to be part of a group of people who have placed this as a top priority.

I yield the floor.

The PRESIDING OFFICER. The Senator from Delaware is recognized.

INAUGURATION OF THE PRESIDENT OF AFGHANISTAN

Mr. KAUFMAN. Mr. President, today, I rise to recognize the inauguration of President Karzai, as he begins his second term as President of Afghanistan. This milestone presents a unique opportunity to begin a new chapter in Afghanistan's history, which I hope will be characterized by transparent governance, accountability, and an even stronger partnership with America.

Our two governments share common interests in the success of Afghanistan and the stability of the region.

When President Karzai during his September visit to Kabul, we discussed counterinsurgency strategy and the importance of stronger government at all levels—national, provincial, and district. Counter-insurgency strategy has proven effective throughout history, and good governance is essential for its success.

President Karzai knows that he must garner greater support among the Afghan people for his government because, ultimately, this is a battle for legitimacy between the Afghan government and the insurgents. We will continue to partner with the Afghans to defeat the Taliban, but counter-insurgency cannot succeed if the Afghan people believe their government is plagued by corruption.

I welcome President Karzai's recognition of corruption as a “dangerous enemy of the state” in his inaugural address earlier today.

His intention to create an anti-corruption unit is an important step to this end, but words are not enough. He must match this rhetoric with action, and immediately take steps to effectively address the problem.

No government official is above the law, and all should be held accountable for their actions. Numerous criminal cases involving government officials—such as recent allegations that the Afghan Minister of Mining accepted a $30 million bribe as part of an illicit deal with a joint venture mining firm—must be thoroughly investigated.

As President Karzai said today, government officials should register their earnings. Those who engage in corrupt behavior should face the full weight of the law and be brought to justice.

Corruption must be addressed for two primary reasons: one, to build the confidence of Afghans in their government; and two, to ensure that the government functions more effectively in providing essential services.

In order to fulfill these two goals, I urge President Karzai to appoint competent governors and cabinet members who respect the rule of law and human rights, and who are publicly committed to the people of Afghanistan.

The stakes are too high to revert to cronynism. Now is the time for President Karzai to appoint and support capable, effective, and law-abiding public servants.

The essential defense against the Taliban is an effective Afghan government. As such, I urge President Karzai to work with the United States and other international partners to produce specific and measurable guidelines for combating corruption, improving government transparency and accountability, providing essential services, strengthening rule of law, tackling the drug trade, and improving the economic infrastructure.

Clear benchmarks must be set, and progress must be monitored to ensure compliance.

This plan cannot be limited to Kabul. It is critical that government officials at all levels are well trained and empowered with the necessary authorities and budgets to improve the lives of all Afghans. We must work together to undermine the Taliban's foothold and role as the de facto provider of rule of law and basic services, especially in southern Afghanistan.

In addition to good governance and essential services a third element of success in counterinsurgency is the training and deployment of effective national security forces.

I welcome President Karzai's stated intention to assume complete Afghan control over security within 5 years. I also echo his calls for NATO partners to take effective steps to accelerate the training of the Afghan National Army—ANA and Police—ANP.

Currently there are not enough Afghan and international forces on the ground to “clear and hold” against the Taliban. In fact, the number of trained Afghan security forces is less than one-third that of Iraq—a geographically smaller country with nearly the same-sized population.

The training of the ANA and ANP must be expedited to build a stronger force of needed counterinsurgents, with the near-term goal of transferring responsibility to the Afghans.

During my two trips to Afghanistan this year, it was clear that the Afghan people identified security as a key concern, and wanted a swift transition from international to Afghan forces. Americans also hope for a swift transition, so we can eventually end our military presence and bring our brave troops home to their families.

I fundamentally disagree with accusations by some in Afghanistan—including President Karzai—that the U.S. presence in Afghanistan is purely self-serving. We are committed to working with President Karzai to secure our shared objectives. It has been said that nations have no permanent allies, only permanent interests. As we stand on the cusp of history together, the United States and Afghanistan are committed to both shared goals and coinciding interests.

As President Obama outlined in March, it is America's goal to disrupt terrorist networks in Afghanistan, to defeat al-Qaeda, and to help to promote a more capable and effective Afghan government. The way to do this is to partner with the Afghan people to defend them against a resurgent Taliban. As Secretary Clinton said, these are mutually reinforcing missions.

There is an underlying urgency to this joint venture, and we cannot succeed without a true partner in the Afghan government.

In his inaugural address, President Karzai said the right things. Now is the time to implement them.

During my visits to Afghanistan, I was impressed by the resolve and vision of the brave people of Afghanistan. In the face of enormous challenges, the majority of Afghans have rejected the Taliban's oppression and chosen to forge a better future for generation future generations.

Today represents an opportunity for President Karzai to fulfill the hopes and dreams of his people, and bring strength, peace and prosperity to Afghanistan through good governance.

As he begins his second term, President Karzai must forge a path that will lead to a brighter future, free from corruption. We need leadership, resolve, and determination, if we are to be successful in Afghanistan.

AMERICAN EDUCATION WEEK

Mr. FEINGOLD. Mr. President, this week I join my colleagues and the Nation in observing the 88th annual American Education Week.

The United States of America has a rich history of providing a free public education to its children, and the education that millions of students receive every year opens countless doors of opportunity to these students. Teachers, administrators, and support staff in our Nation's communities plant the seeds of knowledge in our students, who provide the future American economy, American innovation, and American society. And sometimes I do not feel like enough is said of these individuals who have dedicated their lives to the cause of public education and who have touched the lives of millions of children. Let us reflect on the positive impact teachers and schools have on this country.

While enormous strides have been made in expanding access to public education since our Nation's founding, the United States still has a long way to go before we can say that every child in our Nation has access to a high-quality public education. There is
still a persistent achievement gap in many of our Nation’s schools with respect to low-income and minority students. The nationwide high school graduation rate hovers around 70 percent and is even lower for students of color. Schools must work together to continue to support our educators and help ensure that every child has access to good teachers and high-quality schools. That is why I am looking forward to working with educators as Congress undertakes the reauthorization of the Elementary and Secondary Education Act, also known as No Child Left Behind. We now have the opportunity to rethink the proper role for the Federal Government in education reform and how we can support States and school districts as they continue to work to educate all our Nation’s children and close the persistent achievement gap that still exists in too many of our Nation’s schools. We need to work together to solve problems, strengthen our public school system, and make certain that all our students receive the education they deserve.

As Chief Justice Warren wrote when he delivered the opinion of the Supreme Court in the landmark Brown v. Board of Education decision:

"Today, education is perhaps the most important function of state and local governments. Compulsory school attendance laws and the great expenditures for education both demonstrate our recognition of the importance of education to our democratic society. It is required in the performance of our most basic public responsibilities, even service in the armed forces. It is the very foundation of good citizenship. Today it is a principal instrument in awakening the child to cultural values, in preparing him for later professional training, and in helping him to adjust normally to his environment. In these days, it is doubtful that any child may reasonably be expected to succeed in life if he is denied the opportunity of an education. Such an opportunity, where food was scarce at some point during the last year. This figure amounts to more than one out of every five families lives in poverty. An astonishing 1.1 million children went to sleep hungry at some point in 2008—a 36 percent increase from 2007.

"Poverty means hunger.

No child should ever know what it means to be hungry. Childhood hunger hinders development in the long term, and children who are hungry have difficulty learning and are at much higher risk to be in poverty as adults. Hunger negatively affects children’s behavior, school performance, and cognitive development.

As we celebrate this holiday season, it is important to reflect on how each of us can support our communities. In my home State, the employees and volunteers at the Maryland Food Bank provide 14 million pounds of food annually to those in need. Working with more than 1,000 partner organizations, including soup kitchens, senior centers, daycare centers and afterschool programs, the food bank works to fill the many needs of Maryland families. In these difficult economic times, the services of the Maryland Food Bank are more important than ever.

During the past year, the staff at the food bank’s facilities in Baltimore and Salisbury saw demand increase by 50 percent. Middle-class families who a year ago made donations to the food bank are now turning to the organization to put food on their own tables. Americans with full-time jobs are the fastest growing cohort of those in need. As unemployment continues to rise, families are being forced to spend their savings and are too quickly moving from middle to low income. America’s working poor are most at risk. They live from paycheck to paycheck and have no safety net if their company downsizes or their hours are cut. When money is short, Americans are forced to make excruciating choices.

It is estimated that one-third of Marylanders relying on food stamps must choose between buying food and paying utility bills. Fifty-three percent of those who receive food assistance have unpaid medical bills. The number of working poor families in Maryland is 70 percent higher than it was two decades ago.

In addition to the food bank, I also want to highlight the work of employees at the many social service agencies across our State. These dedicated workers devote their time and energy to helping their community and work side-by-side with the Maryland Food Bank and other organizations to provide meals and services to those in need.

For example, the Maryland Department of Education works closely with the Maryland Food Bank on several projects that provide students with nutritious meals. More than 303,000 Maryland children rely on free or reduced-price meals in schools. Through the Backpack Program, the food bank provides schools such as Baltimore Highlands Elementary with backpacks filled with food. Children receive the backpacks on Friday afternoons to ensure they are not hungry over the weekend.

Kids Cafe is an innovative partnership between the food bank, the Maryland Department of Education, and local afterschool programs that provide nutritious meals and teaches children how to make healthy food choices.

Our seniors are also at risk of food insecurity at much higher levels than the general population. I applaud efforts such as the SNAP Outreach Program in Maryland, which is a partnership between the USDA and local organizations to help register seniors for food assistance programs. Despite these efforts, we need to do more. In my State alone, it would take 82 million pounds of food to support the more than 350,000 Marylanders in need every year.

We must recommit ourselves to serving our communities and work together to support those in need during these difficult times. As Senators and staff leave Washington for their home States and prepare to give thanks and enjoy the company of family and friends, I encourage us all to show our support for those who work daily to make mealtime possible for millions of Americans in need.

225TH BIRTHDAY OF FORMER PRESIDENT ZACHARY TAYLOR

Mr. WARNER. Mr. President, today I wish to recognize the 225th anniversary of the birth of MG Zachary Taylor, a Virginia native son and the 12th President of the United States of America.
Best remembered as a distinguished military hero, Zachary Taylor was known as a resourceful, steadfast, modest and compassionate commander who fought many successful battles, earning from his soldiers and countrymen the affectionate nickname “Old Rough and Ready.”

Zachary Taylor’s personal popularity increased as his national prominence spread. General Taylor defeated Henry Clay, Winfield Scott and Daniel Webster for the Whig Party Presidential nomination. Although he had not sought office, Zachary Taylor was elected the 12th President of the United States.

Slavery was the driving issue of the campaign and the primary challenge of Zachary Taylor’s brief Presidency. In his inaugural address, Zachary Taylor promised that the preservation of the Union would be his first obligation. He was determined to find a solution to end slavery even though he was a southerner and a slave holder. Zachary Taylor urged settlers in New Mexico and California to bypass the territorial stage and draft constitutions for statehood. As Southern Democrats called for a secession convention, Zachary Taylor reacted with a bristling statement that he would hang anyone who tried to disrupt the Union by force or by conspiracy, setting the stage for the Compromise of 1850.

During his 15 months in office, Zachary Taylor also created the Department of the Interior and signed a treaty with Great Britain guaranteeing a neutral canal connecting North and South America.

After laying the cornerstone of the Washington Monument on July 4, 1850, Zachary Taylor fell ill and passed away. An unprecedented 100,000 people gathered to honor one of Orange County’s most famous native sons. First Day Issue Zachary Taylor Dollar coins will be given to county schoolchildren. Please join me in commemo rating the life of Zachary Taylor and the courage and efforts during his term of office to bring a peaceful end to slavery in the United States.

ADDITIONAL STATEMENTS

TRIBUTE TO PETER S. LEVI

Mr. BOND. Mr. President, today I wish to honor a fine Missourian, Peter S. Levi, whose memory will long endure not only for his illustrious career as a lawyer and politician, but for his dedication to his community and his country.

Mr. Levi has worked tirelessly in developing and fostering economic development throughout the Kansas City area. In 1980, he founded the Mid-America Regional Chamber of Commerce, which he has led for over 30 years. He first became involved in the region as executive director of the Mid-America Regional Council. After 13 years as the executive director, he moved on to become president of the Greater Kansas City Chamber of Commerce.

Mr. Levi’s lifelong dedication to the city of Kansas City and surrounding area is evident through his championing of Kansas City and its economy. As one of the Chamber’s most effective presidents, he has seen the chamber grow to represent about 9,000 area businesses while expanding the chamber’s annual budget to over $36 million.

Along with his work with the Chamber of Commerce, Mr. Levi has always worked to inspire those around him with his vigor, sense of duty, and pride in his community. With his many Kansas City friends, I thank Peter for his service to the city of Kansas City, and I wish him all the best in his future endeavors.

REMEMBERING LEWIS MILLETT

Mr. BOXER. Mr. President, I am honored to remember Lewis Millett—a recipient of the Congressional Medal of Honor, a retired Army colonel and a proud American who passed away on November 14, 2009.

Colonel Millett retired from the U.S. Army after a 31-year career that spanned three wars. He was awarded the Medal of Honor for leading a bayonet charge up a heavily defended hill during the Korean war. In his 31-year career in the Army, that included service in World War II, Korea and Vietnam, Colonel Millett received numerous awards, including the Distinguished Service Cross, the Silver Star, two Legions of Merit, three Bronze Stars, four Purple Hearts, and three Air Medals.

Born December 15, 1920, in Mechanic Falls, ME, Millett grew up in Massachusetts, where he joined the State National Guard. In 1940, with the war in Europe underway, he enlisted in the Army Air Corps. But after President Franklin D. Roosevelt said that no Americans would fight on foreign soil, he deserted the Army and joined the Canadian Army. When he arrived in Europe in 1942, the United States was in the war and he was allowed to transfer back to the U.S. Army.

As a member of the 27th Armored Field Artillery of the 1st Armored Division, Colonel Millett participated in the Allied invasion of North Africa, where he earned a Silver Star after driving a burning halftrack loaded with ammunition away from U.S. troops and jumping out before it exploded. After a year in combat, the Army reviewed his record and convicted him of desertion. He was fined $32 and sentenced to 3 days hard labor. He was not required to do the hard time, and 2 weeks later he was made a second lieutenant.

After World War II, he returned to civilian status and joined the Maine National Guard. When the Army called for volunteers in 1949, he returned to Active Duty. He later served in Korea as a company commander and in Vietnam as a military advisor with the intelligence program called Phoenix. Colonel Millett retired from the US Army in 1973.

He is survived by his sons, Lee and Tim, and daughter Elizabeth; a brother, Albert; three sisters, Ellen Larabee, Jean Pepin, and Marion Finnity; and four grandchildren. I extend my heartfelt condolences to them.

The military community, the State of California, and our Nation have lost a proud American and a great warrior.

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Mr. Pate, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States which were referred to the Committee on Foreign Relations.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGE FROM THE HOUSE

At 11:16 a.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bills, which requests the concurrence of the Senate:

H.R. 1939. An act to amend the Small Business Act to improve SCORE, and for other purposes.

H.R. 1942. An act to amend the Small Business Act to improve the Small Business Administration’s entrepreneurial development programs, and for other purposes.

H.R. 3788. An act to amend the Small Business Investment Act of 1958 to establish a program for the Small Business Administration to provide financing to support early-stage small businesses in targeted industries, and for other purposes.
The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC-3724. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives; Empresa Brasileira de Aeronautica S.A. (EMBRAER) Model ERJ 170 and ERJ 190 Airplanes (RIN21120-AA44)(Docket No. FAA–2009–10394)) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC-3725. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives; Empresa Brasileira de Aeronautica S.A. (EMBRAER) Model ERJ 200 Series Airplanes (RIN21120-AA44)(Docket No. FAA–2009–10394) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC-3726. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives; Saab AB, Saab Aerosystems Model SAAB 2000 Airplanes (RIN21120-AA44)(Docket No. FAA–2009–10394) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC-3727. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives; International Aero Engines AG (IAE) V2500–A1, V2527E–A5, V2530–A5, and V2538–DS Turbofan Engines" (RIN21230–AA44)(Docket No. FAA–2009–09494) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC-3728. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives; Turbomeca S.A. ARRUS 1A Turboshaft Engines" (RIN21250–AA44)(Docket No. FAA–2009–09084) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC-3729. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives; Rolls-Royce plc RB211 Trent 800 Series Turbofan Engines" (RIN21250–AA44)(Docket No. FAA–2009–09384) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC-3730. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives; 328 Support Services GmbH Dornier Model 328–100 and –200 Airplanes (RIN21250–AA44)(Docket No. FAA–2009–06166) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC-3731. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives; Airbus Model A340–200 and –300 Series Airplanes (RIN21250–AA44)(Docket No. FAA–2009–06077) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC-3732. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives; Hamilton Sundstrand Power Systems T–627–461 Turbofan Engines" (RIN21250–AA44)(Docket No. FAA–2009–05207) received in the Office of the President of the Senate on November 13, 2009; to the Committee on Commerce, Science, and Transportation.

EC-3733. A communication from the Acting Farm Bill Coordinator, Commodity Credit Corporation, Department of Agriculture, transmitting, pursuant to law, the report of a rule entitled "Farm and Ranch Lands Protection Program" (RIN0578–AA46) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Agriculture, Nutrition, and Forestry.

EC-3734. A communication from the Secretary of the Interior, Department of the Interior, transmitting, pursuant to law, the report of a rule entitled "Final Flood Elevation Determinations" ((44 CFR Part 67)(74 FR 57929)) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC-3735. A communication from the Chief Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "Final Flood Elevation Determinations" ((44 CFR Part 67)(74 FR 57929)) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC-3736. A communication from the Chief Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "Changes in Final Flood Elevation Determinations" ((44 CFR Part 67)(74 FR 57944)) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC-3737. A communication from the Chief Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "Final Flood Elevation Determinations" ((44 CFR Part 67)(74 FR 57944)) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC-3738. A communication from the Chief Counsel, Federal Emergency Management Agency, Department of Homeland Security, transmitting, pursuant to law, the report of a rule entitled "Final Flood Elevation Determinations" ((44 CFR Part 67)(74 FR 57944)) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC-3739. A communication from the Deputy to the Chairman for External Affairs, Federal Deposit Insurance Corporation, transmitting, pursuant to law, the report of a rule entitled "Debt Guarantee Program to Provide for the Establishment of a Limited Six-Month Emergency Guarantee Facility" (RIN 3064–AD37) received in the Office of the President of the Senate on November 18, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC-3740. A communication from the Secretary, Division of Investment Management, Securities and Exchange Commission, transmitting, pursuant to law, the report of a rule entitled "Regulation E (12 CFR Part 241, Subpart A)" (RIN2385–A363) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Banking, Housing, and Urban Affairs.

EC-3744. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Approval and Promulgation of Air Quality Standards for Particulate Matter" (40 CFR Part 50) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Environment and Public Works.

EC-3741. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled "Approval and Promulgation of Air Quality Standards for Particulate Matter" (40 CFR Part 50) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Environment and Public Works.
Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled “Approval and Promulgation of Air Quality Implementation Plans; Ohio and West Virginia; Determinations of Affirmation for the 1971 Fine Particulate Matter Standard” (FRL No. 8982-6) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Environment and Public Works.
EC-3745. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled “Approval and Promulgation of Air Quality Implementation Plans; Virginia; Transportation Conformity Regulations” (FRL No. 8983-1) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Environment and Public Works.
EC-3746. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled “Approval and Promulgation of Air Quality Implementation Plans; Commonwealth of Massachusetts Department of Environmental Protection” (FRL No. 8974-5) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Environment and Public Works.
EC-3747. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled “National Emission Standards for Hazardous Air Pollutants: Perchloroethylene Air Emission Standards for Solvent Recycling Facilities” (FRL No. 8982-1) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Environment and Public Works.
EC-3748. A communication from the Director of the Regulatory Management Division, Office of Policy, Economics, and Innovation, Environmental Protection Agency, transmitting, pursuant to law, the report of a rule entitled “National Emission Standards for Hazardous Air Pollutants: Asphalt Processing and Asphalt Roofing Manufacturing” (FRL No. 8983-5) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Environment and Public Works.
EC-3749. A communication from the Chief Secretary of Health and Human Services, transmitting, pursuant to law, a report of a rule entitled “Approval of a proposed technical assistance agreement for the export of defense articles, including, technical data, and defense services to Hong Kong relative to the design, manufacture, and delivery of the AsiaSat Commercial Communication Satellite in the amount of $50,000,000 or more; to the Committee on Foreign Relations.
EC-3750. A communication from the Deputy Secretary of Health and Human Services, transmitting, pursuant to law, a report relative to a petition to add workers from Baxier Perkins Company to the Special Exposure Cohort; to the Committee on Health, Education, Labor, and Pensions.
EC-3751. A communication from the Director of Regulations and Policy Management, Staff, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled “Listing of Color Additives Exempt From Certification; Astaxanthin Dimethyldisuccinate (Docket No. FDA–2007–C–0044) received in the Office of the President of the Senate on November 17, 2009; to the Committee on Health, Education, Labor, and Pensions.
EC-3752. A communication from the Assistant Secretary of Health and Human Services, Department of State, transmitting, pursuant to law, a report of a rule entitled “Approval of a proposed technical assistance agreement for the export of defense articles, including, technical data, and defense services to Hong Kong relative to the design, manufacture, and delivery of the AsiaSat Commercial Communication Satellite in the amount of $50,000,000 or more; to the Committee on Foreign Relations.
EC-3753. A communication from the Deputy Assistant Administrator, Bureau for Legislative and Public Affairs, U.S. Agency for International Development, transmitting, pursuant to law, the Agency’s response to the GAO report entitled “Information Technology: Federal Agencies Need to Strengthen Investment Board Oversight of Poorly Planned and Performing Projects”; to the Committee on Foreign Relations.
EC-3754. A communication from the Deputy Director of Regulations and Policy Management, Staff, Food and Drug Administration, Department of Health and Human Services, transmitting, pursuant to law, a report relative to a petition to add workers from Baxier Perkins Company to the Special Exposure Cohort; to the Committee on Health, Education, Labor, and Pensions.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. DODD, from the Committee on Banking, Housing, and Urban Affairs, without amendment:
S. 2799. An original bill to amend the Iran Sanctions Act of 1996, to provide for the divestment of assets in Iran by State and local governments and other entities, to identify locations of concern with respect to transshipment, reexportation, or diversion of certain sensitive items to Iran, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs; placed on the calendar.

By Mrs. MURRAY (for herself and Mr. DODD):
S. 2800. A bill to amend subtitle B of title VII of the McKinney-Vento Homeless Assistance Act to provide education for homeless children and youths, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Mr. FRANKEN (for himself and Mrs. MURRAY):
S. 2801. A bill to provide children in foster care with school stability and equal access to education; to the Committee on Health, Education, Labor, and Pensions.
S. 122
At the request of Mr. DODD, the name of the Senator from Pennsylvania (Mr. SPECKER) was added as a cosponsor of S. 122, a bill to amend the Fair Labor Standards Act of 1938 to provide more effective remedies for victims of discrimination in the payment of wages on the basis of sex, and for other purposes.

S. 332
At the request of Mrs. FEINSTEIN, the name of the Senator from Nebraska (Mr. JOHANNES) was added as a cosponsor of S. 332, a bill to establish a comprehensive interagency response to reduce lung cancer mortality in a timely manner.

S. 455
At the request of Mr. ROBERTS, the name of the Senator from Connecticut (Mr. LIEBERMAN) was added as a cosponsor of S. 455, a bill to require the Secretary of the Treasury to mint coins in recognition of 5 United States Army Five-Star Generals—George Marshall, Douglas MacArthur, Dwight Eisenhower, Henry ‘Hap’ Arnold, and Omar Bradley, alumni of the United States Army Command and General Staff College, Fort Leavenworth, Kansas, to coincide with the celebration of the 132nd Anniversary of the founding of the United States Army Command and General Staff College.

S. 456
At the request of Mr. KERRY, the name of the Senator from Iowa (Mr. GRASSLEY) was added as a cosponsor of S. 456, a bill to require the Secretary of the Treasury to mint coins in recognition and celebration of the establishment of the Medal of Honor in 1861, America’s highest award for valor in action against an enemy force which can be bestowed upon an individual from writing, sending, or reading text messages while operating a motor vehicle.

S. 850
At the request of Mr. SCHUMER, the name of the Senator from Alabama (Mr. SESSIONS), the Senator from Texas (Mr. CORNYN) and the Senator from Utah (Mr. HATCH) were added as co-sponsors of S. 1147, a bill to prevent tobacco smuggling, to ensure the collection of all tobacco taxes, and for other purposes.

S. 1066
At the request of Mr. RISCH, the name of the Senator from Mississippi (Mr. WICKER) and the Senator from Maryand (Mr. CARDIN) were added as co-sponsors of S. 1066, a bill to improve the accuracy of fur product labeling, and for other purposes.

S. 1076
At the request of Mr. MENENDEZ, the names of the Senator from Hawaii (Mr. AKAKA) and the Senator from Maryland (Mr. CARDIN) were added as cosponsors of S. 1076, a bill to improve the accuracy of fur product labeling, and for other purposes.

S. 1147
At the request of Mr. KOHL, the names of the Senator from Alabama (Mr. SESSIONS), the Senator from Texas (Mr. CORNYN) and the Senator from Utah (Mr. HATCH) were added as co-sponsors of S. 1147, a bill to prevent tobacco smuggling, to ensure the collection of all tobacco taxes, and for other purposes.

S. 1536
At the request of Mr. SCHUMER, the name of the Senator from Virginia (Mr. WARNER) was added as a cosponsor of S. 1536, a bill to amend title 23, United States Code, to reduce the amount of Federal highway funding available to States that do not enact a law prohibiting an individual from writing, sending, or reading text messages while operating a motor vehicle.

S. 1559
At the request of Mr. KERRY, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of S. 1559, a bill to consolidate democracy and security in the Western Balkans by supporting the Governments and people of Bosnia and Herzegovina and Montenegro in reaching their goal of eventual NATO membership, and to welcome further NATO partnership with the Republic of Serbia, and for other purposes.

S. 1569
At the request of Mr. BARRASSO, the name of the Senator from Wyoming (Mr. ENZI) was added as a cosponsor of S. 1569, a bill to suspend temporarily the duty on certain acrylic fiber tow containing a minimum of 92 percent acrylonitrile.

S. 1709
At the request of Mr. THUNE, the name of the Senator from Wyoming (Mr. ENZI) was added as a cosponsor of S. 1709, a bill to amend the National Agricultural Research, Extension, and Teaching Policy Act of 1977 to establish a grant program to promote efforts to develop, implement, and sustain veterinary services, and for other purposes.

S. 1780
At the request of Mrs. LINCOLN, the name of the Senator from Iowa (Mr. GRASSLEY) was added as a cosponsor of S. 1780, a bill to amend title 38, United States Code, to deem certain service in the reserve components as active service for purposes of laws administered by the Secretary of Veterans Affairs.

S. 148
At the request of Mr. KOHL, the name of the Senator from Pennsylvania (Mr. RISCH), the Senator from Mississippi (Mr. WICKER) and the Senator from Massachusetts (Mr. KERRY) were added as co-sponsors of S. 148, a bill to restore the rule that agreements between manufacturers and retailers, distributors, or wholesalers and manufacturers and service which the manufacturer's product or service cannot be sold violates the Sherman Act.
S. 1359

At the request of Mr. Rockefeller, the name of the Senator from Michigan (Ms. Stabenow) was added as a cosponsor of S. 1359, a bill to reinstate Federal matching of State spending of child support incentive payments.

S. 1963

At the request of Mr. Akaka, the name of the Senator from North Carolina (Mr. Burr) was added as a cosponsor of S. 1963, a bill to amend title 38, United States Code, to provide assistance to caregivers of veterans, to improve the provision of health care to veterans, and for other purposes.

S. 2128

At the request of Mr. LeMieux, the names of the Senator from Idaho (Mr. Risch) and the Senator from Georgia (Mr. Chambliss) were added as cosponsors of S. 2128, a bill to provide for the establishment of the Office of Deputy Secretary for Health Care Fraud Prevention.

S. 2727

At the request of Mr. Lugar, the names of the Senator from Arizona (Mr. Kyl), the Senator from Tennessee (Mr. Vitter), the Senator from Massachusetts (Mr. Kerry) and the Senator from Delaware (Mr. Kaufman) were added as cosponsors of S. 2727, a bill to provide for continued application of arrangements under the Protocol on Inspection and Continuous Monitoring Activities Relating to the Treaty Between the United States of America and the Union of Soviet Socialist Republics on the Reduction and Limitation of Strategic Offensive Arms in the period following the Protocol’s termination on December 5, 2009.

S. 2730

At the request of Mr. Brown, the name of the Senator from New Jersey (Mr. Menendez) was added as a cosponsor of S. 2730, a bill to extend and enhance the COBRA subsidy program under the American Recovery and Reinvestment Act of 2009.

S. 2743

At the request of Mrs. Snowe, the name of the Senator from New Jersey (Mr. Menendez) was added as a cosponsor of S. 2743, a bill to amend title 10, United States Code, to provide for the award of a military service medal to members of the Armed Forces who served honorably during the Cold War, and for other purposes.

S. 2767

At the request of Mr. Thune, the name of the Senator from Alabama (Mr. Sessions) was added as a cosponsor of S. 2767, a bill to repeal the authority of the Secretary of the Treasury to extend the Troubled Asset Relief Program.

S. RES. 316

At the request of Mr. Menendez, the name of the Senator from Nevada (Mr. Reid) and Mr. Casey was added as a cosponsor of S. Res. 316, a resolution calling upon the President to ensure that the foreign policy of the United States reflects appropriate understanding and sensitivity concerning issues related to human rights, ethnic cleansing, and genocide documented in the United States record relating to the Armenian Genocide, and for other purposes.

S. RES. 37

At the request of Mr. Rockefeller, the names of the Senator from Wyoming (Mr. Enzi), the Senator from North Dakota (Mr. Dorgan) and the Senator from Pennsylvania (Mr. Casey) were added as cosponsors of S. Res. 337, a resolution designating December 6, 2009, as “National Miners Day”.

AMENDMENT NO. 2785

At the request of Mr. Coburn, the names of the Senator from Oklahoma (Mr. Inhofe) and the Senator from North Carolina (Mr. Burr) were added as cosponsors of amendment No. 2785 proposed to S. 1963, a bill to amend title 38, United States Code, to provide assistance to caregivers of veterans, to improve the provision of health care to veterans, and for other purposes.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mrs. Murray (for herself and Mr. Franken):

S. 2800. A bill to amend subtitle B of title VII of the McKinney-Vento Homeless Assistance Act to improve the provision of health care to homeless children and youth, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mrs. Murray. Mr. President, I rise today to talk about legislation that I introduced with Senator Franken today that is essential to the academic success of millions of vulnerable children and youth.

The Educational Success for Children and Youth Without Homes Act responds to the growing crisis of homelessness in our Nation. The legislation will help homeless children and youth thrive in school, despite the constant moves, trauma, and loss associated with homelessness.

This legislation is needed now more than ever. The economic downturn and foreclosure crisis have had a significant impact on homelessness. Public schools reported a 17-percent increase in the number of homeless students in 2007. In Washington state, the number of homeless students has increased dramatically. For example, the number of homeless students enrolled in Whatcom County schools increased by 66 percent over the past 2 years; in Evergreen Public Schools, there has been a 56-percent increase over the past 2 years. This fall, many schools face a veritable tidal wave of homelessness. Over one million children and youth are now homeless in our Nation.

The recession has contributed to homelessness and put extraordinary strains on millions of students: children who are homeless with their families, and youth who are homeless on their own. This reality was brought starkly to light in the recent New York Times series about runaway and homeless youth. The series found a 40-percent increase in the number of homeless youth living on their own last year, more than double the number in 2003. It found that “Foreclosures, layoffs, rising food and fuel prices and inadequate supplies of low-cost housing have stretched families to the extreme, and those pressures have trickled down to teenagers and peers.”

School offers homeless children and youth structure, normalcy, support, and hope—it is a place where they can obtain the skills that they will need to avoid poverty and homelessness as adults. Yet these students face great educational challenges. High mobility, precarious living conditions, and severe poverty combine to create major barriers to school enrollment and regular attendance. Many homeless children and youth lack basic supplies and a reasonable environment where they can do homework. As a result of their circumstances, homeless students often perform below their peers in math and reading and are more likely to be held back a grade.

We must do more to assist these students so they do not continue to be left behind. The Educational Success for Children and Youth Without Homes Act of 2009 would do just that. The bill authorizes the Department of Education for homeless children and youth program. It makes a strong law even stronger by reinforcing and expanding the law’s key provisions: school stability, enrollment, and support for academic achievement.

This legislation will enhance the right of homeless children to stay in the same school, so that children who have lost their homes do not also lose their schools. It will assist schools in meeting the challenges of transporting homeless students by increasing the authorized funding level and allowing other Federal funds for educating low-income students to be used for homeless transportation. When staying in the same school is not possible, or not in a child’s best interest, the legislation will help the student make a seamless transition to a new school.

This bill will help students like Kyle, a 4th-grade student in Spokane. Due to the instability of homelessness, Kyle moved around with his family most of his life. In fact, he moved eleven times. There were large gaps where he had not gone to school at all, because of his family’s frequent moves. Yet although Kyle moved eleven times, the homeless education program in Spokane was able to keep him stable in one school. Because he had the opportunity to attend one school consistently, the school district was able to determine that his academic and behavioral struggles were caused by more than just homelessness. A special education evaluation revealed that he was nearly deaf in both ears. He now has hearing aids in both ears and told his teacher:
"I can hear now, and I am being good. I want to be a crossing guard."

Yet many more children like Kyle are not receiving the assistance they need due to lack of funding. In fact, only 9 percent of school districts are able to receive funding through the McKinney-Vento program currently. This legislation would increase the authorized funding level, so that more school districts can participate in the homeless education program and reach more children and youth experiencing homelessness.

One of the most successful features of the McKinney-Vento program is the requirement for every school district to designate a liaison for homeless children and youth. Liaisons identify homeless students, ensure their enrollment and attendance, and connect them to community resources. Liaisons are the backbone of this program, the unsung heroes who have become a lifeline for children and youth in crisis. Yet most liaisons do not have the capacity to carry out their required duties; they wear many hats and struggle to meet the growing demands of this population. As a result, too many homeless children and youth are falling through the cracks and missing out on school. The Educational Success for Children and Youth Without Homes Act will strengthen the critical position of homeless liaison by ensuring that liaisons have the time, resources, and training to fulfill their mandated duties.

The Educational Success for Children and Youth Without Homes Act also recognizes the unique needs of certain groups of homeless children: preschool-aged homeless children, and unaccompanied homeless youth.

Young children who are homeless have higher rates of developmental delays and other problems that set them back as they start out life, yet they face numerous barriers to participating in early childhood programs. They miss out on services that can mitigate the harmful effect of homelessness on their development. This legislation will increase homeless children’s participation in preschool programs by requiring public preschool programs to identify and prioritize homeless children for enrollment, and to develop the capacity to serve all identified homeless children.

Unaccompanied homeless youth struggle to go to school without the basic necessities of life or a parent to guide them. We must assist unaccompanied homeless youth to overcome the unique educational challenges related to being without a home and without a parent or guardian. This legislation will help ensure that unaccompanied homeless youth have the supports necessary to stay in school, graduate with their peers, and move on to a brighter future.

The history of litigation under the McKinney-Vento Act makes clear that we must do a better job helping educators learn about homelessness and support them in implementing the law. To this end, the legislation provides funding for technical assistance and training, and requires participation in professional development activities.

I am pleased to be joined by Senator FRANKEN in cosponsoring this legislation to assist homeless students, and I am honored to cosponsor Senator FRANKEN’s legislation, the Fostering Success in Education Act, to assist students who are in foster care. These bills recognize the similarities, and the differences, between students who are homeless and those who are in foster care. It is our intention to work with our Senate colleagues to ensure that children and youth who are currently served through the McKinney-Vento Act under the category of “awaiting foster care placement” will be transitioned to the Fostering Success in Education program, so that their unique needs may be best met.

As we look forward to the reauthorization of the Elementary and Secondary Education Act, we must recognize that children who do not know where they will sleep at night, or where their next meal will come from, face far greater challenges than simply remembering their homework. We must acknowledge that children who bounce between schools with each change of residence have little hope of taking advantage of even the best school programs. The most qualified teacher, or the most exceptional math textbook, will not benefit children who are not enrolled in school, not attending regularly, and not assisted to overcome the barriers caused by homelessness. The Educational Success for Children and Youth Without Homes Act builds upon the proven successes of the McKinney-Vento Act’s Education of Homeless Children and Youth program, while addressing remaining challenges. It is critical legislation that will help ensure that the homeless children who do not become the homeless adults of tomorrow.

Mr. FRANKEN (for himself and Mrs. MURRAY):

S. 2801. A bill to provide children in foster care with school stability and equal access to educational opportunities; to the Committee on Health, Education, Labor, and Pensions.

Mr. FRANKEN. Mr. President, a quality education is not just a positive counterweight to the abuse, neglect, and instability that children in foster care have experienced. That is why Senator MURRAY and I are introducing the Fostering Success in Education Act. The act builds on previous Federal efforts to increase the school stability and success of foster children.

The very placement of children in foster care has deprived many children of their opportunity to obtain a decent education. The primary reason is that children in foster care frequently move between foster homes, and often change schools when they move. Research shows that students lose 4 to 6 months of educational progress each time they change schools. It therefore becomes nearly impossible for foster children—who change schools multiple times—to make significant educational progress.

Moreover, foster children often change schools in the middle of the school year. When this happens, it is hard for them to catch up with their classmates, since they didn’t learn the material their classmates studied earlier in the year.

Because different schools offer different courses, it is also difficult for foster children to transfer their course credits from prior schools after they move. Many foster children therefore end up repeating courses and even grades.

But what is even more disturbing is that foster children are often segregated from other students, and inappropriately placed in schools at group foster homes and residential treatment facilities. At these separate schools, foster children typically receive a subpar education, making it difficult for them to transition smoothly to regular public schools later on.

As a result of all these challenges, many foster children fall behind their peers in school, lose hope, and ultimately drop out. Consider, for example, the school experience of Carrie, a 19-year-old young woman in Minnesota, who was placed in foster care in eighth grade. When Carrie moved to her first foster home, she had to transfer to a new school. Being uprooted from her family was difficult enough, but she also had to cope with the transition to her new school—just when she most needed the support of her friends and teachers at her old school. Moreover, because she changed schools in the middle of the school year, she found it difficult to keep up with her classmates in her new school.

There was no need to add further instability to Carrie’s life by making her change schools. Her old school—the school where she lived for her kindergarten—was just 20 minutes away from her foster home. It would have been perfectly reasonable to transport Carrie back to that school.

Over her next 5 years in foster care, Carrie ended up 7 moving between 7 different foster care placements and schools. The schools where she spent most of her time in high school separated her from other children in her community, and from equal educational opportunities. For example, in ninth grade, Carrie attended a school at a residential treatment facility, where her education consisted of sitting in a classroom with children as young as Carrie and receiving instruction with little help from an instructor. Given the multiple educational disruptions Carrie experienced, it is not surprising that she believes she left high school with only a ninth grade education.

Unfortunately, Carrie’s school experience is not unique. Many foster children in Minnesota, and across the
country, have experienced a similar pattern of moving between multiple schools, wasting time in segregated schools, and leaving school without much to show for all their years of education.

Last year, Congress decided that it was time to do something about this situation. Congress enacted the Fostering Connections to Success Act, a child welfare law that, among other things, requires child welfare agencies to collaborate with local education agencies to improve the school stability of foster children.

Child welfare agencies, however, can't go it alone. To fulfill the vision of the Fostering Connections Act, they need the full cooperation of State and local education agencies.

That is why Senator MURRAY and I have decided to place requirements on State and local education agencies that mirror those placed on child welfare agencies in the Fostering Connections Act. For example, our bill requires State and local education agencies to collaborate with child welfare agencies to provide foster children who move to new school districts with the right to attend their schools of origin— or, in other words, the right to attend their former schools or the schools they attended before they were placed in foster care.

If Carrie had this right when she was placed in foster care, she would have been able to remain in the school she had attended since kindergarten. When it’s not in the best interest of particular foster children to remain in their schools of origin, our bill requires State and local education agencies to work with child welfare agencies to enroll foster children immediately in new schools. This is an important element of our bill because foster children often spend weeks out of school as a result of enrollment delays.

In addition, our bill provides funding to help school districts and child welfare agencies address the educational needs of foster children, such as funding to provide foster children with transportation back to schools in their former school districts.

Finally, our bill clarifies that foster children have a right to the same educational opportunities as other children in their community. This means, for example, that foster children cannot be placed in separate schools merely based on the misguided belief that foster children cannot fit in at a regular public school.

In addition to working with Senator MURRAY on the Fostering Success in Education Act, we have collaborated on a related bill—the Educational Success for Children and Youth Without Homes Act, which Senator MURRAY introduced earlier today. The Educational Success for Children and Youth Without Homes Act will improve the educational stability of homeless children, who, like foster children, face significant educational challenges because they often move between school districts. While there are many similarities between the protections provided to homeless and foster children in our bills, our bills also address the unique circumstances of each group.

I am grateful to Carrie, and the many other foster and homeless youth who have bravely spoken out about their difficult school experiences. Their efforts will help prevent other children entering foster care or experiencing homelessness in the future from suffering during school.

I believe it is time that we listen to these youth and take steps to ensure that we don’t deprive homeless and foster children of their right to an equal education. Senator MURRAY and I therefore plan on working hard in the coming months to achieve the reforms we lay out in the bills we’re introducing today, and I would urge my colleagues to support both of these important bills.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, 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 CONTENTS.**

(a) **Short Title.—**This Act may be cited as the “Fostering Success in Education Act.”

(b) **Table of Contents.—**The table of contents for this Act is the following:

Sec. 1. Short title; table of contents.

Sec. 2. Findings; sense of Congress.

Sec. 3. Purpose.

Sec. 4. Definitions.

Sec. 5. Regulations.

Sec. 6. Effective date.

**TITLE I—EDUCATIONAL RIGHTS FOR CHILDREN IN FOSTER CARE**

Subtitle A—Required Educational Rights, Protections, and Services for Children in Foster Care

Sec. 101. Required educational rights, protections, and services for children in foster care.

Sec. 102. Remedies; rule of construction.

Sec. 103. Conforming amendments.

Subtitle B—State Foster Care and Education Plan Grants

Sec. 111. State foster care and education plan requirements and grants.

Sec. 112. Subgrants.

Sec. 113. Responsibilities of the Secretary.

Sec. 114. Authorization of appropriations.

**TITLE II—SOCIAL SECURITY ACT AMENDMENTS**

Sec. 201. Social Security Act amendments.

**SEC. 2. FINDINGS; SENSE OF CONGRESS.**

(a) **Findings.—**Congress makes the following findings:

(1) Educational success is vital to every young person’s well being and success in making a successful transition to adulthood, and economic stability.

(2) At the end of fiscal year 2007, approximately 500,000 children were in foster care in the United States, with nearly 800,000 children having spent at least some time in foster care in the United States during the year.

(3) Numerous studies have demonstrated that children in foster care fall behind the general student population with respect to test scores, graduation rates, and successful transitions to postsecondary education.

(4) Only one-third of high school students in foster care graduate on time and only 3 percent of such students graduate from college.

(5) On average, children in foster care move to new foster care placements 2 times per year, and often change schools when they move.

(6) Studies indicate that with each school move, children, on average, fall 4 to 6 months behind their classmates. Because foster children often change schools multiple times, it is difficult for them to make significant educational progress.

(7) Children in foster care are frequently denied the ability to remain in the same school as a result of changes in their living situations.

(8) In addition, children in foster care who are required to change schools are frequently denied immediate enrollment in a new school, which results in detrimental disruptions to their education.

(9) Moreover, the enrolling school frequently does not have access to the child’s complete and accurate education records, which often results in inappropriate placement in inappropriate classes and educational settings.

(10) When foster children change schools, they often have difficulties transferring credits from previous schools and meeting the new set of graduation requirements in the new school.

(11) In 2008, Congress enacted the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Public Law 110–351), which requires, among other things, child welfare agencies to ensure that a child in foster care remains in the same school after moving to a new placement or, when remaining in the same school is not in the child’s best interest, is enrolled in a new school immediately, and that the child’s education records are transferred promptly. While the Fostering Connections to Success and Increasing Adoptions Act of 2008 requires child welfare agencies to coordinate with local educational agencies, the local educational agencies must play a critical role in the process. Otherwise, the education provisions of the Act cannot be fully implemented.

(b) **Sense of Congress.—**It is the sense of Congress that:

(1) in order to successfully meet the needs of the 500,000 children in foster care in the United States, State educational agencies, local educational agencies, State child welfare agencies, and local child welfare agencies must work together at the Federal, State, and local level to—

(A) address the unique needs of this population; and

(B) ensure school stability, immediate enrollment, and access to appropriate services; and

(2) such efforts will significantly increase the secondary school graduation rates and improve educational outcomes for children in foster care.

**SEC. 3. PURPOSE.**

The purpose of this Act is to ensure that the educational needs of children in foster care are addressed in a seamless and complete manner by—

(1) requiring the State educational agency of a recipient State to work together with the State child welfare agency to ensure that the educational needs of each child in foster care in the State are being met;

(2) requiring local child welfare agencies and local educational agencies of a recipient State to work together to ensure that the educational needs of each child in foster care in the State are being met;
SEC. 4. DEFINITIONS.

In this Act:

(1) CHILD IN FOSTER CARE.—The term “child in foster care” means a child whose care and placement capability is the responsibility of a public agency, or Tribal agency that administers a State plan under part B or E of title IV of the Social Security Act (42 U.S.C. 621 et seq.; 670 et seq.), without regard to whether foster care maintenance payments are made under section 472 of the Social Security Act (42 U.S.C. 672) on behalf of the child.

(2) COURT REPRESENTATIVE.—The term “court representative” means an individual appointed by a court to represent a child in a juvenile court dependency proceeding.

(3) EDUCATION DECISIONMAKER.—The term “education decisionmaker” means—

(A) a parent of a child in foster care; or

(B) a person identified by the dependency court to make education decisions for a child in foster care who is someone other than the child’s parent.

(4) EDUCATION RECORDS.—The term “education records” means documents and other materials relating to a child’s enrollment and education, including transcripts, reports, plans, evaluations, and assessments maintained by a local educational agency.

(5) ELEMENTARY SCHOOL.—The term “elementary school” has the meaning given the term in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(6) ENROLLMENT.—The term “enrollment” means attending classes in a public preschool program, an elementary school, or secondary school and participating fully in the activities of such school or program.

(7) LOCAL CHILD WELFARE AGENCY.—The term “local child welfare agency” means, with respect to a child in foster care, the public agency in the local political subdivision, regardless of whether the subdivision is a county, a town, a city, a borough, or any political subdivision or tribal organization, that is responsible for the placement and care of the child.

(8) LOCAL EDUCATIONAL AGENCY.—The term “local educational agency” has the meaning given the term in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

(9) LOCAL CHILD WELFARE AGENCY.—The term “local child welfare agency” means, with respect to a child in foster care, the public agency in the local political subdivision, regardless of whether the subdivision is a county, a town, a city, a borough, or any political subdivision or tribal organization, that is responsible for the placement and care of the child.

(10) PLACEMENT.—The term “placement” means the current or proposed living situation for a child in foster care, which can include a group home or other congregate care setting.

(11) PUBLIC AGENCY.—The term “public agency” means any State or local government entity.

(12) PUBLIC PREESCHOOL PROGRAM.—The term “public preschool program” means a preschool program funded, administered, or overseen by a State educational agency, local educational agency, or other State agency.

(13) RECIPIENT STATE.—The term “recipient State” means a State that receives funds under part B or E of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311 et seq.).

(14) SCHOOL OF ORIGIN.—The term “school of origin” means, with respect to a child in foster care, any of the following:

(A) The school in which the child was enrolled prior to entry into foster care.

(B) The school in which the child is enrolled when a change in foster care placement occurs or is proposed.

(C) The school attended when last permanently housed, as such term is used in section 722(g)(3)(G) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11322(g)(3)(G)).

(15) SCHOOL ATTENDANCE.—The term “school attendance” means the activities of such school or program.

(16) SCHOOL ATTENDANCE AREA.—The term “school attendance area” includes the student’s school and all the schools, school districts, and services needed to meet the challenging and services needed to meet the challenging needs of the student.

(17) SCHOOL OF ORIGIN.—The term “school of origin” means the school in which the child was enrolled when last permanently housed as such term is used in section 722(g)(3)(G) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11322(g)(3)(G)).

(18) SCHOOL SELECTION DECISION.—The term “school selection decision” means a school selection decision as described in section 101(b)(4).

(19) SECONDARY SCHOOL.—The term “secondary school” has the meaning given the term in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801 et seq.).

(20) SECRETARY.—The term “Secretary” means the Secretary of Education.

(21) SPECIAL EDUCATION AND RELATED SERVICES.—The terms “special education” and “related services” have the meaning given such terms in section 9101 of the Individuals with Disabilities Education Act (20 U.S.C. 1401).

(22) STATE.—The term “State” means each of the 50 States, the District of Columbia, and the Commonwealth of Puerto Rico.

(23) STATE CHILD WELFARE AGENCY.—The term “State child welfare agency” means the State agency responsible for administering the programs authorized under subpart 1 of part B and part E of title IV of the Social Security Act (42 U.S.C. 621 et seq.; 670 et seq.).

(24) STATE EDUCATIONAL AGENCY.—The term “State educational agency” has the meaning given the term in section 9101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7801).

SEC. 5. REGULATIONS.

Not later than 60 days after the date of enactment of this Act, the Secretary shall develop, issue, and publish in the Federal Register a notice of proposed rulemaking to implement the provisions of this title. The issuance, amendment, and repeal of any regulations promulgated under this title shall comply with section 553 of title 5, United States Code.

SEC. 6. EFFECTIVE DATE.

Except as otherwise provided, this Act and the amendments made by this Act shall take effect on the date of enactment of this Act, except that subtitle A, and the amendments made by such subtitle, shall apply with respect to recipient States that receive funds under part A of title I of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311 et seq.) on or after the date of enactment of this Act.

TITLE I—EDUCATIONAL RIGHTS FOR CHILDREN IN FOSTER CARE

Subtitle A—Required Educational Rights, Protections, and Services for Children in Foster Care

SEC. 101. REQUIRED EDUCATIONAL RIGHTS, PROTECTIONS, AND SERVICES FOR CHILDREN IN FOSTER CARE.

(a) RIGHTS OF CHILDREN IN FOSTER CARE.—Each recipient State shall ensure that each child in foster care in the State has the following rights:

(1) SCHOOL ATTENDANCE.—A child in foster care shall have the right to enroll in, and continue to enroll in, any of the child’s schools of origin when the child is placed in foster care and during all subsequent changes in placement (including when the child returns home, as required under subparagraph (B)), it is determined that the school selection decision process that is in the child’s best interest to be immediately enrolled in a different school.

(b) SCHOOL OF ORIGIN.—In the case of a child in foster care for whom the child welfare case is closed as a result of the child returning home or achieving another permanency outcome during a school year:

(i) the child shall be entitled to complete the school year in the school that the child is attending unless the entity making the school selection decision determines that a change in schools is in the child’s best interest, and

(ii) necessary transportation to the current school shall be arranged and funded by the local educational agency in which the current school is located.

(c) TREATMENT AS RESIDENT.—A child in foster care who remains in a school of origin shall be treated by the local educational agency serving such school as if the child resides in the school district and is entitled to all school privileges.

(d) IMMEDIATE ENROLLMENT.—If it is determined through the school selection process that it is not in the best interest of a child in foster care to attend a school of origin, or if the child selection process indicated that the child is not entitled to be immediately enrolled in a new school in the child’s school attendance area, regardless of the status of records normally required for enrollment such as previous academic records, medical or immunization records, proof of residency, or other documentation requirements.

(e) RECORDS.—(A) IN GENERAL.—The education records of a child in foster care shall be maintained so that the records are available, in a timely fashion, when a child enters a new school or school district;

(B) immediately sent to the enrolling school as complete as possible, even if the student owes fees or fines or was not withdrawn from the previous school in conformance with local withdrawal procedures; and

(C) maintained in accordance with section 444 of the General Education Provisions Act (commonly referred to as the “GEP Act”) (20 U.S.C. 790).

(B) RECORDS FOR ACADEMIC DECISIONS.—The education records needed for academic placement decisions and decisions regarding the transfer of school credits for a child in foster care shall be released immediately to an enrolling school by facsimile or other available electronic means.

(C) EQUAL ACCESS.—Each child in foster care shall have equal access to the same education and opportunities as other students attending the school or school district, including:

(i) having the same opportunities, access, and services needed to meet the challenging State student academic achievement standards and section 111(b)(1) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 6311(b)(1)) that are provided to other students;

(ii) receiving educational services and transportation services that are comparable to the services offered other children in the child’s school;

(iii) equal access to the full range of educational offerings, including

(A) services under title I of such Act (20 U.S.C. 1601 et seq.); and

(B) publicly funded early childhood programs and public preschool programs;
(III) Early Head Start or Head Start programs under the Head Start Act (42 U.S.C. 9801 et seq.); (IV) public charter and magnet schools; (V) dual enrollment courses and dual enrollment higher education courses; (VI) career and technical education programs; (VII) summer school; and (VIII) extracurricular activities; and (ii) as appropriate, prioritization in the educational offerings described in clause (i) in accordance with Federal and State law; (D) being integrated with other students in all schools or programs within a school that are operated, licensed, or funded by a public entity; (E) attending the elementary school or secondary school that serves the child’s school attendance area, based on the school selection decision made for the child; (F) the provision of the educational agency in the State designates a school that serves the child’s school attendance area unless—
(1) the local child welfare agency refers the child to another appropriate school placement; (2) the local child welfare agency makes a school selection decision on an expedited basis for a child in foster care regarding whether it is in the child’s best interest to attend a school of origin; or (3) if the child is a child with a disability, as defined in section 602 of the Individuals with Disabilities Education Act (20 U.S.C. 1401), the arrangement for, and provision of, the transportation, records transfers, and special education and related services as required under such Act, including—
(aa) the timely conduct of evaluations as required by section 614(a) of such Act (20 U.S.C. 1414(a)); (bb) the prompt transmittal of records under section 614(d)(2)(C)(ii) of such Act (20 U.S.C. 1414(d)(2)(C)(ii)); and (cc) when appropriate, the appointment of a dependent parent for a child who is immediately enrolled in a school in accordance with any school selection decision made for the child; (G) the child has access to special education and related services under the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.); (H) the child is enrolled in a school of origin that is not the school that serves the child’s school attendance area, based on the school selection decision made for the child; and (I) the child is afforded the same free, appropriate public preschool education as is provided to other children; and (ii) the right to receive the protections of this subtitle.

(8) TRANSPORTATION.—
(A) IN GENERAL.—A child in foster care shall be provided with free transportation to and from the child’s school of origin or other school in which the child is enrolled, in accordance with this subsection, paragraphs (4)(H) and (5)(D) of section (b), and section 475(1)(G)(ii)(II) of the Social Security Act (42 U.S.C. 675(1)(G)(ii)(II)).
(B) CHILDREN WITH DISABILITIES.—In the case of a child in foster care that receives services under part A or C of the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq., 1431 et seq.), nothing in this Act or section 475(1)(G)(ii)(II) of the Social Security Act (42 U.S.C. 675(1)(G)(ii)(II)) shall relieve a local educational agency of the agency’s responsibility to provide the child with transportation as part of such services.

(9) REQUIREMENTS OF EDUCATION SYSTEM FOR CONTINUITY IN FOSTER CARE.—(A) IN GENERAL.—Not more than 120 days after the enactment of this Act, any State or local educational agency in the State that has a school attendance law or other law, regulation, practice, or policy that may prohibit the provision of attendance at a school of origin for a child in foster care or that may prohibit implementation of any other requirement of this title, shall undertake in the current time period, regulations, practice, or policy to ensure that children in foster care—
(i) are afforded the same free, appropriate public preschool education as is provided to other children; and (ii) receive the protections of this subtitle.
(B) NO DELAY.—Nothing in this subsection shall be construed to permit a State or local educational agency to delay implementation of this Act until such review and revision is completed.

(10) FOSTER CARE LIASON.—(A) IN GENERAL.—The State educational agency shall ensure that each local educational agency and the local child welfare agency in the State that has a school attendance law or other law, regulation, practice, or policy that may prohibit the provision of attendance at a school of origin for a child in foster care or that may prohibit implementation of any other requirement of this title, shall undertake in the current time period, regulations, practice, or policy to ensure that children in foster care—
(i) are afforded the same free, appropriate public preschool education as is provided to other children; and (ii) receive the protections of this subtitle.
(B) NO DELAY.—Nothing in this subsection shall be construed to permit the State or local educational agency to delay implementation of this Act until such review and revision is completed.

(11) C O L L A B O R A T I O N.—The coordinator shall collaborate with representatives from the State child welfare agency, the State’s program supported under subtitle B of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11431 et seq.), when appropriate, and any State or local educational agency necessary to implement the requirements of this title and the provisions of parts B and E of title IV of the Social Security Act (42 U.S.C. 671 et seq.), to inform and report to the educational needs of children in foster care.

(12) SPECIAL RULE.—In the case of a State that receives a grant under section 111 in an amount that is more than the minimum allotment described in section 111(b)(1)(B), the coordinator, in accordance for this title, shall not be the same individual who is assigned the role of State Coordinator for purposes of the State’s program supported under section 111 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11432 et seq.).

(13) D I S P E R S I B I L I T Y.—The responsibilities of a coordinator described in subparagraph (A) shall include, at minimum—
(i) ensuring that the requirements of this title and clauses (ii)(I), (iii), and (iv) of section 475(1)(G)(ii)(II) of the Social Security Act (42 U.S.C. 675(1)(G)(ii)(II)) are carried out; (ii) gathering and making public information on the problems children in foster care face in gaining access to public preschool programs and schools; (iii) monitoring the progress of the State and local educational agencies in addressing any problems or difficulties in meeting the requirements of this title; (iv) ensuring the success of the programs under this title; (v) providing technical assistance to local educational agencies and local child welfare agencies on how to comply with this title; (vi) ensuring the implementation of this title and the educational outcomes of children in foster care and reporting such information to the appropriate State officials and to the Secretary; and (vii) ensuring effective implementation of a dispute resolution procedure, as described in paragraph (5), and a complaint management system, as described in paragraph (6).

(14) FOSTER CARE LIASON.—(A) IN GENERAL.—The State educational agency shall ensure that each local educational agency and the local child welfare agency in the State that have in gaining access to public preschool programs and schools; (B) RESPONSIBILITIES.—The foster care liaison shall ensure, at minimum, that—
(i) each child in foster care served by the local educational agency and with the education decisionmaker and parent of the child, initiate the school selection decision process under this paragraph if the education decisionmaker believes that a child should remain or enroll in a school of origin.

(15) TIMING.—A school selection decision may be requested for a child in foster care within 60 days of the child’s placement in foster care or any change in that child’s placement, or any change in the child’s placement in foster care.

(16) NOTIFICATION OF FOSTER CARE LIASON.—The local child welfare agency shall notify the foster care liaison described in paragraph (3) for the local educational agency serving the school in which the child is eligible, including—
(i) the names and addresses of all children in foster care over the age of 6 and under age 14 who are enrolled in a school in the school district or who are otherwise served by the local educational agency; and (ii) the identification of each school in which a child in foster care is enrolled.

(17) DEPENDENCY COURT DECISION.—Notwithstanding any other provision of this title, if the court with dependency jurisdiction over a child in foster care initiates or
makes a school selection decision for such child, or appoints another person to initiate or make a school selection decision, the court’s determination shall be binding on all parties, the State educational agency, and the appropriate local educational agency.

(E) SOURCES OF INFORMATION; FACTORS.—
(i) SOURCES OF INFORMATION.—The entity making school selection decisions for a child in foster care shall consider information and factors provided by—
(I) the State child welfare agency, local child welfare agencies, State educational agency, local educational agency, or other public agency; and
(II) the parties, the State educational agency, the parent, educational decisionmaker, foster parent, court representative, and teachers of the child.

(ii) INFORMATION AND FACTORS.—The information and factors described in clause (i) shall include—
(I) the harmful impact of school mobility on the child’s academic progress, achievement, and social and emotional well-being;
(II) the age of the child;
(III) the child’s need for special instruction, and social and emotional well-being;
(IV) personal safety issues, including safety as it relates to family violence;
(V) the child’s need for special instruction, including special education and related services, and where the child can best be met;
(VI) the health of child in foster care pending the resolution of the dispute, except that such procedure shall not be subject to the transportation requirements of paragraph (5)(D) and subsection (a); and
(VII) the time remaining in the school year;
(VIII) the school placement of family members;
(IX) the number of previous school changes;
(X) the child’s connection to the school of origin under section 475(i)(2)(B); and
(XI) the extent to which the educational program of the school of origin is appropriate, meets the child’s needs and interests, and nurtures the child’s talents; and
(XII) the availability of special programs, academically rigorous courses, and extra-curricular activities that are appropriate for the child.

(F) CONSIDERATIONS.—An entity making a school selection decision under this paragraph shall consider the wishes of the child.

(G) EXCLUDED FACTORS.—The cost of transportation to or from a school shall not be a consideration when making a school selection decision.

(H) TRANSPORTATION.—
(i) IN GENERAL.—The local educational agency serving the school of origin in which a child in foster care shall remain or enroll, based on the school selection decision for the child, shall collaborate with the local child welfare agency to ensure that the child is provided transportation to the school of origin in a cost-effective manner and in accordance with section 475(i)(4)(II)(B) of the Social Security Act (42 U.S.C. 675(i)(4)(II)(B)).

(ii) COST OF TRANSPORTATION.—In carrying out clause (i), a local educational agency shall provide the transportation described in such clause for a child in foster care if—
(I) the local child welfare agency reimburses the local educational agency for the cost of such transportation, in accordance with section 475(i)(4)(II)(B) of the Social Security Act (42 U.S.C. 675(i)(4)(II)(B));
(II) the local educational agency agrees to pay for the cost of such transportation; or
(III) the local educational agency and the local child welfare agency agree to share the cost of such transportation.

5. SCHOOL SELECTION DECISION DISPUTE RESOLUTION.

(A) IN GENERAL.—The State educational agency, or another State agency designated by the State, shall develop and oversee a fair and impartial dispute resolution procedure to provide for school selection decisions, and disputes, except that such procedure shall not be applied to disputes regarding school selection decisions made by a court.

(B) COMMISSIONER OF EDUCATION.—The dispute resolution procedure described in subparagraph (A) shall include, at a minimum—
(I) a procedural safeguard system to resolve disputes and render prompt school selection decisions;
(II) written notice of the school selection decision and basis for the decision to the—
(I) parent, educational decisionmaker, and court representative of the child; and
(II) local child welfare agency serving the child;
(iii) a right to appeal a school selection decision, an impartial and prompt review of such decision, and a written determination of the administrative appeal; and
(iv) a right to initiate a dispute under this paragraph that is provided to—
(I) the educational decisionmaker, and court representative of the child; and
(II) a representative from the local child welfare agency or local educational agency serving the child;
(C) SCHOOL PLACEMENT DURING DISPUTE.—If a dispute arises over the school selection decision, the child shall remain in the child’s current school until full resolution of the dispute, unless—
(I) the dependency court determines otherwise and selects a different school for the child; or
(ii) the State child welfare agency or local child welfare agency with responsibility for the child’s health and safety would be at risk if the child remained in such school prior to a determination made under subparagraph (A) and selects a different school for the child.

(D) TRANSPORTATION.—In the case of a dispute under this paragraph regarding a child in foster care, the local educational agency shall—
(i) provide transportation for children in foster care immediately in a public preschool program, including through the use of existing transportation services for children in foster care; and
(ii) provide transportation for children in foster care immediately in a public preschool program, including through the use of existing transportation services for children in foster care, to existing transportation services for children in foster care.

(E) COMPLAINT MANAGEMENT SYSTEM.—Each State shall maintain a complaint management system by which individuals and organizations acting on behalf of a child in foster care can request that the State investigate and correct violations of this subtitle in a timely manner on behalf of a child in foster care or a group of children in foster care.

5. SCHOOL READINESS FOR CHILDREN IN FOSTER CARE.

(A) STATE AND LOCAL EDUCATIONAL AGENCIES.—(I) In general.—The State and local educational agency shall ensure that public preschool programs funded, administered, or overseen by the State educational agency or local educational agency, the State agency that funds such public preschool programs shall—
(i) develop, review, and revise its policies and practices to remove barriers to the enrollment, attendance, retention, and success of children in foster care in public preschool programs funded, administered, or overseen by the agency;
(ii) provide preschool-aged children in foster care with the rights described in subsection (a), and comply with the requirements of this subsection with respect to such children, except that such programs—
(I) shall not be required to enroll a child in foster care immediately in a public preschool program that is operating at full capacity when enrollment is sought for the child, unless otherwise required by State law; and
(ii) shall not be subject to the dispute resolution procedures of the State educational agency or local educational agencies, but shall—
(aa) ensure that all of the dispute resolution procedures available through such programs and the State agency that funds, administers, or oversees such programs are accessible to the educational decisionmaker, court representative of a child in foster care, and a representative from the local child welfare agency; and
(bb) provide individuals with a written explanation of their dispute and appeal rights; and
(iii) shall not be subject to the transportation requirements of section (a)(6), but shall remove barriers to existing transportation services for children in foster care and shall, to the maximum extent practicable, arrange or provide transportation for children in foster care to attend public preschool programs, including the children’s school of origin;
(ii) certify and prioritize preschool-aged children in foster care for enrollment and increase such children’s enrollment and attendance in public preschool programs, including through transportation, strategies to serve such children and families; and
(iii) review the educational and related needs of children in foster care and their families in such agencies’ service areas, in coordination with the State child welfare agency, the local child welfare agency, and the foster care liaison designated under paragraph (9), and develop policies and practices to meet identified needs.

4. SHARING INFORMATION.

(A) IN GENERAL.—The State educational agency and local educational agency shall
review and eliminate any barriers to information-sharing with State child welfare agencies and local child welfare agencies, while continuing to protect the privacy interests of all children, as required by Federal or State law.

(B) IMMEDIATE AVAILABILITY.—To ensure a child in foster care’s immediate enrollment in a new school (including a preschool program), all education records of the child shall be made available in accordance with subsection (a)(4). A school sending education records shall undertake steps to eliminate barriers to the receipt of such records as complete and accurate as possible.

(C) COMPLIANCE WITH FERPA.—Education records of a child in foster care shall be—

(i) maintained and provided to other schools in a manner consistent with section 444 of the General Education Provisions Act (comprising paragraph (1) of the “Family Educational Rights and Privacy Act of 1974”) (20 U.S.C. 672(a)); and

(ii) provided to the child welfare agency or other child welfare system advocates in a manner that complies with such section.

(D) EXPEDITED TRANSFER.—Each foster care liaison described in paragraph (3) and coordinator described in paragraph (2) within a State shall work to expedite the transfer of education records of children in foster care.

(9) TRANSFER OF CREDITS; DIPLOMA.—

(A) IN GENERAL.—The State and each local educational agency of the State shall ensure that each group home or placement facility—

(i) is in compliance with State and Federal laws requiring the education of children in foster care; and

(ii) in the case of a child with an individualized education program under section 614 of the Individuals with Disabilities Education Act (20 U.S.C. 1414), an alternative setting is available if such a setting is created by application or entrance deadlines and other admissions requirements that children in foster care cannot meet because of frequent school changes.

(B) NO FORCED PRIVATE PLACEMENT.—The State shall ensure that each group home or placement facility in its jurisdiction in which a child in foster care may be placed does not explicitly or implicitly condition such placement on attendance at a private school owned, funded or operated by an agency associated with the facility.

(C) NO SCHOOL SEGREGATION.—The State shall ensure that a child in foster care, including a child enrolled in a group home or placement facility—

(i) shall not be educated in a segregated setting due to the child’s status as a child in foster care; and

(ii) shall have access to—

(I) a public elementary school or secondary school; or

(II) in the case of a child with an individualized education program under section 614 of the Individuals with Disabilities Education Act (20 U.S.C. 1414), an alternative setting is available if such a setting is created by application or entrance deadlines and other admissions requirements that children in foster care cannot meet because of frequent school changes.

(D) LOCAL EDUCATIONAL AGENCY ROLE.—Each local educational agency of the State shall—

(i) cooperate with the implementation of programs, activities, services, and vouchers described in subparagraph (A); and

(ii) ensure that such programs, activities, services, and vouchers are coordinated with other programs, activities, services, and vouchers provided under title IV-E of Public Law 108-446, the Foster Care Independence Program established under such Act; and

(E) INFORMATION SHARING.—The State educational agency and local educational agencies shall—

(11) by adding at the end the following:

‘‘(15) the State and State educational agency will ensure that the requirements of section 101 of the Fostering Success in Education Act are met,’’

(2) in section 112(c)(1) (2 U.S.C. 6312(c)(1))—

(A) in subparagraph (N), by striking ‘‘and’’ at the end of the provision;

(B) in subparagraph (O), by striking the period at the end and inserting ‘‘and’’; and

(C) by adding at the end the following:

‘‘(P) in paragraph (2) and when making a grant under section 101 of the Fostering Success in Education Act that relate to the local educational agency.’’

Subtitle B—State Foster Care and Education Plan Grants

SEC. 111. STATE FOSTER CARE AND EDUCATION PLAN REQUIREMENTS AND GRANTS.

(a) General Authority.—From amounts appropriated to carry out this subtitle and not reserved under subsection (b)(2), the Secretary shall make grants to States, from allotments under subsection (b)(1), to enable the States to carry out activities, and award subgrants, in accordance with subsection (d).

(b) Allotments and Reservations.—

(1) Allotments.—Subject to subparagraphs (B) and (C), the Secretary is authorized to make an allotment to each State with an approved State foster care and education plan under section 1112(b) in an amount that bears the same relation to the total amount available under this paragraph for a fiscal year as the number of children in foster care who reside in the State bears to the total number of children in foster care who reside in all States with approved State foster care and education plans.

(B) Minimum Allotment.—The amount of a State’s allotment under this paragraph for a fiscal year shall not be less than $300,000.

(C) Rateable Reductions.—In the case of a fiscal year for which the amounts available to carry out this subtitle are not sufficient to award grants to States in the amounts described in subparagraphs (A) and (B), the Secretary shall ratably reduce the amount of all such grants.

(2) Reservations.—

(A) Authorization for Technical Assistance and Evaluation.—Of the funds made available to carry out this section, the Secretary shall reserve 0.10 percent of such funds to—

(i) technical assistance to States that receive grants under this subtitle; and

(ii) rigorous evaluation of the activities funded with grants under this subtitle in accordance with section 113.

(B) Students in Territories.—Of the funds made available to carry out this section, the Secretary shall reserve 0.05 percent of such funds to—

(i) provide technical assistance to students in the territories of Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, and the District of Columbia under this subtitle; and

(ii) develop and disseminate materials to improve the education and training of students in the territories.

(C) Indian Students.—Of the funds made available to carry out this section, the Secretary shall reserve 0.10 percent of such funds for—

(i) providing assistance to the Secretary of the Interior for programs that are for Indian children in foster care, as described in section 1112(b)(3), and

(ii) training and technical assistance to States and Indian Tribes to improve the education and training of Indian children in foster care.

(D) Educational Rights and Privacy Act.—Of the funds made available to carry out this section, the Secretary shall reserve 0.05 percent of such funds to—

(i) provide information on the Family Educational Rights and Privacy Act of 1974 to each grantee;

(ii) establish procedures for the development and implementation of the grantee’s plan for the protection of the rights of children in foster care under section 111(a), and

(iii) provide assistance to States in implementing the Family Educational Rights and Privacy Act of 1974.

(E) State and Local Education Agencies.—Of the funds made available to carry out this section, the Secretary shall reserve 0.10 percent of such funds for—

(i) providing technical assistance to State educational agencies and local education agencies on the requirements of this title and for maintaining a complaint management system as of the date of the plan will be achieved.

(F) General Authority.—The Secretary shall carry out this section—

(i) by making grants to entities that meet the requirements under section 111(a), and

(ii) by providing technical assistance to States and local education agencies on the requirements of this title.

(G) In General.—The Secretary shall—

(i) make contracts, subcontracts, and grants under this section to States and local education agencies to carry out the requirements of this section,

(ii) ensure that the requirements of this section are met,

(iii) provide grants to States and local education agencies for the purposes of this section,

(iv) provide technical assistance to States and local education agencies under this section, and

(v) ensure that the requirements of this section are met.

(H) Amendments.—The Secretary shall carry out this section—

(i) by making contracts, subcontracts, and grants under this section to States and local education agencies under this section,

(ii) ensure that the requirements of this section are met,

(iii) provide grants to States and local education agencies under this section, and

(iv) provide technical assistance to States and local education agencies under this section.

(I) Reporting.—The Secretary shall—

(i) provide technical assistance to States and local education agencies under this section,

(ii) provide grants to States and local education agencies under this section,

(iii) ensure that the requirements of this section are met,

(iv) provide technical assistance to States and local education agencies under this section,

(v) provide grants to States and local education agencies under this section, and

(vi) provide technical assistance to States and local education agencies under this section.

(J) Amendments.—The Secretary shall carry out this section—

(i) by making contracts, subcontracts, and grants under this section to States and local education agencies under this section,

(ii) ensure that the requirements of this section are met,

(iii) provide grants to States and local education agencies under this section, and

(iv) provide technical assistance to States and local education agencies under this section.

(K) Amendments.—The Secretary shall carry out this section—

(i) by making contracts, subcontracts, and grants under this section to States and local education agencies under this section,

(ii) ensure that the requirements of this section are met,

(iii) provide grants to States and local education agencies under this section, and

(iv) provide technical assistance to States and local education agencies under this section.

(L) Amendments.—The Secretary shall carry out this section—

(i) by making contracts, subcontracts, and grants under this section to States and local education agencies under this section,

(ii) ensure that the requirements of this section are met,

(iii) provide grants to States and local education agencies under this section, and

(iv) provide technical assistance to States and local education agencies under this section.

(M) Amendments.—The Secretary shall carry out this section—

(i) by making contracts, subcontracts, and grants under this section to States and local education agencies under this section,

(ii) ensure that the requirements of this section are met,

(iii) provide grants to States and local education agencies under this section, and

(iv) provide technical assistance to States and local education agencies under this section.

(N) Amendments.—The Secretary shall carry out this section—

(i) by making contracts, subcontracts, and grants under this section to States and local education agencies under this section,

(ii) ensure that the requirements of this section are met,

(iii) provide grants to States and local education agencies under this section, and

(iv) provide technical assistance to States and local education agencies under this section.

(O) Amendments.—The Secretary shall carry out this section—

(i) by making contracts, subcontracts, and grants under this section to States and local education agencies under this section,

(ii) ensure that the requirements of this section are met,

(iii) provide grants to States and local education agencies under this section, and

(iv) provide technical assistance to States and local education agencies under this section.
are receiving assistance under this subtitle; and

(iii) ensuring that the State is in compliance with the requirements under this title.

(B) Local child welfare agency—A State child welfare agency shall collaborate with the State child welfare agency in carrying out the responsibilities under this paragraph.

(2) Monitoring—The Secretary shall—

(A) make recommendations regarding procedures and policies for implementing this title;

(B) review and advise the State on the plans before the plan's submission or resubmission;

(C) ensure that the State is in compliance with the requirements described in paragraph (1), (ii), and (iii) of section 475(1)(G) of the Social Security Act (42 U.S.C. 675(1)(G));

(D) identify and remove any barriers to remaining or enrolling in a school of origin, or to enrolling promptly in a new school for a child in foster care if such enrollment is in the child's best interest or (iii) other barriers impeding the rights of a child in foster care;

(E) ensure that the schools served by the local educational agency promptly transfer the school credits and partial school credits of children in foster care, and provide children in foster care with access to credit recovery programs or services.

SEC. 112. SUBGRANTS.

(a) IN GENERAL.—The State educational agency shall, in accordance with section 111(b)(2), award subgrants, on a competitive basis, to public agencies, including local educational agencies and local child welfare agencies, that exist in schools served by the local educational agencies, to carry out the requirements of this title.

(b) TECHNICAL ASSISTANCE.—The Secretary shall—

(A) make recommendations regarding the implementation of this title;

(B) review and advise the State on the plan before the plan's submission or resubmission;

(C) ensure that the State is in compliance with the requirements under this title; and

(D) identify and remove any barriers that exist in schools served by the local educational agency.

(c) NOTIFICATIONS.—The Secretary shall—

(I) notify the State if any subgrant is not in compliance with the requirements under this title;

(II) provide the State with an explanation of the basis for the determination of noncompliance;

(III) provide the State with an explanation of any actions that the Secretary may take to address the noncompliance;

(IV) assist the State in addressing the noncompliance.

(d) USE OF FUNDS.—A public agency, or a partnership of public agencies, receiving a subgrant under this section shall submit an application to the State educational agency for the purposes of carrying out its responsibilities under this title.

(e) INFORMATION.—The Secretary shall—

(1) require applications for grants under this subtitle to be submitted to the Secretary no later than the expiration of the 60-day period beginning on the date that funds are available for purposes of making such grants; and

(2) award such grants not later than the expiration of the 120-day period beginning on such date.

(f) DETERMINATION BY SECRETARY.—The Secretary shall—

(1) make recommendations regarding the implementation of this title;

(2) review and advise the State on the plan before the plan's submission or resubmission;

(3) ensure that the State is in compliance with the requirements described in this title;

(4) assist in funding State-level education coordinators in the State child welfare agency and local education liaisons within local child welfare agencies to be specific points of contact on education issues.

SECT. 113. RESPONSIBILITIES OF THE SECRETARY.

(a) REVIEW OF STATE PLANS.—

(1) IN GENERAL.—The Secretary of Education, in collaboration with the Secretaries of Health and Human Services, shall review each plan submitted under this subtitle and section 111(c). If the plan meets the requirements of section 111 and is reasonably calculated to ensure that all children in foster care in the State receive all rights, benefits, and protections required by this title, the Secretary shall approve the plan.

(b) DISAPPROVAL.—

(A) IN GENERAL.—If a plan does not meet the requirements described in paragraph (1), the Secretary shall disapprove the plan and provide the State educational agency with specific findings as to what needs to be corrected for approval.

(c) TECHNICAL ASSISTANCE.—The Secretary shall provide—

(1) training, support, and technical assistance to a State educational agency receiving a grant to assist the State educational agency in carrying out its responsibilities under this title; and

(2) training, support, and technical assistance to a State that has had the State's plan described in section 111 approved.

(d) SUBMISSION AND DISTRIBUTION.—The Secretary shall—

(1) require applications for grants under this subtitle to be submitted to the Secretary no later than the expiration of the 60-day period beginning on the date that funds are available for purposes of making such grants; and

(2) award such grants not later than the expiration of the 120-day period beginning on such date.

(e) DETERMINATION BY SECRETARY.—The Secretary shall make recommendations regarding the implementation of this title.
(2) DATA COLLECTION AND DISSEMINATION.—The Secretary shall—
(A) directly or through grants, contracts, or cooperative agreements, periodically collect and disseminate data and information regarding the education of children in foster care; and
(B) require each State receiving a grant under this subtitle to annually provide—
(1) a statement described in section 101(b)(12)(A); and
(2) such other data and information as the Secretary determines to be necessary and relevant to carry out this subtitle.

(f) EVALUATION AND DISSEMINATION.—The Secretary shall conduct evaluation and dissemination activities regarding programs designed to meet the educational needs of elementary and secondary school students who are children in foster care.

(g) REPORT.—Not later than 4 years after the date of enactment of this Act, the Secretary shall prepare and submit to the Committee on Education and Labor of the House of Representatives and the Committee on Health, Education, Labor, and Pensions of the Senate a report on the status of the education of children in foster care, which shall include information on—
(1) the educational outcomes of children in foster care; and
(2) the actions of the Secretary and the effectiveness of the programs supported under this title.

SEC. 114. AUTHORIZATION OF APPROPRIATIONS.
There is authorized to be appropriated to carry out the subtitle, $150,000,000 for each of the fiscal years 2011 through 2015.

TITLE II—SOCIAL SECURITY ACT AMENDMENTS

SEC. 201. SOCIAL SECURITY ACT AMENDMENTS.
(a) EDUCATIONAL STABILITY FOR FOSTER CARE CHILDREN.—Section 475(1)(G) of the Social Security Act (42 U.S.C. 675(1)(G)) is amended—
(1) in clause (i)—
(A) by striking “or” at the end of subclause (I) and inserting “and”; and
(B) by striking subclause (II), and inserting in its place the following:
“(II) assures that the State agency and local child welfare agencies have identified staff within the agencies to be the point people with the State and local educational agencies related to educational issues, including the implementation of the requirements of clauses (ii)(I), (iii), and (iv) of subparagraph (G) of section 475(1) and the provisions of section 101 of the Fostering Success in Education Act; and
“(III) by adding at the end the following:
“(ii) such provisions shall include—
(1) the educational outcomes of children in foster care; and
(2) the actions of the Secretary and the effectiveness of the programs supported under this title.

(b) STATE PLAN REQUIREMENT.—Section 471 of the Social Security Act (42 U.S.C. 675(1)) is amended—
(1) in clause (32), by striking “or” at the end of subclause (I) and inserting “and”; and
(2) by adding at the end the following:
“(34) by providing that the State agency and local child welfare agencies will collaborate with the State and local educational agencies to collect the data and other information regarding the education of children in foster care; and
“(34) by providing that the State agency and local child welfare agencies have identified staff within the agencies to be the point people with the State and local educational agencies related to educational issues, including the implementation of the requirements of clauses (ii)(I), (iii), and (iv) of subparagraph (G) of section 475(1), as well as to coordinate with educational agency liaisons and coordinators to implement the provisions of section 101 of the Fostering Success in Education Act.”.

By Mr. SPECTER:
S. 2805. A bill to amend the Food and Nutrition Act of 2008 to increase the amount made available to purchase commodities for the emergency food assistance program in fiscal year 2010; to the Committee on Agriculture, Nutrition, and Forestry.

Mr. SPECTER. Mr. President, I seek recognition to introduce legislation to deal with the pressing problem of hunger in the United States. The report of the Economic Research Service of the Department of Agriculture on Monday, November 16—3 days ago—disclosed some startling facts about hunger in America. There are 49 million Americans who experienced hunger last year. Among that number, 17 million were children, and 500,000 of those children were under the age of 6, which is a critical stage in childhood development.

The hunger problem hit disproportionately higher for Hispanics at 27 percent higher and African Americans at 26 percent higher. It is hard to find a sufficiently tough word to describe it—scandalous, outrageous, criminal, repugnant—that in this land of plenty, we should find Americans who are hungry. It is unacceptable to have people hungry anywhere in the world, but right here in our own backyard for this situation to exist is beyond the pale.

Having read the article on the 16th, I contacted the Secretary of Agriculture, Tom Vilsack, discussed the issue with him, and I am now introducing legislation which will add $250 million to the food banks to try to deal with this issue on an emergency basis. It would be my hope that this is the kind of legislation which could be passed very promptly—hopefully, before Christmas of this year during our current session—to take some immediate action to replenish the food banks so people in America are not hungry.

Mr. President, I ask unanimous consent that my full statement be printed in the RECORD.

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

The USDA report contains alarming data on the struggles faced by too many American families. In 2008, 17 million households reported being food insecure, that is to say they lacked access to enough food for an active and healthy life. This is an increase from 13 million households in 2007. In my state of Pennsylvania, 11.2 percent of our households reported food insecurity, and 4.2 percent reported very low food security, meaning they were unable to eat at various times over the year.

Of these 49 million Americans who reported hunger, 12 million adults and 5.2 million children reported periods of extreme hunger, possibly going days without eating. The data shows that black and Hispanic households experienced food insecurity at rates far higher than the national average at 26 percent and 27 percent respectively.

Among the 17 million children, nearly half a million under the age of 6 were hungry. This is a critical stage of childhood development that is being undermined by a lack of access to proper nutrition, which is necessary for learning and academic achievement.

Fortunately, Congress has taken steps to address this important issue, appropriating for fiscal year 2010 $9.2 billion for the School Lunch Program and for the Commodity Supplemental Food Program which provides nutrition assistance to mothers, children and the elderly. The economic stimulus package contained more than $20 billion for nutrition assistance. Yet, this USDA study shows us that more is needed.

That is why I am introducing legislation to double spending on The Emergency Food Assistance Program, or TEFAP, from $250 to $500 million annually. Through TEFAP, the USDA makes commodity and food purchases and then distributes nutrition assistance to states based on need. The numbers show us there is great need.

According to Feeding America, which operates 205 food banks nationwide and 10 in the Commonwealth of Pennsylvania, 99 percent of their food banks experienced an increase in demand during the month of September 2009 and 91 percent of food banks reported unemployment as a critical factor driving the increase in emergency food assistance. Unfortunately 51 percent of these food banks had to turn someone away in the last year. By doubling TEFAP spending, Congress would significantly increase the amount of food being delivered to local food banks, ensuring that less Americans go hungry.
According to the Department of Agriculture, nearly 27 percent of the 356 billion pounds of available food in America is wasted each year. That is nearly 100 billion pounds of waste, when accounting for the charity Feeding America only 5 billion pounds of food is needed to eliminate hunger. In a country with such a food abundance, it is criminal that children go to bed hungry. Our country has an established network of food assistance providers in place. Government agencies, community food banks, food pantries, soup kitchens, shelters and churches all strive to address the challenge of combating hunger. Let us provide them the resources they need. The legislation I am introducing today will do that and will stem the tide of hunger.

Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

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

S. 2805

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

SECTION 1. FINDINGS.

Congress finds that—

(1) more than 1 in 7 households in the United States struggled to find enough to eat during 2008; 

(2) poverty is the primary cause of food insecurity and hunger in the United States; 

(3) according to the Economic Research Service of the Department of Agriculture on household food security in the United States found that in 2008, 17,000,000 households were food insecure, an increase from 13,000,000 in 2007; 

(4) the term “low food security” means people being unable to consistently get enough to eat and the term “very low food security” means people being hungry at various times over the year and being unable to eat because of lack of money to purchase food; 

(5) the 17,000,000 food insecure households in the United States are home to 49,000,000 Americans, of whom—

(A) 17,000,000 are children, among whom nearly 5,000,000 in the developmentally critical years under the age of 6 are going hungry; and

(B) 12,000,000 adults and 5,200,000 children reported going hungry, possibly going days without eating; 

(6) good nutrition is necessary for learning and academic achievement; and

(7) Black and Hispanic households experienced food insecurity at far higher rates (25.7 percent in the case of Black households and 26.9 percent in the case of Hispanic households) than the national average.

SEC. 2. AVAILABILITY OF COMMODITIES FOR THE EMERGENCY FOOD ASSISTANCE PROGRAM.

Section 2(b)(2)(B) of the Food and Nutrition Act of 2009 (7 U.S.C. 2016a(a)(2)) is amended—

(1) by striking “(B)” by striking “(A)” and inserting “(B)” at the end; 

(2) by redesignating subparagraph (C) as subparagraph (D); 

(3) in subparagraph (E) (as so redesignated)—

(A) by striking “each of fiscal years 2010 through 2012” and inserting “fiscal year 2012”; and

(B) by striking “subparagraph (B)” and inserting “subparagraph (D)” and

(4) by inserting after subparagraph (B) the following:

“(C) for fiscal year 2011, $250,000,000, as adjusted in accordance with subparagraph (E); and”;

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 335—EX-PRESING THE SENSE OF THE SENATE THAT THE GOVERNMENT OF THE ISLAMIC REPUBLIC OF IRAN HAS SYSTEMATICALLY VIOLATED ITS OBLIGATIONS TO UPHOLD HUMAN RIGHTS PROVIDED FOR UNDER ITS CONSTITUTION AND INTERNATIONAL LAW

Mr. LEVIN (for himself, Mr. McCaIN, Mr. GraHAM, Mr. LieBerman, Mr. CorkiER, and Mr. NelSON of Florida) submitted the following resolution; which was considered and agreed to:

S. RES. 335

Whereas the 1979 Constitution of the Islamic Republic unhesitatingly guarantees certain human rights and fundamental freedoms, which encompass civil and political rights, along with economic, social, and cultural rights;

Whereas the Islamic Republic of Iran is a party to four major United Nations human rights treaties: the Convention on the Rights of the Child (which it ratified on July 13, 1994), the International Convention on the Elimination of All Forms of Racial Discrimination (which it ratified on August 29, 1988), and the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights (both of which it ratified on June 24, 1975);

Whereas the Government of Iran has routinely violated the human rights of its citizens, including—

(1) torture and cruel, inhuman, or degrading treatment or punishment, including flogging, and amputations;

(2) high incidence and increase in the rate of executions carried out in the absence of due process and fair trial guarantees, including public executions and executions of juvenile offenders;

(3) stoning as a method of execution and persons in prison who continue to face sentences of execution by stoning;

(4) arrests, violent repression, and sentencing of women exercising their right to peaceful assembly, a campaign of intimidating women against women’s rights defenders, and continuing discrimination against women and girls;

(5) increasing discrimination and other human rights violations against persons belonging to religious, ethnic, linguistic, or other minorities;

(6) ongoing, systematic, and serious restrictions of freedom of peaceful assembly and association and freedom of opinion and expression, including the continuing closures of media outlets, arrests of journalists, and the censorship or expression in online forums such as blogs and websites; and

(7) severe limitations and restrictions on freedom of religion and belief, including arrest, intimidation, and lengthy jail sentences for those exercising their right to freedom of religion or belief, including a provision in the proposed draft penal code that sets out a mandatory death sentence for apostasy, the abandoning of one’s faith;

Whereas, since March 9, 2007, Robert Levinson, a United States citizen, has been missing in the Islamic Republic of Iran, and the Government of Iran has provided little information to his whereabouts or assistance in ensuring his safe return to the United States;

Whereas Ja’far Kiani was publicly stoned to death in July 2007 in the Islamic Republic of Iran in contravention of an order from the Head of the Judiciary granting a temporary stay of execution;

Whereas, since May 2008, Reza Taghavi, a 71-year old Iranian-American, has been imprisoned without a trial or formal charges;

Whereas, on October 15, 2008, authorities in the Islamic Republic of Iran sentenced Esha Momeni, a graduate student at California State University, Northridge, for her peace- ful activities in connection with the women’s rights movement in the Islamic Republic of Iran, and refused to grant her permission to leave Iran for 10 months following her release from prison in November 2008;

Whereas Iranian-American journalist Roxana Saberi was jailed in January 2009 and sentenced in a closed-door, one-hour trial to eight years in prison for charges of espionage before her release in May 2009;

Whereas, on June 19, 2009, the United Na- tions High Commissioner for Human Rights expressed concerns about the increasing number of illegal arrests not in conformity with the law and the illegal use of excessive force in responding to protests following the June 12, 2009, elections, resulting in at least dozens of deaths and hundreds of injuries;

Whereas the Government of Iran closed the Center for Defenders of Human Rights, headed by Nobel Peace prize winner Shirin Ebadi, in December 2008, and the Association of Ira- nian Journalists in August 2009, the country’s largest independent association for journalists;

Whereas, on August 1, 2009, authorities in the Islamic Republic of Iran began a mass trial of over 100 individuals in connection with election protests, most of whom were held incommunicado for weeks, in solitary confinement, with little or no access to their lawyers and families, many of whom showed signs of torture and drugging;

Whereas, in early October 2009, the judi- cary of the Islamic Republic of Iran sentenced four individuals to death after the disputed electoral election, effectively providing the individuals adequate access to legal representation during their trials;

Whereas the Supreme Leader of Iran, Ali Khamenei, issued a statement on October 28, 2009, effectively criminalizing dissent regarding the national election in the Islamic Re- public of Iran this past June, further re- stricting the right to freedom of expression;

Whereas the Government of Iran does not allow independent nongovernmental associations and labor unions to perform their role in peacefully defending the rights of all per- sons;

Whereas, on November 4, 2009, security forces in the Islamic Republic of Iran used force to disperse thousands of protesters, resulting in a number of injuries and arrests, in violation of international stand- ards regarding the proportionate use of force against peaceful demonstrations;

Whereas the Government of Iran has expelled students from universities, particularly over the past two years, in reprisal for their being critical of the government;

Whereas the Government of Iran has im- posed restrictions on the travel of individ- uals, including artists and filmmakers since the recent elections, in reprisal for their po- litical views or their criticism of the govern- ment, such as those presently imposed on human rights lawyer Abdolfattah Soltani,
human rights activist Emad Baghi, film director Jafar Panahi, and actress Fatemeh Motamed Arya; and

Whereas, according to Amnesty International, at least 83 people were known to have been executed in 2008, including eight juvenile offenders and two men who were executed by stoning; Now, therefore, be it

Resolved—(1) that the Senate:

(a) calls for authorities in the Islamic Republic of Iran to respect the rights of the people of Iran to freedom of speech, press, religion, association, and assembly;

(b) condemns the Government of Iran's human rights violations and calls on the Government of Iran to hold those responsible accountable for their actions;

(c) reminds the Government of Iran of its constitutional obligations under its 1979 Constitution and four international covenants to which it is a signatory;

(d) calls for the immediate release from detention of opposition figures, human rights defenders, journalists, and all others held for peacefully exercising their right to expression, assembly, and association;

(e) urges the Government of Iran to ensure that anyone placed on trial for committing acts of sedition or any other criminal acts benefits from all of his or her rights to a fair trial, including proceedings that are open to the public, the right to be represented by counsel, and guarantees that no statements shall be admitted into evidence that were shown to have been obtained through torture, inhuman, or degrading treatment;

(f) calls for the Government of Iran to ensure that those currently in detention are treated humanely, to provide detainees immediate medical treatment that may be needed, and calls for the Government of Iran to hold accountable those responsible for torture of detainees; and

(g) calls for authorities in the Islamic Republic of Iran, consistent with their obligations under the International Covenant on Civil and Political Rights, to guarantee all persons the "freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing, or in the form of art, or through any other media of his choice".

SENATE RESOLUTION 356—CALLING UPON THE GOVERNMENT OF TURKEY TO FACILITATE THE REOPENING OF THE EUMENICAL PATRIARCHATE'S THEOLOGICAL SCHOOL OF HALKI WITHOUT CONDITION OR FURTHER DELAY

Mr. CARDIN (for himself, Mr. BROWNBACK, Mr. REID, Mrs. SHAHEEN, Ms. SNOWE, and Mr. MENENDEZ) submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 356

Whereas the Ecumenical Patriarchate is an institution with a history spanning 17 centuries, serving as the center of the Orthodox Christian Church throughout the world;

Whereas the Ecumenical Patriarchate sits at the crossroads of East and West, offering a unique perspective on the religions and cultural communities around the world;

Whereas the Ecumenical Patriarch is formally accorded the title of Archbishop of Constantinople by a synod convened in Constantinople in the 3rd century; and

Whereas since November 1991, His All Holiness, Bartholomew I, has served as Archbishop of Constantinople, New Rome and Ecumenical Patriarch;

Whereas Ecumenical Patriarch Bartholomew I was awarded the Congressional Gold Medal in honor of his outstanding and enduring contributions toward religious understanding and peace;

Whereas during the 110th Congress, 75 Senators of the majority of members of the Committee on Foreign Affairs of the House of Representatives wrote to President George W. Bush and the Prime Minister of Turkey the congressional concern, which continues today, regarding the absence of religious freedom for Ecumenical Patriarch Bartholomew I in the area of church-controlled or state-controlled religious personnel in appropriate institutions around the world;

Whereas the Government of Turkey has been a participating state of the Organization for Security and Cooperation in Europe (OSCE) since signing the Helsinki Final Act in 1975;

Whereas in 1989, the OSCE participating states adopted the Vienna Concluding Document, committing to respect the right of representatives, including religious personnel in appropriate institutions;

Whereas the continued closure of the Ecumenical Patriarchate's Theological School of Halki has been an ongoing issue of concern for the American people and the United States Congress and has been repeatedly raised by members of the Commission on Security and Cooperation in Europe and by United States delegations to the OSCE's annual Human Dimension Implementation Meeting;

Whereas in his address to the Grand National Assembly of Turkey on April 6, 2009, President Erdogan underscored our longstanding concern over the continued closure of this unique institution.

Whereas over the years there have been occasional indications by the Turkish authorities of pending action to reopen the Seminary, to date all have failed to materialize. In a potentially promising development, Turkey's Prime Minister, Recep Tayyip Erdogan, met with the Ecumenical Patriarch Bartholomew I in August 2009, and, in an address to a wider gathering of minority religious leaders that day, concluded by stating, "We should not be of those who gather, talk, and disperse. A result should come out of this.";

(2) urges the Government of Turkey to address other longstanding concerns relating to the Ecumenical Patriarchate.

Resolved, That the Senate—

(1) welcomes the historic meeting between Prime Minister Recep Tayyip Erdogan and Ecumenical Patriarch Bartholomew I;

(2) the Government of Turkey to facilitate the reopening of the Ecumenical Patriarchate's Theological School of Halki without condition or further delay; and

(3) urges Prime Minister Erdogan to facilitate the reopening of the Ecumenical Patriarchate.
I am particularly mindful of the fact that the continued closure of the Theological School of Halki stands in clear violation of Turkey’s obligations under the 1989 OSCE Vienna Concluding Document, which affirmed the right of religious communities to provide “training of religious personnel in appropriate institutions.”

At a time when Turkey is seeking to chart a new course, the resolution of this longstanding issue would not only be a demonstration of Ankara’s good will, but, as President Obama mentioned in his address to the Turkish Grand National Assembly in April, will send such an important signal inside Turkey and beyond. I remain hopeful and encourage Prime Minister Erdoğan to act decisively and without condition on this matter before his upcoming visit to Washington in early December.

To underscore the importance attached to the reopening of the Theological School of Halki and our solidarity with the Ecumenical Patriarch, I am pleased to introduce a resolution on this issue together with Mr. BROWNBACK, Mr. REID, ** **

SENATE RESOLUTION 357—URGING THE PEOPLE OF THE UNITED STATES TO OBSERVE GLOBAL FAMILY DAY AND ONE DAY OF PEACE AND SHARING

Mr. INOUYE (for himself and Mr. REID) submitted the following resolution; which was referred to the Committee on the Judiciary:

S. Res. 357

Whereas in 2002, the people of the world celebrated for the first time the Global Family Day, with the United Nations General Assembly Resolution 138, expressing the sense of Congress that the President of the United States should urge all nations and citizens to observe this day;

Whereas in 2004, the UN General Assembly Resolution 138 was replaced by Senate Concurrent Resolution 138, asserting that a day of peace and sharing is related to the Millennium Development Goals and the United Nations’ mission to promote social and economic justice worldwide;

Whereas in 2009, the UN General Assembly Resolution 138 was replaced by Senate Concurrent Resolution 138, which begins: “Whereas in 2009, the UN General Assembly Resolution 138 was replaced by Senate Concurrent Resolution 138, asserting that a day of peace and sharing is related to the Millennium Development Goals and the United Nations’ mission to promote social and economic justice worldwide;”

Whereas in 2010, many people around the world celebrated for the first time Global Family Day, with the United Nations General Assembly Resolution 138, expressing the sense of Congress that the President of the United States should urge all nations and citizens to observe this day; and

Whereas in 2011, the UN General Assembly Resolution 138 was replaced by Senate Concurrent Resolution 138, asserting that a day of peace and sharing is related to the Millennium Development Goals and the United Nations’ mission to promote social and economic justice worldwide; and

Whereas in 2012, the UN General Assembly Resolution 138 was replaced by Senate Concurrent Resolution 138, asserting that a day of peace and sharing is related to the Millennium Development Goals and the United Nations’ mission to promote social and economic justice worldwide;

I am pleased to introduce a resolution on this issue together with Mr. BROWNBACK, Mr. REID, ** **

AMENDMENTS SUBMITTED AND PROPOSED

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

TEXT OF AMENDMENTS

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

SEC. 1. SHORT TITLE. TABLE OF CONTENTS.

(a) Short Title.—This Act may be cited as the “Patient Protection and Affordable Care Act”.

(b) Table of Contents.—The table of contents of this Act is as follows:

Part I—Establishment of Qualified Health Plans

Sec. 1001. Amendments to the Public Health Service Act.

Sec. 1002. Health insurance consumer information.

Sec. 1003. Ensuring that consumers get the value for their dollars.

Sec. 1004. Effective dates.

Subtitle B—Immediate Actions to Preserve and Expand Coverage

Sec. 1081. Immediate access to insurance for uninsured individuals with a preexisting condition.

Sec. 1082. Reinsurance for early retirees.

Sec. 1083. Immediate information that allows consumers to identify affordable coverage options.

Sec. 1084. Administrative simplification.

Sec. 1085. Effective dates.

Subtitle C—Quality Health Insurance Coverage for All Americans

Part I—Health Insurance Market Reforms

Sec. 1201. Amendment to the Public Health Service Act.

Subtitle A—Individual and Group Market Reforms

Sec. 1301. Legislative reforms.

Sec. 1302. Related definitions.

Part II—Other Provisions

Sec. 1251. Preservation of right to maintain coverage.

Sec. 1252. Rating reforms must apply uniformly to all health insurance issuers and group health plans.

Sec. 1253. Effective dates.

Subtitle D—Available Coverage Choices for All Americans

Part I—Establishment of Qualified Health Plans

Sec. 1301. Qualified health plan defined.

Sec. 1302. Essential health benefits requirements.

Sec. 1303. Special rules.

Sec. 1304. Related definitions.

Part II—Consumer Choices and Insurance Competition Through Health Benefit Exchanges

Sec. 1311. Affordable choices of health benefit plans.

Sec. 1312. Consumer choice.

Sec. 1313. Financial integrity.

Part III—State Flexibility Relating to Services and Exchanges

Sec. 1321. State flexibility in operation and enforcement of Exchanges and related requirements.

Resolved. That the Senate urgently requests—

(1) the people of the United States to observe Global Family Day and One Day of Peace and Sharing with appropriate activities stressing the need—

(A) to eradicate violence, hunger, poverty, and suffering; and

(B) to establish greater trust and fellowship among peace-loving countries and families everywhere; and

(2) American businesses, labor organizations, and faith and civic leaders to join in promoting appropriate activities for Americans and in extending appropriate greetings from the families of the United States to families in the rest of the world.

Mr. INOUYE. Mr. President, today, I am submitting a Senate resolution to observe Global Family Day, One Day of Peace and Sharing, and am pleased to be joined in this endeavor by Senator REID.

We are a global society, interconnected by highly efficient modes of communication and transportation. With continued advancements in technology, nations will become more interdependent upon each other. For this reason, I will continue to support and advocate for world peace. This is not a lofty pursuit. I have great confidence that if nations use everything at their disposal, they can provide peaceful, diplomatic options instead of war.

I am particularly mindful of the fact that the continued closure of the Theological School of Halki stands in clear violation of Turkey’s obligations under the 1989 OSCE Vienna Concluding Document, which affirmed the right of religious communities to provide “training of religious personnel in appropriate institutions.”

We are a global society, interconnected by highly efficient modes of communication and transportation. With continued advancements in technology, nations will become more interdependent upon each other. For this reason, I will continue to support and advocate for world peace. This is not a lofty pursuit. I have great confidence that if nations use everything at their disposal, they can provide peaceful, diplomatic options instead of war.
Sec. 1322. Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers.

Sec. 1323. Community health insurance option.

Sec. 1324. Level playing field.

PART IV—STATE FLEXIBILITY TO ESTABLISH PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

Sec. 1331. State flexibility to establish basic health programs for low-income individuals not eligible for Medicaid.

Sec. 1332. Waiver for State innovation.

Sec. 1333. Provisions relating to offering of plans in more than one State.

PART V—REINSURANCE AND RISK ATTENUATION

Sec. 1341. Transitional reinsurance program for individual and small group markets in each State.

Sec. 1342. Establishment of risk corridors for plans in individual and small group markets.

Sec. 1343. Risk adjustment.

Subtitle E—Affordable Coverage Choices for All Americans

PART I—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

SUBPART A—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

Sec. 1401. Refundable tax credits providing premium assistance for coverage under a qualified health plan.

Sec. 1402. Reduced cost-sharing for individuals enrolling in qualified health plans.

SUBPART B—ELIGIBILITY DETERMINATIONS

Sec. 1411. Procedures for determining eligibility for Exchange participation, premium tax credits and reduced cost-sharing, and individual responsibility exemptions.

Sec. 1412. Advance determination and payment of premium tax credits and cost-sharing reductions.

Sec. 1413. Streamlining of procedures for enrollment through an exchange and State Medicaid, CHIP, and health subsidy programs.

Sec. 1414. Disclosures to carry out eligibility requirements for certain programs.

Sec. 1415. Premium tax credit and cost-sharing reduction payments disregarded for Federal and Federally-assisted programs.

PART II—SMALL BUSINESS TAX CREDIT

Sec. 1421. Credit for employee health insurance expenses of small businesses.

Subtitle F—Shared Responsibility for Health Care

PART I—INDIVIDUAL RESPONSIBILITY

Sec. 1501. Requirement to maintain minimum essential coverage.

Sec. 1502. Reporting of health insurance coverage.

PART II—EMPLOYER RESPONSIBILITIES

Sec. 1511. Automatic enrollment for employees of large employers.

Sec. 1512. Employer requirement to inform employees of coverage options.

Sec. 1513. Shared responsibility for employers.

Sec. 1514. Reporting of employer health insurance coverage.

Sec. 1515. Offering of Exchange-participating qualified health plans through cafeteria plans.

Subtitle G—Miscellaneous Provisions

Sec. 1552. Transparency in government.

Sec. 1553. Prohibition against discrimination on assisted suicide.

Sec. 1554. Access to the1.

Sec. 1555. Freedom not to participate in Federal health insurance programs.

Sec. 1556. Equity for certain eligible survivors.

Sec. 1557. Nondiscrimination.

Sec. 1558. Protections for employees.

Sec. 1559. Oversight.

Sec. 1560. Rules of construction.

Sec. 1561. Health information technology enrollment standards and protocols.

Sec. 1562. Conforming amendments.

TITLE II—ROLE OF PUBLIC PROGRAMS

Subtitle A—Improved Access to Medicaid

Sec. 1501. Medicaid coverage for the lowest income populations.

Sec. 1502. Income eligibility for nonelderly determined using modified gross income.

Sec. 1503. Reforms to offer premium assistance for employer-sponsored insurance.

Sec. 1504. Medicaid coverage for former teachers.

Sec. 1505. Payments to territories.

Sec. 1506. Special adjustment to FMAP determination for certain States recovering from a major disaster.

Sec. 1507. Medicaid Improvement Fund reformed.

Subtitle B—Enhanced Support for the Children’s Health Insurance Program

Sec. 1511. Additional federal financial participation for CHIP.

Sec. 1512. Technical corrections.

Subtitle C—Medicaid and CHIP Enrollment Simplification

Sec. 1521. Enrollment Simplification and coordination with State Health Insurance Exchanges.

Sec. 1522. Permitting hospitals to make presumptive eligibility determinations for all Medicaid eligible populations.

Subtitle D—Improvements to Medicaid Services

Sec. 1531. Coverage for freestanding birth centers.

Sec. 1532. Concurrent care for children.

Sec. 1533. State eligibility option for family planning services.

Sec. 1534. Clarification of definition of medically assisteligible.

Subtitle E—New Options for States to Provide Long-Term Services and Supports

Sec. 1541. Community First Choice Option.

Sec. 1542. Removal of barriers to providing home and community-based services.

Sec. 1543. Money Follows the Person Rebalancing Demonstration.

Sec. 1544. Protection for recipients of home and community-based services against spousal impoverishment.

Sec. 1545. Funding to expand State Aging and Disability Resource Centers.

Sec. 1546. Sense of the Senate regarding long-term care.

Subtitle F—Medicaid Prescription Drug Coverage

Sec. 1551. Prescription drug rebates.

Sec. 1552. Elimination of exclusion of coverage of certain drugs.

Sec. 1553. Providing adequate pharmacy reimbursement.

Subtitle G—Medicaid Disproportionate Share Hospital (DSH) Payments

Sec. 1561. Proportionate share hospital payments.

Sec. 1562. Medicaid for Patients and Providers

Sec. 1563. Adult health quality measures.

Sec. 1564. Payment Adjustment for Health Care-Acquired Conditions.

Sec. 1565. State option to provide health homes for enrollees with chronic conditions.

Sec. 1566. Demonstration project to evaluate integrated care around a hospital.

Sec. 1567. Medicaid Global Payment System Demonstration Project.

Sec. 1568. Pediatric Accountable Care Organization Demonstration Project.

Sec. 1569. Medicaid emergency psychiatric demonstration project.

Subtitle J—Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC)

Sec. 1571. MACPAC assessment of policies affecting all Medicaid beneficiaries.

Subtitle K—Protection for American Indians and Alaska Natives

Sec. 1581. Special rules relating to Indians.

Sec. 1582. Elimination of sunset for reimbursement for all Medicare part B services furnished by certain Indian hospitals and clinics.

Subtitle L—Maternal and Child Health Services

Sec. 1591. Maternal, infant, and early childhood home visiting programs.

Sec. 1592. Support, education, and research for postpartum depression.

Sec. 1593. Personal responsibility education.

Sec. 1594. Restoration of funding for asthma education.

Sec. 1595. Inclusion of information about the importance of having a health care power of attorney in transition planning for children aging out of foster care and independent living programs.

TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE

Subtitle A—Transforming the Health Care Delivery System

PART I—LINKING PAYMENT TO QUALITY OUTCOMES UNDER THE MEDICARE PROGRAM

Sec. 1601. Hospital Value-Based purchasing program.

Sec. 1602. Improvements to the physician quality reporting system.

Sec. 1603. Improvements to the physician feedback program.

Sec. 1604. Quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs.

Sec. 1605. Quality reporting for PPS-exempt cancer hospitals.

Sec. 1606. Plans for a Value-Based purchasing program for skilled nursing facilities and home health agencies.

Sec. 1607. Value-based payment modifier under the physician fee schedule.

Sec. 1608. Payment adjustment for conditions acquired in hospitals.

PART II—NATIONAL STRATEGY TO IMPROVE HEALTH CARE QUALITY

Sec. 1611. National strategy.

Sec. 1612. Interagency Working Group on Health Care Quality.
Sec. 3013. Quality measure development.
Sec. 3014. Quality measurement.
Sec. 3015. Data collection; public reporting.

PART III—ENCOURAGING DEVELOPMENT OF NEW Payment Models
Sec. 3021. Establishment of Center for Medicare and Medicaid Innovation within CMS.
Sec. 3022. Medicare shared savings program.
Sec. 3023. Nonshared savings program on payment bundling.
Sec. 3024. Independence at home demonstration program.
Sec. 3025. Hospital readmissions reduction program.
Sec. 3026. Community-Based Care Transition Program.
Sec. 3027. Extension of gainsharing demonstration.

Subtitle B—Improving Medicare for Patients care services.

PART I—ENSURING BENEFICIARY ACCESS TO PHYSICIAN care and OTHER Services
Sec. 3101. Increase in the physician payment update.
Sec. 3102. Extension of the work geographic index floor and revisions to the practice expense geographic adjustment under the Medicare program.
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SEC. 2715. DEVELOPMENT AND UTILIZATION OF UNIFORM EXPLANATION OF COVERAGE DOCUMENTS AND STANDARDIZED DEFINITIONS.

(a) In General.—Not later than 12 months after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall develop standards for use by a health plan and a health insurance issuer offering group or individual health insurance coverage, in providing to enrollees a summary of benefits and coverage explanation that accurately describes the benefits and coverage under the applicable plan or coverage. In developing such standards, the Secretary shall consult with the National Association of Insurance Commissioners (referred to in this section as the ‘NAIC’), a working group composed of representatives of health insurance and related consumer advocacy organizations, health insurance issuers, health care professionals, patient advocates including those representing individuals with limited English proficiency, and other qualified individuals.

(b) REQUIREMENTS.—The standards for the uniform explanation of coverage described under subsection (a) shall provide for the following:

(1) APPEARANCE.—The standards shall ensure that the summary of benefits and coverage is presented in a uniform format that does not exceed 4 pages in length and does not include more than 12 points text.

(2) LANGUAGE.—The standards shall ensure that the summary is presented in a culturally and linguistically appropriate manner and utilizes terminology understandable by the average plan enrollee.

(3) CONTENTS.—The standards shall ensure that the summary of benefits and coverage includes:

(A) uniform definitions of standard insurance terms and medical terms (consistent with subsection (g)) so that consumers may compare health insurance coverage and understand the terms of coverage (or exception to such coverage);

(B) a description of the coverage, including cost-sharing for:

(i) each of the categories of the essential health benefits described in subparagraphs (A) through (J) of section 1302(b)(1) of the Patient Protection and Affordable Care Act; and

(ii) other benefits, as identified by the Secretary;

(C) the exceptions, reductions, and limitations on coverage;

(D) the cost-sharing provisions, including deductible, coinsurance, and co-payment obligations;

(E) the renewable and continuation of coverage provisions;

(F) a coverage facts label that includes examples to illustrate common benefits scenarios, including pregnancy and serious or chronic medical conditions and related cost sharing.

(ii) the outline is a summary of the policy or certificate and that the coverage document itself should be consulted to determine the governing contractual provisions;

(i) a contact number for the consumer to call with additional questions and an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

(c) PERIODIC REVIEW AND UPDATING.—The Secretary shall periodically review and update, as appropriate, the standards developed under this section.

(d) REQUIREMENT TO PROVIDE.—

(1) IN GENERAL.—Not later than 24 months after the date of enactment of the Patient Protection and Affordable Care Act, each medical entity defined in paragraph (3) shall provide, prior to any enrollment restriction, a summary of benefits and coverage explanation pursuant to the standards developed by the Secretary under subsection (a) to—

(A) an applicant at the time of application;

(B) an enrollee prior to the time of enrollment or reenrollment, as applicable; and

(C) a policyholder or certificate holder at the time of issuance of the policy or delivery of the certificate.

(2) COMPLIANCE.—An entity described in paragraph (3) is deemed to be in compliance with this section if the summary of benefits and coverage explanation (a) is provided in paper or electronic form.

(3) ENTITIES IN GENERAL.—An entity described in this paragraph is—

(A) a health insurance issuer (including a group health plan that is not a self-insured plan) offering health insurance coverage within the United States; or

(B) in the case of a self-insured group health plan, the plan sponsor or designated administrator of the plan (as such terms are defined in section 3(16) of the Employee Retirement Income Security Act of 1974).

(4) NOTICE OF MODIFICATIONS.—If a group health plan or health insurance issuer makes any material modification in any of the terms of the benefits and coverage described in subparagraphs (A) through (J) of section 1302(b)(1) of the Patient Protection and Affordable Care Act of 2010 that is not reflected in the most recently provided summary of benefits and coverage, the plan or issuer shall provide notice of such modification to enrollees not later than 60 days prior to the date on which such modification will become effective.

(5) PREEMPTION.—The standards developed under subsection (a) shall preempt any requirement or regulation, except as required to be based on recognized clinical practice guidelines.

(b) REQUIREMENT TO PROVIDE.—An entity described in subsection (d)(3) that willfully fails to provide the information required under this section shall be subject to a fine of not more than $1,000 for each such failure. Such failure with respect to each enrollee shall constitute a separate offense for purposes of this subsection.

(g) DEVELOPMENT OF STANDARD DEFINITIONS.—

(1) IN GENERAL.—The Secretary shall, by regulation, provide for the development of standards for the definitions of terms used in health insurance coverage, including the insurance terms described in paragraph (2) and the medical terms described in paragraph (3).

(2) INSURANCE-RELATED TERMS.—The insurance-related terms described in this paragraph are premium, deductible, co-insurance, co-payment, out-of-pocket limit, preferred provider, non-preferred provider, out-of-network provider, network, primary benefit, secondary benefit, and customary and reasonable fees.

(3) MEDICAL TERMS.—The medical terms described in this paragraph are hospitalization, home care, skilled nursing care, rehabilitation services, hospice services, emergency medical transportation, and such other terms as the Secretary determines are important to define so that consumers may compare the medical benefits offered by health insurance and understand the extent to which such benefits differ in scope from those medical benefits (or exceptions to those benefits).

SEC. 2716. PROHIBITION OF DISCRIMINATION BASED ON SALARY.

(a) IN GENERAL.—No plan sponsor of a group health plan (other than a self-insured plan) shall make any modification to the plan that would be the equivalent of establishing contribution requirements for enrollment in the plan or coverage that provide for the payment by employees with lower hourly or annual compensation of a lower dollar or percentage contribution than the payment required of similarly situated employees with a higher hourly or annual compensation.

(b) LIMITATION.—Subsection (a) shall not be construed to prevent a plan from establishing contribution requirements for enrollment in the plan or coverage that provide for the payment by employees with lower hourly or annual compensation of a lower dollar or percentage contribution than the payment required of similarly situated employees with a higher hourly or annual compensation.

SEC. 2717. ENSURING THE QUALITY OF CARE.

(a) QUALITY REPORTING.—

(1) IN GENERAL.—Not later than 2 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with experts in health care quality and stakeholders, shall develop reporting requirements by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and health care provider reimbursement structures that—

(A) improve health outcomes through the implementation of activities that include quality reporting, patient safety, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical home model as defined in section 3602 of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage;

(B) implement activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post-discharge reimbursement by an appropriate health care professional;

(C) implement activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage;

(D) implement wellness and health promotion activities.

(2) REPORTING REQUIREMENTS.—

(A) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall annually submit to the Secretary, and to enrollees under the plan or coverage, a report on whether the benefits under the plan or coverage satisfy the elements described in subparagraphs (A) through (D) of paragraph (1).

(B) TIMING OF REPORTS.—A report under subparagraph (A) shall be made available to...
an enrollee under the plan or coverage during each open enrollment period.

"(C) AVAILABILITY OF REPORTS.—The Secretary shall make reports submitted under subparagraph (B) available to the public through an Internet website.

"(D) PENALTIES.—In developing the reporting requirements under paragraph (1), the Secretary shall make regulations and impose appropriate penalties for non-compliance with such requirements.

"(E) EXCEPTIONS.—In developing the reporting requirements under paragraph (1), the Secretary may provide for exceptions to such requirements for group health plans and health insurance issuers that substantially and consistently provide care and services that improve health risks and health outcomes through an Internet website.

The Secretary shall make reports received or regulatory fees.

SEC. 1002. HEALTH INSURANCE CONSUMER INFORMATION.

(a) CLEAR ACCOUNTING FOR COSTS.—A health insurance issuer offering group or individual health insurance coverage shall, with respect to each plan year, submit to the Secretary a report concerning the percentage of total premium revenue that such coverage expends—

"(1) on reimbursement for clinical services provided to enrollees under such coverage;

"(2) for activities that improve health care quality; and

"(3) for all other non-claims costs, including an explanation of the nature of such costs, and excluding State taxes and licensing or regulatory fees.

The Secretary shall make reports received under this subsection available to the public on the Internet website of the Department of Health and Human Services.

"(b) ENSURING THAT CONSUMERS RECEIVE VALUE FOR PREMIUM PAYMENTS.—

"(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—A health insurance issuer offering group or individual health insurance coverage shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, in an amount that is equal to the amount by which premium revenue expended by the issuer on activities described in subsection (a)(3) exceeds—

"(2) for activities that improve health care quality; and

"(3) for all other non-claims costs, including an explanation of the nature of such costs, and excluding State taxes and licensing or regulatory fees.

The Secretary shall make reports received under this subsection available to the public on the Internet website of the Department of Health and Human Services.

"(b) ENSURING THAT CONSUMERS RECEIVE VALUE FOR PREMIUM PAYMENTS.—

"(1) REQUIREMENT TO PROVIDE VALUE FOR PREMIUM PAYMENTS.—A health insurance issuer offering group or individual health insurance coverage shall, with respect to each plan year, provide an annual rebate to each enrollee under such coverage, on a pro rata basis, in an amount that is equal to the amount by which premium revenue expended by the issuer on activities described in subsection (a)(3) exceeds—

"(2) for activities that improve health care quality; and

"(3) for all other non-claims costs, including an explanation of the nature of such costs, and excluding State taxes and licensing or regulatory fees.

The Secretary shall make reports received under this subsection available to the public on the Internet website of the Department of Health and Human Services.

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"(2) for activities that improve health care quality; and

"(3) for all other non-claims costs, including an explanation of the nature of such costs, and excluding State taxes and licensing or regulatory fees.

The Secretary shall make reports received under this subsection available to the public on the Internet website of the Department of Health and Human Services.
shall become effective for fiscal years beginning with fiscal year 2010.

(b) SPECIAL RULE.—The amendments made by sections 1002 and 1003 shall take effect on the date of enactment of this Act and notwithstanding the date on which such program is established and ending on January 1, 2014.

(c) MAINTENANCE OF EFFORT.—To be eligible for a contract under paragraph (1), an entity shall—

(1) IN GENERAL.—The Secretary may carry out the program under this section directly or through contracts to eligible entities.

(2) ELIGIBLE ENTITIES.—To be eligible for a contract under paragraph (1), an entity shall—

(A) be a State or nonprofit private entity;

(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require; and

(C) agree to utilize contract funding to establish and administer a qualified high risk pool for eligible individuals.

(2) MONITORING BY SECRETARY OF PREMIUM INCREASES.—

(A) IN GENERAL.—Beginning with plan years beginning in 2014, the Secretary, in conjunction with the States and consistent with the provisions of subsection (a)(2), shall monitor premium increases of health insurance coverage offered through an Exchange and outside of an Exchange.

(B) COMPETITIVE IN OPENING EXCHANGE.—In determining under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act whether to offer qualified health insurance coverage under a large group contract through an Exchange, the State shall take into account any excess of premium growth outside of the Exchange as compared to the rate of such growth inside the Exchange.

(C) GRANTS IN SUPPORT OF PROCESS.—

(i) PREMIUM REVIEW GRANTS DURING 2009 THROUGH 2013.—The Secretary shall carry out a program to award grants to States during the 5-year period beginning with fiscal year 2010 to assist such States in carrying out subsection (a), including—

(A) the identification of Part 2014 high risk pools that are appropriate under State law, approving premium increases for health insurance coverage; and

(B) in providing information and recommendations to the Secretary under subsection (b)(1).

(ii) ECHOS OF PREMIUM INCREASES.—Beginning with plan years beginning in 2014, States shall report to the Secretary through the Secretary through the Exchange on an annual basis the rate of premium increases for health insurance coverage in each State.

(C) IMMEDIATE ACCESS TO INSURANCE COVERAGE.—In determining under section 1902(a)(10) whether to offer qualified health insurance coverage to eligible individuals during the period beginning on the date on which such program is established and ending on January 1, 2014, the Secretary shall—

(1) IN GENERAL.—The Secretary shall establish a temporary high risk insurance pool program to provide health insurance coverage for eligible individuals during the period beginning on the date on which such program is established and ending on January 1, 2014.

(2) MAINTENANCE OF EFFORT.—To be eligible to enter into a contract with the Secretary under this subsection, a State shall agree not to reduce the annual amount the State expended for the operation of one or more State high risk pools during the year preceding the year in which such contract is entered into.

(3) QUALIFIED HIGH RISK POOL.—

(i) IN GENERAL.—Out of all funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary $250,000,000 to be available for expenditure for grants under paragraph (1) and subparagraph (B).

(ii) FUNDING.—(A) OUT-OF-POCKET LIMIT.—In determining the amount of the total allowed costs of benefits provided under such coverage that is not less than 65 percent of such costs, and

(B) POOLING.—In determining the amount of the total allowed costs of benefits provided under such coverage under this section that are in excess of the administrative costs of the high risk pool, the Secretary, out of any moneys in the Treasury, shall appropriate to pay claims against (and the administrative costs of) the high risk pool

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as prohibiting States from applying or enacting such or other laws or regulations, or the Secretary from issuing regulations, under which the State in its entirety (including all its regions) shall be eligible for a grant to establish a high risk pool.

(4) ELIGIBLE INDIVIDUAL.—An individual shall be eligible for a qualified high risk pool if—

(A) the individual is an individual—

(i) who is not a citizen or national of the United States or is lawfully present in the United States or is a lawfully admitted permanent resident; and

(ii) who is an individual who from the date of enactment of this Act, except that the amendments made by sections 1002 and 1003 were not covered by creditable coverage (as defined in section 2701(c)(1) of the Public Health Service Act as in effect on the date of enactment of this Act) during the 6 months after the date of enactment of this Act, with respect to which such individual is applying for coverage through the high risk pool; and

(5) SANCTIONS.—An issuer or employment-based health plan shall be responsible for re-billing the program under this section 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 enroll in coverage through the Exchange.

(6) CONSTRUCTION.—Nothing in this subsection shall be construed as prohibiting States from enrolling in the Exchange through the program.

(7) NON-DISCRIMINATION.—Nothing in this subsection shall be construed as prohibiting States from enrolling in the Exchange through the program.

(8) CONSTRUCTION.—Nothing in this subsection shall be construed as prohibiting States from enrolling in the Exchange through the program.

(9) CONSTRUCTION.—Nothing in this subsection shall be construed as prohibiting States from enrolling in the Exchange through the program.

(10) CONSTRUCTION.—Nothing in this subsection shall be construed as prohibiting States from enrolling in the Exchange through the program.

(11) CONSTRUCTION.—Nothing in this subsection shall be construed as prohibiting States from enrolling in the Exchange through the program.

(12) CONSTRUCTION.—Nothing in this subsection shall be construed as prohibiting States from enrolling in the Exchange through the program.

(13) CONSTRUCTION.—Nothing in this subsection shall be construed as prohibiting States from enrolling in the Exchange through the program.

(14) CONSTRUCTION.—Nothing in this subsection shall be construed as prohibiting States from enrolling in the Exchange through the program.

(15) CONSTRUCTION.—Nothing in this subsection shall be construed as prohibiting States from enrolling in the Exchange through the program.

(16) CONSTRUCTION.—Nothing in this subsection shall be construed as prohibiting States from enrolling in the Exchange through the program.

(17) CONSTRUCTION.—Nothing in this subsection shall be construed as prohibiting States from enrolling in the Exchange through the program.

(18) CONSTRUCTION.—Nothing in this subsection shall be construed as prohibiting States from enrolling in the Exchange through the program.

(19) ONH—

(A) IN GENERAL.—Beginning with plan years beginning in 2014, the Secretary, in conjunction with the States and consistent with the provisions of subsection (a)(2), shall monitor premium increases of health insurance coverage outside of the Exchange as compared to the rate of such growth inside the Exchange.

(B) COMPETITIVE IN OPENING EXCHANGE.—In determining under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act whether to offer qualified health insurance coverage under a large group contract through an Exchange, the State shall take into account any excess of premium growth outside of the Exchange as compared to the rate of such growth inside the Exchange.

(C) GRANTS IN SUPPORT OF PROCESS.—

(i) PREMIUM REVIEW GRANTS DURING 2009 THROUGH 2013.—The Secretary shall carry out a program to award grants to States during the 5-year period beginning with fiscal year 2010 to assist such States in carrying out subsection (a), including—

(A) the identification of Part 2014 high risk pools that are appropriate under State law, approving premium increases for health insurance coverage; and

(B) in providing information and recommendations to the Secretary under subsection (b)(1).

(ii) ECHOS OF PREMIUM INCREASES.—Beginning with plan years beginning in 2014, States shall report to the Secretary through the Exchange on an annual basis the rate of premium increases for health insurance coverage in each State.

(C) IMMEDIATE ACCESS TO INSURANCE COVERAGE.—In determining under section 1902(a)(10) whether to offer qualified health insurance coverage to eligible individuals during the period beginning on the date on which such program is established and ending on January 1, 2014, the Secretary shall—

(1) IN GENERAL.—The Secretary shall establish a temporary high risk insurance pool program to provide health insurance coverage for eligible individuals during the period beginning on the date on which such program is established and ending on January 1, 2014.

(2) MAINTENANCE OF EFFORT.—To be eligible to enter into a contract with the Secretary under this subsection, a State shall agree not to reduce the annual amount the State expended for the operation of one or more State high risk pools during the year preceding the year in which such contract is entered into.

(3) QUALIFIED HIGH RISK POOL.—

(i) IN GENERAL.—Out of all funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary $250,000,000 to be available for expenditure for grants under paragraph (1) and subparagraph (B).

(ii) FUNDING.—(A) OUT-OF-POCKET LIMIT.—In determining the amount of the total allowed costs of benefits provided under such coverage that is not less than 65 percent of such costs, and

(B) POOLING.—In determining the amount of the total allowed costs of benefits provided under such coverage under this section that are in excess of the administrative costs of the high risk pool, the Secretary, out of any moneys in the Treasury, shall appropriate to pay claims against (and the administrative costs of) the high risk pool

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as prohibiting States from applying or enforcing such paragraph or other provisions under law with respect to health insurance issuers.

(4) OVERSIGHT.—The Secretary shall establish—

(1) an appeals process to enable individuals to appeal a determination under this section; and

(2) procedures to protect against waste, fraud, and abuse.

(5) FUNDING; TERMINATION OF AUTHORITY.—

(1) IN GENERAL.—There is appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, $5,000,000,000 to pay claims against (and the administrative costs of) the high risk pool under this section that are in excess of the amount of premiums collected from eligible individuals enrolled in the high risk pool. Such funds shall be available without fiscal year limitation.

(2) INSUFFICIENT FUNDS.—If the Secretary estimates for any fiscal year that the aggregate amounts available for the payment of the expenses of the high risk pool will be less than the actual amount of such expenses, the Secretary shall make such adjustments as are necessary to eliminate such deficit.

(3) TERMINATION OF AUTHORITY.—
in accordance with this section.

SEC. 1102. REINSURANCE FOR EARLY RETIRES.

(a) ADMINISTRATION.—

(1) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary shall establish a temporary reinsurance program to provide reinsurance to participating employment-based plans for a portion of the cost of providing health insurance coverage to early retirees (and to the eligible spouses, surviving spouses, and dependents of such retirees) during the period beginning on the date on which such program is established and ending on January 1, 2014.

(b) PARTICIPATION.—

(1) EMPLOYMENT-BASED PLAN.—The term “employment-based plan” means a group self-funded, or delivered through the purse of the costs attributable to such claim that exceed $15,000, subject to the limits contained in paragraph (3).

(2) LIMIT.—To be eligible for reimbursement under the program, a claim submitted by a participating employment-based plan shall not be less than $15,000 nor greater than $90,000. Such amounts shall be adjusted each fiscal year based on the percentage increase in the Medical Care Component of the Consumer Price Index for Urban Consumers (rounded to the nearest multiple of $1,000) for the year involved.

(3) USE OF FUNDS.—Amounts paid to a participating employment-based plan under this subsection shall be used to lower costs for the plan. Such payments may be used to reduce premium costs for an entity described in subsection (a)(2)(B)(i) or to reduce premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs paid by participants. Such payments shall not be used as general revenues for an entity described in subsection (a)(2)(B)(i). The Secretary shall develop a standardized format (as reported under section 2718(a) of the Public Health Service Act) through which a resident of any State may provide ways for residents of any State to reduce the extent that such high risk pool is offered in such State; and

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

(b) ENHANCING COMPETITIVE PURCHASING OPTIONS.—

(1) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Secretary shall develop a standardized format for use for the information relating to the coverage options described in subsection (a)(2). Such format shall include a minimum amount of information on the percentage of total premium revenue expended on nonclinical costs (as reported under section 2718(a) of the Public Health Service Act) availability, premium rates, and cost sharing with respect to such coverage options and be consistent with the standards adopted for the uniform explanation of coverage as provided for in section 2715 of the Public Health Service Act.

(2) USE OF FORMAT.—The Secretary shall use the format developed under paragraph (1) in compiling information concerning coverage options on the Internet website established under subsection (a).

(b) APPENDIX TO CONTRACT.—The Secretary may carry out this section through contracts entered into with qualified entities.

SECT. 1104. ADMINISTRATIVE SIMPLIFICATION.

(a) PURPOSE OF ADMINISTRATIVE SIMPLIFICATION.—Section 261 of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d note) is amended by—

(1) by inserting “uniform” before “standards”;

(2) by inserting “and to reduce the clerical burden on health plans” before the period at the end.
(b) OPERATING RULES FOR HEALTH INFORMATION TRANSACTIOMS.—

(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 for the electronic exchange of health information that are necessary for the exchange of information that are not defined by a standard or its implementation specifications as adopted for purposes of this part."

(2) TRANSACTION STANDARDS; OPERATING RULES AND COMPLIANCE.—Section 1175 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 paragraph:

"(g) OPERATING RULES.—The Secretary shall—

(A) advise the Secretary as to whether a nonprofit entity meets the requirements under paragraph (2);

(b) review the operating rules developed and recommended by such nonprofit entity;

(c) determine such operating rules represent a consensus view of the health care stakeholders and are consistent with and do not conflict with other existing standards;

(d) evaluate whether such operating rules are consistent with electronic standards adopted for health information technology; and

(E) submit to the Secretary a recommendation as to whether the Secretary should adopt such operating rules."

(4) IMPLEMENTATION.—

"(A) IN GENERAL.—The standards and associated operating rules adopted by the Secretary shall—

(i) be associated with the extent feasible and appropriate, enable determination of an individual’s eligibility and financial responsibility for specific services prior to or at the point of care;

(ii) be comprehensive, requiring minimum augmentation by paper or other communications;

(iii) provide for timely acknowledgment, response, and status reporting that supports a transparent claims and denial management process (including adjudication and appeals); and

(iv) describe all data elements (including reason and remark codes) in unambiguous terms, require that such data elements be required, upon standards adopted in other fields, and prohibit additional conditions (except where necessary to implement State or Federal law, or to protect against fraud and abuse);

(B) REDUCTION OF CLERICAL BURDEN.—In adopting standards and operating rules for the transactions referred to under paragraph (1), the Secretary shall seek to reduce the number and complexity of forms (including paper and electronic forms) and data entry required by patients and providers; and

(C) PLAN AT THE END THE FOLLOWING NEW SUBSECTION:

"(5) OPERATING RULES.—The Secretary shall adopt a single set of operating rules for each transaction referred to under subsection (a)(1) with the goal of creating as much uniformity as possible in the implementation of the electronic standards as possible. Such operating rules shall be consensus-based and reflect the necessary business rules affecting health plans and health care providers and the manner in which they operate pursuant to standards issued under Health Insurance Portability and Accountability Act of 1996.

(2) SERVICE CENTER OPERATING RULES.—In adopting operating rules under this subsection, the Secretary shall consider recommendations for operating rules developed by a qualified nonprofit entity that meets the following requirements:

(A) The entity focuses its mission on administrative simplification.

(B) The entity demonstrates a 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 standards development organizations.

(C) The entity has a public set of guiding principles that ensure the operating rules and process are open and transparent, and supports nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory practices.

(D) The entity builds on the transaction standards under Health Insurance Portability and Accountability Act of 1996.

(E) The entity allows for public review and updates of the operating rules.

(F) The operating rules represent a consensus view of the health care stakeholders and are consistent with and do not conflict with other existing standards.

(G) The operating rules are consistent with electronic standards adopted for health information technology; and

(H) Submit to the Secretary a recommendation as to whether the Secretary should adopt such operating rules.

(3) HEALTH PLAN CERTIFICATION.—

"(1) ELIGIBILITY FOR A HEALTH PLAN.—

(A) ELIGIBILITY FOR A HEALTH PLAN, HEALTH CLAIM STATUS, ELECTRONIC FUNDS TRANSFERS, HEALTH CARE PAYMENT AND REMITTANCE ADVICE.—Not later than December 31, 2014, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with all applicable certification standards (as described under paragraph (7) of section 1171) and associated operating rules (as described under paragraph (9) of such section) for electronic funds transfers, eligibility for a health plan, health claim status, and health care payment and remittance advice, respectively.

(B) HEALTH CLAIMS OR EQUIVALENT ENCOUNTER INFORMATION, ENROLLMENT AND DISENROLLMENT IN A HEALTH PLAN, HEALTH PLAN PREMIUM PAYMENTS, HEALTH CLAIM ATTACHMENTS, REFERRAL CERTIFICATION AND AUTHORIZATION.—Not later than December 31, 2015, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with all applicable certification standards and associated operating rules for electronic encounters, enrollment and disenrollment in a health plan, health claim status, and health care payment and remittance advice, respectively.

(C) ELIGIBILITY FOR A HEALTH PLAN, HEALTH CLAIM STATUS, ELECTRONIC FUNDS TRANSFERS, HEALTH CARE PAYMENT AND REMITTANCE ADVICE.—Not later than December 31, 2015, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with all applicable certification standards and associated operating rules for electronic encounters, enrollment and disenrollment in a health plan, health claim status, and health care payment and remittance advice, respectively.

(D) HEALTH CLAIMS OR EQUIVALENT ENCOUNTER INFORMATION, ENROLLMENT AND DISENROLLMENT IN A HEALTH PLAN, HEALTH PLAN PREMIUM PAYMENTS, HEALTH CLAIM ATTACHMENTS, REFERRAL CERTIFICATION AND AUTHORIZATION.—Not later than December 31, 2015, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with all applicable certification standards and associated operating rules for electronic encounters, enrollment and disenrollment in a health plan, health claim status, and health care payment and remittance advice, respectively.

(E) COMPLIANCE WITH REVISED STANDARDS AND OPERATING RULES.—

(A) IN GENERAL.—A health plan (including entities described under paragraph (3)) shall file a statement with the Secretary in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with all applicable certification standards and associated operating rules for electronic encounters, enrollment and disenrollment in a health plan, health claim status, and health care payment and remittance advice, respectively.

(B) COMPLIANCE WITH REVISED STANDARDS AND OPERATING RULES.—

(A) ELIGIBILITY FOR A HEALTH PLAN, HEALTH CLAIM STATUS, ELECTRONIC FUNDS TRANSFERS, HEALTH CARE PAYMENT AND REMITTANCE ADVICE.—Not later than December 31, 2014, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with all applicable certification standards and associated operating rules for electronic encounters, enrollment and disenrollment in a health plan, health claim status, and health care payment and remittance advice, respectively.

(B) HEALTH CLAIMS OR EQUIVALENT ENCOUNTER INFORMATION, ENROLLMENT AND DISENROLLMENT IN A HEALTH PLAN, HEALTH PLAN PREMIUM PAYMENTS, HEALTH CLAIM ATTACHMENTS, REFERRAL CERTIFICATION AND AUTHORIZATION.—Not later than December 31, 2015, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with all applicable certification standards and associated operating rules for electronic encounters, enrollment and disenrollment in a health plan, health claim status, and health care payment and remittance advice, respectively.

(C) ELIGIBILITY FOR A HEALTH PLAN, HEALTH CLAIM STATUS, ELECTRONIC FUNDS TRANSFERS, HEALTH CARE PAYMENT AND REMITTANCE ADVICE.—Not later than December 31, 2015, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with all applicable certification standards and associated operating rules for electronic encounters, enrollment and disenrollment in a health plan, health claim status, and health care payment and remittance advice, respectively.

(D) HEALTH CLAIMS OR EQUIVALENT ENCOUNTER INFORMATION, ENROLLMENT AND DISENROLLMENT IN A HEALTH PLAN, HEALTH PLAN PREMIUM PAYMENTS, HEALTH CLAIM ATTACHMENTS, REFERRAL CERTIFICATION AND AUTHORIZATION.—Not later than December 31, 2015, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with all applicable certification standards and associated operating rules for electronic encounters, enrollment and disenrollment in a health plan, health claim status, and health care payment and remittance advice, respectively.

(E) COMPLIANCE WITH REVISED STANDARDS AND OPERATING RULES.—

(A) ELIGIBILITY FOR A HEALTH PLAN, HEALTH CLAIM STATUS, ELECTRONIC FUNDS TRANSFERS, HEALTH CARE PAYMENT AND REMITTANCE ADVICE.—Not later than December 31, 2014, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with all applicable certification standards and associated operating rules for electronic encounters, enrollment and disenrollment in a health plan, health claim status, and health care payment and remittance advice, respectively.

(B) HEALTH CLAIMS OR EQUIVALENT ENCOUNTER INFORMATION, ENROLLMENT AND DISENROLLMENT IN A HEALTH PLAN, HEALTH PLAN PREMIUM PAYMENTS, HEALTH CLAIM ATTACHMENTS, REFERRAL CERTIFICATION AND AUTHORIZATION.—Not later than December 31, 2015, a health plan shall file a statement with the Secretary, in such form as the Secretary may require, certifying that the data and information systems for such plan are in compliance with all applicable certification standards and associated operating rules for electronic encounters, enrollment and disenrollment in a health plan, health claim status, and health care payment and remittance advice, respectively.
“(ii) establishes a standard (as described under subsection (a)(1)(B)) or associated operating rules (as described under subsection (i)(5)) for any other financial and administrative transactions.

“(B) DATE OF COMPLIANCE.—A health plan shall comply with such requirements not later than the effective date of the applicable standard or operating rule.

“(6) AUDITS OF HEALTH PLANS.—The Secretary shall conduct periodic audits to ensure that health plans (including entities described in paragraph (3)) are in compliance with any standards and operating rules that are described under paragraph (1) or subsection (a)(1)(B).

“(1) REVIEW AND AMENDMENT OF STANDARDS AND OPERATING 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, and not less than biennially thereafter, the Committee, acting through the review committee, shall conduct hearings to evaluate and review the adopted standards and operating rules established under this section.

“(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 operating rules. The review committee shall ensure that such standards and operating rules establish a 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 adopted standards and operating rules described in paragraph (1) or operating rules established under subsection (a)(1)(B) shall be adopted 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.—

“(1) PUBLIC COMMENT PERIOD.—The Secretary shall accept and consider public comments on any interim final rule published under this paragraph for 60 days after the date of such publication.

“(ii) EXPAND PLANS.—The effective date of any amendment to existing standards or operating rules that is adopted through an interim final rule published under this paragraph shall be the date of filing the closing of such public comment period.

“(4) REVIEW COMMITTEE.—

“(A) DEFINITION.—For the purposes of this subsection, the term ‘review committee’ means a committee chartered by or within the Department of Health and Human Services that is 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 ensure coordination, as appropriate, with the standards that support the certified electronic health record that is certified under subparagraph (G) of this section of the National Coordinator for Health Information Technology.

“(5) OPERATING RULES FOR OTHER STANDARDS AND OPERATING RULES.—The Secretary shall adopt a single set of operating rules (pursuant to the process described under subsection (g)) for any transaction for which a standard has been adopted pursuant to subsection (a)(1)(B).

“(6) PENALTIES.—

“(1) PENALTY FEE.—

“(A) IN GENERAL.—Not later than April 1, 2014, and annually thereafter, the Secretary shall assess a penalty fee (as determined under subsection (B)) against a health plan that has failed to meet the requirements under subsection (h) with respect to certification and documentation of compliance with—

“(i) the standards and associated operating rules described under paragraph (1) of such subsection; and

“(ii) a standard (as described under subsection (a)(1)(B)) and associated operating rules (as described under subsection (i)(5)) for any other financial and administrative transactions.

“(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 established under subsection (h).

“(C) ADDITIONAL PENALTY FOR MISREPRESENTATION.—A health plan that knowingly provides inaccurate or incomplete information in a transaction or for documentation of compliance under subsection (h) shall be subject to a penalty fee that is double the amount that would otherwise be imposed under the subsection.

“(D) ANNUAL PER INCREASE.—The amount of the penalty fee imposed under this 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—

“(i) an amount equal to $20 per covered life under such plan; or

“(ii) an amount equal to $40 per covered life under the plan if such plan has knowingly provided inaccurate or incomplete information (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 the most recent statements and filings that have been submitted by such health plan to the Securities and Exchange Commission.

“(G) NOTICE AND DISPUTE PROCEDURE.—The Secretary shall establish procedures for assessment of penalty fees under this section that provides a health plan with reasonable notice and a dispute resolution procedure. The Secretary shall also provide for a notice of assessment by the Secretary of the Treasury (as described under paragraph (4)(B)).

“(3) PENALTY PER REPORT.—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 assessed a penalty fee under this subsection.

“(4) COLLECTION OF PENALTY FEE.—

“(A) IN GENERAL.—The Secretary of the Treasury, acting through the Financial Management Service, will be passed on to a health plan on a pro-rata basis and added to any penalty fee collected from the plan.

“(B) ADMINISTRATIVE FEES.—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 from the plan.

“(C) PROMULGATION OF RULES.—The Secretary shall promulgate a final rule to establish a unique health plan identifier (as described in section 1173(b) of the Social Security Act (42 U.S.C. 1320d-2(a)(2)(B))) that is consistent with the input of the National Committee on 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.

“(D) ELECTRONIC FUNDS TRANSFER.—The Secretary shall promulgate a final rule to establish a standard for electronic funds transfers (as described in section 1173(a)(2)(J) of the Social Security Act, as added by subsection (b)(2)(A)). 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.

“(E) HEALTH CLAIMS ATTACHMENTS.—The Secretary shall promulgate a final rule to establish a set of standard claims attachments (as described in section 6621 of the Internal Revenue Code) and a single set of associated operating rules for health claims attachments (as described in section 1173(a)(2)(B)) of the Social Security Act (42 U.S.C. 1320d-2(a)(2)(B)) that is consistent with section 1173(a)(2)(B) of the X12 Version 5010 transaction standards. The Secretary may do so on an interim final basis and shall adopt a transaction standard and a single set of associated operating rules not later than January 1, 2014, in a manner ensuring that such standard is effective not later than January 1, 2016.

“(D) EXPANSION OF ELECTRONIC TRANSACTIONS IN MEDICARE.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)(1)) is amended—

“(1) in paragraph (23), by striking the ‘or’ at the end;

“(2) in paragraph (24), by striking the period and inserting ‘; or’; and

“(3) by inserting after paragraph (24) the following new paragraph:

“(25) not later than January 1, 2014, for which the payment is other than by electronic transfer (notwithstanding any limitations under any other provision of law), and electronic remittance in a form as specified in ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard.”.

SEC. 1105. EFFECTIVE DATE.

This subtitle shall take effect on the date of enactment of this Act.
SEC. 2701. FAIR HEALTH INSURANCE PREMIUMS.

(a) Prohibiting discriminatory premium rates.—

(1) In general.—Except as provided in this section, a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage.

(2)(A) In general.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage, except with respect to:

(i) a group health plan or health insurance issuer offering coverage in the large group market; and

(ii) a group health plan or health insurance issuer offering coverage in the small group market or the individual market.

(B)age-based exclusions.—A group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusion with respect to such plan or coverage, except with respect to:

(i) a group health plan or health insurance issuer offering coverage in the large group market; and

(ii) a group health plan or health insurance issuer offering coverage in the small group market or the individual market, if the health insurance issuer offers health insurance coverage in the individual or group market in the State to offer such coverage through the State Exchange (as provided for under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act), the provisions of this subsection shall apply to all such coverage offered in such market in the State.

SEC. 2702. GUARANTEED AVAILABILITY OF COVERAGE.

(a) Guaranteed issuance of coverage in the individual and group market.—Subsection (a) of section 2701 (as added by paragraph (4)) shall apply to each family member covered under the plan or coverage.

(b)(1) Health status.--A health insurance issuer described in subsection (a) may not impose any preexisting condition exclusion with respect to such plan or coverage, except with respect to:

(i) a group health plan or health insurance issuer offering coverage in the large group market; and

(ii) a group health plan or health insurance issuer offering coverage in the small group market or the individual market.

(2) Tobacco use.--With respect to family coverage under a group health plan or health insurance coverage offered in such market in the State to offer such coverage through the State Exchange (as provided for under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act), the provisions of this subsection shall apply to all such coverage offered in such market in the State.

(3) Evidence of insurability including disability.—(A) In general.—A health insurance issuer described in subsection (a) may not impose any preexisting condition exclusion with respect to such plan or coverage, except with respect to:

(i) a group health plan or health insurance issuer offering coverage in the large group market; and

(ii) a group health plan or health insurance issuer offering coverage in the small group market or the individual market.

(B) Any other health status-related factor determined appropriate by the Secretary.

(c) Programs of health promotion or disease prevention.—

(1) In general.—For purposes of subsection (b)(2), a program of health promotion or disease prevention (referred to in this section as a wellness program) shall be a program offered by an employer that is designed to promote health or prevent disease that meets the applicable requirements of this section if:

(i) No conditions based on health status factor.—If none of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program as described in paragraph (3) are complied with by the participant, such wellness program shall not violate this section if the requirements of paragraph (2) are complied with.

(ii) Conditions based on health status factor.—If any of the conditions for obtaining a premium discount or rebate or other reward for participation in a wellness program as described in paragraph (3) are complied with by the participant, such wellness program shall not violate this section if the requirements of paragraph (2) are complied with.

(2) Wellness programs that do not subject requirements.—If—

(A) A program that reimburses all or part of the cost for memberships in a fitness center or gym;

(B) A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.

(3) Wellness programs that reward individuals for costs of health care related to a health condition through the waiver of the copayment or deductible requirement under group health plan for the individual or a family member covered under the plan.

(4) Program that reimburses individuals for costs of smoking cessation programs without regard to whether the individual quits smoking.

(5) Program that provides a reward to individuals for attending a periodic health education seminar.

(6) Program subject to requirements.—If—

(A) A program that reimburses individuals for the costs of smoking cessation programs with respect to the plan that requires satisfaction of a standard related to a health status factor, such wellness program shall not violate this section if the requirements of paragraph (3) are complied with.

(B) The reward for the wellness program, together with the reward for other wellness programs with respect to the plan that requires satisfaction of a standard related to a health status factor, shall not exceed 30 percent of the cost of enrollment under the plan. In addition to employees or individuals, any class of dependents (such as the Secretary shall review the rating areas established by each State under subparagraph (A) to ensure the adequacy of such areas for purposes of carrying out the requirements of this title. If the Secretary determines a State’s rating areas are not adequate to meet such criteria, the Secretary may establish rating areas for that State. (3) Permissible age bands.—The Secretary, in consultation with the National Association of Insurance Commissioners, shall define the permissible age bands for rating purposes under paragraph (1)(A)(ii).

(4) Applications based on age or tobacco use.—With respect to family coverage under a group health plan or health insurance coverage offered in such market in the State to offer such coverage through the State Exchange (as provided for under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act), the provisions of this subsection shall apply to all such coverage offered in such market in the State.

(5) Special rule for large group market.—If a plan permits health insurance coverage under the plan to be included as a part of group health insurance under the plan, the plan shall be treated as a group health plan and the provisions of this section shall apply to such plan as it relates to the group as if such plan were an individual health insurance coverage plan.

(6) Genetic information.—The prohibition against use of genetic information may not be applied with respect to family coverage under a group health plan or health insurance coverage offered in such market in the State to offer such coverage through the State Exchange (as provided for under section 1312(f)(2)(B) of the Patient Protection and Affordable Care Act).
as spouses or spouses and dependent children may participate fully in the wellness program, such reward shall not exceed 30 percent of the cost of the coverage in which an employee or individual and any dependents are enrolled. For purposes of this paragraph, the cost of coverage shall be determined based on the total amount of employee contributions and any premium that would otherwise not be provided under the plan. The Secretary of Labor, Health and Human Services, and the Treasury may increase the reward available under this subparagraph to up to 50 percent of the cost of coverage if the Secretarys determine that such an increase is appropriate.

(b) The wellness program shall be reasonably designed to promote health or prevent disease. A program complies with the preceding sentence if the program has a reasonable chance of preventing disease in, participating individuals and it is not overly burdensome, is not a subterfuge for discriminating based on a health status factor, and is not highly suspect in the method chosen to promote health or prevent disease.

(C) The plan shall give individuals eligible for the program the opportunity to qualify for the reward under the program at least once each year.

(D) The full reward under the wellness program shall be available to all similarly situated individuals. For such purpose, among other things:

(i) The reward is not available to all similarly situated individuals for a period unless the wellness program allows—

(I) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard; and

(ii) for a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard.

(ii) If reasonable under the circumstances, the plan or issuer may seek verification, such as a statement from an individual's physician, that a health status factor makes it unreasonably difficult or medically inadvisable to attempt to satisfy the otherwise applicable standard.

(E) The plan or issuer involved shall disclose in all plan materials describing the terms of the wellness program the availability of a reasonable alternative standard (or waiver of the otherwise applicable standard) required under subparagraph (D). If plan materials disclose that such a program is available, without describing it, or disclosure under this subparagraph shall not be required.

(k) Existing Programs.—Nothing in this section shall prohibit a program of health promotion or disease prevention that was established prior to the date of enactment of this section and applied with all applicable regulations, and that is operating on such date, from continuing to be carried out for as long as such regulations remain in effect.

(l) Wellness Program Demonstration Project.—

(1) In general.—Not later than July 1, 2014, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall establish a 10-State demonstration project. States shall adopt the provisions of subsection (j) to programs of health promotion offered by a health insurance issuer that offers health insurance coverage in the individual market in such State.

(2) Expansion of Demonstration Project.—If the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, determines that the demonstration project described in paragraph (1) is effective, such Secretaries may, beginning on July 1, 2017, expand such demonstration project to include additional participating States.

(3) Requirements.—

(A) Maintenance of coverage.—The Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall not approve the participation of a State in the demonstration project under this section unless the Secretaries determine that the State’s project is designed in a manner that—

(i) will not result in any decrease in coverage; and

(ii) will not increase the cost to the Federal Government in providing credits under section 36B of the Internal Revenue Code of 1986 or cost-sharing assistance under section 1402 of the Patient Protection and Affordable Care Act.

(B) Other requirements.—States that participate in the demonstration project under this subsection—

(i) may permit premium discounts or rebates or the modification of otherwise applicable copayments or deductibles for adhering to, or participating in, a reasonably designed program of health promotion and disease prevention;

(ii) shall ensure that requirements of consumer protection are met in programs of health promotion in the individual market;

(iii) shall require verification from health insurance issuers that offer health insurance coverage in the individual market of such State that premium discounts—

(I) do not create undue burdens for individuals insured in the individual market;

(II) do not result in any decrease in coverage;

(III) are not a subterfuge for discrimination;

(iv) shall ensure that consumer data is protected in accordance with the requirements of section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note); and

(v) shall ensure and demonstrate to the satisfaction of the Secretary that the discounts or other rewards provided under the plan do not exceed the expected level of participation in the wellness program involved and the anticipated effect the program will have on utilization or medical claim costs.

(2) Reports.—

(A) In general.—Not later than 3 years after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall submit a report to the appropriate committees of Congress concerning—

(i) the effectiveness of wellness programs (as defined in subsection (j)) in promoting health and preventing disease;

(ii) the impact of such wellness programs on the availability of and affordability of coverage for participants and non-participants of such programs;

(iii) the impact of premium-based and cost-sharing incentives on participant behavior and the role of such programs in changing behavior; and

(iv) the effectiveness of different types of rewards.

(B) Data collection.—In preparing the report described in paragraph (1), the Secretaries shall gather appropriate information from employers who provide employees with access to wellness programs, including State and Federal agencies.

(3) Termination.—Nothing in this section shall be construed as prohibiting the Secretaries of Labor, Health and Human Services, or the Treasury from promulgating regulations implementing this section and applied with all applicable regulations, and that is operating on such date, from continuing to be carried out for as long as such regulations remain in effect.

(4) SEC. 2706. NON-DISCRIMINATION IN HEALTH CARE.

(a) Providers.—A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality performance.

(b) Individuals.—The provisions of section 1558 of the Patient Protection and Affordable Care Act (relating to non-discrimination) shall apply to a group health plan or health insurance issuer offering group or individual health insurance coverage.

(5) SEC. 2707. COMPREHENSIVE HEALTH INSURANCE COVERAGE.

(a) Coverage for Essential Health Benefits.—A health insurance issuer that offers health insurance coverage in the individual or small group market shall ensure that such coverage includes the essential health benefits package required under section 1332(a) of the Patient Protection and Affordable Care Act.

(b) Cost-Sharing Under Group Health Plans.—A group health plan shall ensure that any annual cost-sharing imposed under this Act (or any amendment made by this Act) does not result in any surcharge, or the value of a cost-sharing mechanism (such as a deductible, a waiver of all or part of a cost-sharing mechanism (such as deductibles, copayments, or coinsurance), the alteration of, or the elimination of, a benefit that would otherwise not be provided under the plan. The Secretary of Labor, Health and Human Services, and the Treasury may increase the reward available under this subparagraph to up to 50 percent of the cost of coverage if the Secretaries determine that such an increase is appropriate.

(2) Expansion of Demonstration Project.—If the Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, determines that the demonstration project described in paragraph (1) is effective, such Secretaries may, beginning on July 1, 2017, expand such demonstration project to include additional participating States.

(D) Requirements.—

(A) Maintenance of coverage.—The Secretary, in consultation with the Secretary of the Treasury and the Secretary of Labor, shall not approve the participation of a State in the demonstration project under this section unless the Secretaries determine that the State’s project is designed in a manner that—

(i) will not result in any decrease in coverage; and

(ii) will not increase the cost to the Federal Government in providing credits under section 36B of the Internal Revenue Code of 1986 or cost-sharing assistance under section 1402 of the Patient Protection and Affordable Care Act.

(B) Other requirements.—States that participate in the demonstration project under this subsection—

(i) may permit premium discounts or rebates or the modification of otherwise applicable copayments or deductibles for adhering to, or participating in, a reasonably designed program of health promotion and disease prevention;

(ii) shall ensure that requirements of consumer protection are met in programs of health promotion in the individual market;

(iii) shall verify in accordance with the applicable regulations, and that is operating on such date, from continuing to be carried out for as long as such regulations remain in effect.
(2) CONTINUATION OF COVERAGE.—With respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act, this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply to such plan or coverage, regardless of whether the individual renews such coverage after such date of enactment.

(b) ALLOWANCE FOR FAMILY MEMBERS TO JOIN CURRENT COVERAGE.—With respect to a group health plan or health insurance coverage in which an individual was enrolled on the date of enactment of this Act which is renewed after such date, family members of such individual shall be permitted to enroll in such coverage if such enrollment is permitted under the terms of the plan in effect as of such date of enactment.

(c) ALLOWANCE FOR NEW EMPLOYEES TO JOIN CURRENT PLAN.—A group health plan that provides coverage on the date of enactment of this Act may provide for the enrollment of new employees (and their families) in such plan, and this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply with respect to such plan and such new employees (and their families).

(d) EFFECT ON COLLECTIVE BARGAINING AGREEMENTS.—In the case of health insurance coverage maintained pursuant to or more collective bargaining agreements between employee representatives and one or more employers that was ratified before the date of enactment of this Act, the provisions of this subtitle and subtitle A (and the amendments made by such subtitles) shall not apply until the date on which the last of the collective bargaining agreements relating to the coverage terminates. Any coverage amendment made pursuant to a collective bargaining agreement relating to the coverage may include the coverage necessary to conform to any requirement added by this subtitle or subtitle A (or amendments) shall not be treated as a termination of such collective bargaining agreement.

(e) DEFINITION.—In this title, the term “grandfathered health plan” means any group health plan or health insurance coverage to which this section applies.

SEC. 1253. RATING REFORMS MUST APPLY UNFORMLY TO ALL HEALTH INSURANCE ISSUERS AND GROUP HEALTH PLANS.

Any standard or requirement adopted by a State pursuant to this title, or any amendment thereto, shall be uniformly applied to all health plans in each insurance market to which the standard and requirements apply. The preceding sentence shall also apply to a State standard or requirement relating to the standard or requirement required by this title (or any such amendment) that is not the same as the standard or requirement that is not pre-empted under section 1321(d).

SEC. 1253. EFFECTIVE DATES.

This subtitle (and the amendments made by the provisions of this subtitle) shall become effective for plan years beginning on or after January 1, 2014.

Subtitle D—Available Coverage Choices for All Americans

PART I—ESTABLISHMENT OF QUALIFIED HEALTH PLANS

SEC. 1301. QUALIFIED HEALTH PLAN DEFINED.

(a) QUALIFIED HEALTH PLAN.—In this title:

(1) IN GENERAL.—The term “qualified health plan” means a health plan that—

(A) is issued or recognized by each Exchange through which such plan is offered;

(B) provides the essential health benefits package described in section 1302(a); and

(C) is offered by a health insurance issuer that—

(i) is licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage under this title; and

(ii) agrees to charge the same premium rate for each qualified health plan of the issuer with regard to whether the plan is offered directly by the issuer or through an agent; and

(D) meets the essential health benefits requirements described in section 1311(d) and such other requirements as an applicable Exchange may establish.

(2) INCLUSION OF CO-OP PLANS AND COMMUNITY HEALTH INSURANCE OPTION.—Any reference in this title to a qualified health plan shall be deemed to include a qualified health plan offered through the CO-OP program under subtitle B (and the Community Health Insurance Option Program under section 1323), unless specifically provided for otherwise.

(b) TERMS RELATING TO HEALTH PLANS.—In this title:

(1) HEALTH PLAN.—

(A) IN GENERAL.—The term “health plan” means health insurance coverage and a group health plan.

(B) EXCEPTION FOR SELF-INSURED PLANS AND MEASURES.—Except to the extent specifically provided by this title, the term “health plan” shall not include a group health plan or multiple employer welfare arrangement to the extent the plan or arrangement is not subject to insurance regulation under section 514 of the Employee Retirement Income Security Act of 1974.

(C) HEALTH INSURANCE COVERAGE AND ISSUERS.—The terms “health insurance coverage” and “health insurance issuer” have the meanings given such terms by section 1302(b) of the Public Health Service Act.

(2) GROUP HEALTH PLAN.—The term “group health plan” has the meaning given such term by section 1301(a) of the Public Health Service Act.

SEC. 1302. ESSENTIAL HEALTH BENEFITS REQUIREMENTS.

(a) ESSENTIAL HEALTH BENEFITS PACKAGE.—In this title, the term “essential health benefits” with respect to any health plan, coverage that—

(1) provides for the essential health benefits defined by the Secretary under subsection (b);

(2) limits cost-sharing for such coverage in accordance with subsection (c); and

(3) subject to paragraphs (1) and (2), provides either the bronze, silver, gold, or platinum level of coverage described in subsection (d).

(b) ESSENTIAL HEALTH BENEFITS.—

(1) IN GENERAL.—The Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered under the categories:

(A) Ambulatory patient services.

(B) Emergency services.

(C) Inpatient hospital services.

(D) Maternity and newborn care.

(E) Mental health and substance use disorder services, including behavioral health treatment.

(F) Prescription drugs.

(G) Rehabilitation and habilitative services and devices.

(H) Laboratory services.

(I) Preventive and wellness services and chronic disease management.

(J) Pediatric services, including oral and vision care.

(2) LIMITATION.—

(A) IN GENERAL.—The Secretary shall ensure that the scope of the essential health benefits under paragraph (1) is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary after consulting the Secretary of Labor. The Secretary of Labor shall conduct a survey of employer-sponsored coverage to determine the benefits typically covered by employers, and shall submit a report on such survey to the Secretary.

(B) CERTIFICATION.—In defining the essential health benefits (paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such essential health benefits meet the limitation described in paragraph (2).

(3) NOTICE AND HEARING.—In defining the essential health benefits described in paragraph (1), and in revising the benefits under paragraph (4)(H), the Secretary shall provide notice and an opportunity for public comment.

(4) REQUIRED ELEMENTS FOR CONSIDERATION.—In defining the essential health benefits under paragraph (1), the Secretary shall ensure that such essential health benefits reflect an appropriate balance among the categories described in such subsection, so that benefits are not unduly weighted toward any category;

(B) not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life;

(C) take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups;

(D) ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals’ age or expected length of life or of the individuals’ present or predicted disability, degree of medical dependency, or quality of life;

(E) provide that a qualified health plan shall not be treated as not meeting the essential health benefits described in paragraph (1) unless the plan provides that—

(i) coverage for emergency department services will be provided without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that are more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan; and

(ii) if such services are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network.

(F) provide that if a plan described in section 1311(b)(2)(B)(i)(II) (relating to stand-alone dental benefits plans) is offered through an Exchange, and another plan offered through such Exchange shall not fail to be treated as a qualified health plan solely because the plan does not offer coverage of benefits described in such section that are otherwise required under paragraph (1)(A); and
(G) periodically review the essential health benefits under paragraph (1), and provide a report to Congress and the public that contains—
(i) an assessment of whether enrollees are facing any difficulty accessing needed services for reasons of coverage or cost;
(ii) an assessment of whether the essential health benefits need to be modified or updated to account for changes in medical evidence or scientific advancement;
(iii) information on how the essential health benefits will be modified or updated to address any such gaps in access or changes in the evidence base;
(iv) an assessment of the potential of additional or expanded benefits and the interaction between the addition or expansion of benefits and reductions in existing benefits to meet actuarial limitations described in paragraph (2); and
(v) the periodically update the essential health benefits under paragraph (1) to address any gaps in access to coverage or changes in the evidence base the Secretary identifies in the review conducted under subparagraph (G).

(5) RULE OF CONSTRUCTION.—Nothing in this title shall be construed to prohibit a health plan from providing benefits in excess of the essential health benefits described in this subsection.

(c) REQUIREMENTS RELATING TO COST-SHARING.

(1) ANNUAL LIMITATION ON COST-SHARING.—
(A) IN GENERAL.—The dollar amount under subparagraph (A)(i) shall be increased to an amount equal to twice the amount in effect under subparagraph (A)(ii) for plan years beginning in the calendar year, determined after application of clause (i).
(B) IN GENERAL.—The term "cost-sharing" includes—
(i) deductibles, coinsurance, copayments, or similar charges;
(ii) any other expenditure required of an insured individual which is a qualified medical expense (within the meaning of section 223(d)(2) of the Internal Revenue Code of 1986) for non-network providers, or spending for non-covered services.

(2) PREMIUM ADJUSTMENT PERCENTAGE.—For purposes of paragraphs (1)(B)(i) and (2)(B)(i), the premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013 (as determined by the Secretary).

(3) LEVELS OF COVERAGE.—
(A) BRONZE LEVEL.—A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.
(B) SILVER LEVEL.—A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan.
(C) GOLD LEVEL.—A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan.
(D) PLATINUM LEVEL.—A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan.

(4) LIMITATION ON COST-SHARING.—
(A) IN GENERAL.—Under regulations issued by the Secretary, the level of coverage of a plan shall be determined on the basis that the essential health benefits described in subsection (b) are provided at the standard population (and without regard to the population the plan may actually provide benefits to).
(B) EMPLOYER CONTRIBUTIONS.—The Secretary may issue regulations under which employer contributions to a health savings account (within the meaning of section 223 of the Internal Revenue Code of 1986) may be taken into account in determining the level of coverage for a plan of the employer.

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SEC. 1302. COVERAGE OF ABORTION SERVICES.

(a) Special Rules Relating to Coverage of Abortion Services.

(1) Voluntary Choice of Coverage of Abortion Services.

(A) In General.—Notwithstanding any other provision of this title (or any amendment made by this title), and subject to subparagaph (C)(D) (i) nothing in this title (or any amendment made by this title), shall be construed to require a qualified health plan to provide coverage of services described in subparagraph (B) of section 1302 of this title.
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(B)(i) or (B)(ii) as part of its essential health benefits for any plan year; and

(ii) the issuer of a qualified health plan shall determine whether or not the plan provides coverage of services described in subparagraph (B)(i) or (B)(ii) as part of such benefits for the plan year.

(B) ABORTION SERVICES.—

(A) ABORTIONS FOR WHICH PUBLIC FUNDING IS PROHIBITED.—The services described in this clause 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.

(ii) ABORTIONS FOR WHICH PUBLIC FUNDING IS ALLOWED.—The services described in this clause 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.

(C) PROHIBITION ON FEDERAL FUNDS FOR ABDUCTION SERVICES IN COMMUNITY HEALTH INSURANCE OPTION.—

(i) DETERMINATION BY SECRETARY.—The Secretary may not determine, in accordance with subparagraph (A)(ii), that the community health insurance option established under clause (i) of paragraph (B) shall provide coverage of services described in subparagraph (B)(i) as part of benefits for the plan year unless the Secretary—

(I) assures compliance with the requirements of paragraph (2);

(ii) assures, in accordance with applicable provisions of generally accepted accounting requirements, circulars on funds management of the Office of Management and Budget, and guidance on accounting of the Governmental Accounting Standards Board that Federal funds are used for such coverage; and

(iii) notwithstanding section 1323(e)(1)(C) or any other provision of this title, takes all necessary steps to assure that the United States does not bear the insurance risk for a community health insurance option’s coverage of services described in subparagraph (B)(i).

(ii) STATE REQUIREMENT.—If a State requires, in addition to the essential health benefits required under section 1321(b)(3) (A), coverage of services described in subparagraph (B)(i) for enrollees of a community health insurance option offered in such State beginning on the first day of the plan year, an employer who employs an average of at least 1 employee on business days during a calendar year and who employs at least 1 employee on the first day of the plan year shall provide such coverage.

(D) CONSIDERATIONS.—In making such estimate, the Secretary—

(i) may take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care;

(ii) shall estimate such costs as if such coverage were included for the entire population covered; and

(iii) may take into account costs at less than $1 per enrollee, per month count, or actuarial amount, as applicable, for coverage provided under section 1 131 of the Patient Protection and Affordable Care Act.

(E) ACTUARIAL VALUE OF OPTIONAL SERVICE COVERAGE.—

(i) IN GENERAL.—The Secretary shall estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under a qualified health plan of the services described in paragraph (1)(B)(i).

(ii) CONSIDERATIONS.—In making such estimate, the Secretary—

(I) may take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care;

(ii) shall estimate such costs as if such coverage were included for the entire population covered; and

(iii) may take into account such a cost at less than $1 per enrollee, per month.

(F) PROVIDE CONSCIENCE PROTECTIONS.—No individual, entity, or facility shall be treated as subject to the rule in paragraph (3) if such entity, entity, or facility may be discriminated against because of a willingness or unwillingness, if doing so is contrary to the religious or moral beliefs of the provider or facility, to provide, pay for, provide coverage of, or refer for abortions.

(G) APPLICATION OF STATE AND FEDERAL LAWS REGARDING ABORTION.—

(i) NO PREEMPTION OF STATE LAWS REGARDING ABORTION.—Nothing in this Act shall be construed to preempt or otherwise have any effect on Federal or State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor.

(ii) NO EFFECT ON FEDERAL LAWS REGARDING ABORTION.—

(A) IN GENERAL.—Nothing in this Act shall be construed to have any effect on Federal laws regarding—

(I) conscience protection;

(ii) willingness or refusal to provide abortion; and

(iii) discrimination on the basis of the willingness or refusal to provide, pay for, cover, or refer for abortion or to provide or participate in training to provide abortion.

(B) NO EFFECT ON FEDERAL CIVIL RIGHTS LAW.—Nothing in this subsection shall alter the rights and obligations of employees and employers under title VII of the Civil Rights Act of 1964.

(C) APPLICATION OF EMERGENCY SERVICES LAW.—Nothing in this Act shall be construed to relieve any health care provider from providing emergency services as required under the Emergency Medical Treatment and Labor Act, including section 1867 of the Social Security Act (popularly known as “EMTALA”).

SEC. 1304. RELATED DEFINITIONS.

(A) DEFINITIONS RELATING TO MARKETS.—In this title:

(1) GROUP MARKET.—The term “group market” means the health insurance market maintained by an employer, including any small employer market maintained by an employer.

(2) INDIVIDUAL MARKET.—The term “individual market” means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(3) LARGE AND SMALL MARKETS.—The terms “large group market” and “small group market” mean the health insurance market 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 a large employer (as defined in subsection (b)(1)) or by a small employer (as defined in subsection (b)(2)), respectively.

(B) EMPLOYERS.—In this title:

(1) LARGE EMPLOYER.—The term “large employer” means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(2) SMALL EMPLOYER.—The term “small employer” means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(3) STATE OPTION TO TREAT 50 EMPLOYEES AS SMALL.—In the case of plan years beginning before January 1, 2016, a State may elect to apply paragraph (2) to an employer who employs an average of at least 50 employees on business days during the plan year for purposes of determining whether such employer is a small employer for purposes of this subsection—

(A) APPLICATION OF AGGRESSION RULE FOR EMPLOYERS.—All persons treated as a single employer, including affiliated employers, (M), or (or (or section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

(C) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

(D) CONTINUATION OF PARTICIPATION FOR GROWING SMALL EMPLOYERS.—If a qualified employer that is a small employer makes enrollment in qualified health insurance coverage available to its employees through an Exchange; and
(ii) the employer ceases to be a small employer by reason of an increase in the number of employees of such employer;

the employer shall continue to be treated as a small employer for purposes of this sub/title beginning with the increase and ending with the first day on which the employer does not make such enrollment available to its employees.

(c) In this title, the term “Secretary” means the Secretary of Health and Human Services.

(d) In this title, the term “State” means each of the 50 States and the District of Columbia.

PART II—CONSUMER CHOICES AND IN-SUBSCRIPTION THROUGH HEALTH BENEFIT EXCHANGES

SEC. 1311. AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS.

(a) ASSISTANCE TO STATES TO ESTABLISH AMERICAN HEALTH BENEFIT EXCHANGES.—

(1) PLANNING AND ESTABLISHMENT GRANTS.—

There shall be appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, an amount necessary to enable the Secretary to make awards, not later than 1 year after the date of enactment of this Act, to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

(2) AMOUNT.—For each fiscal year, the Secretary shall determine the total amount of funds to be made available to each State for grants under this subsection.

(3) USE OF FUNDS.—A State shall use any amount awarded under this subsection for activities (including planning activities) related to establishing an American Health Benefit Exchange, as described in subsection (b).

(b) AMERICAN HEALTH BENEFIT EXCHANGE.—

(1) IN GENERAL.—Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange (referred to in this title as an “Exchange”) for the State that—

(A) facilitates the purchase of qualified health plans;

(B) assists employers in fulfilling requirements under paragraph (1)(A) by creating individual Internet portals designed to assist qualified employers in determining whether they are eligible to participate in an Exchange or eligible for the premium tax credit or cost-sharing reduction; and

(C) meets the requirements of subsection (d).

(2) MERGER OF INDIVIDUAL AND SHOP EXCHANGES.—A State may elect to provide only one Exchange for providing both Exchange and SHOP Exchange services to both qualified individuals and qualified small employers, but only if the Exchange has adequate resources to assist such individuals and employers.

(c) RESPONSIBILITIES OF THE SECRETARY.—

(1) IN GENERAL.—The Secretary shall, by regulations, establish criteria for the certification of health plans as qualified health plans. Such criteria shall require that, to be certified, a plan shall, at a minimum—

(A) meet the essential coverage requirements, and not employ marketing practices or benefit design features that have the effect of discouraging the enrollment in such plan by individuals with significant health needs;

(B) ensure a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 1302(b) of the Public Health Service Act), and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;

(C) include within health insurance plan networks those essential community providers, where available, that serve predominately low-income, medically-underserved individuals, such as health care providers defined in section 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act, as applicable.

(D) (i) b accused with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (or a group market in the State; and

(ii) receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans;

(E) implement a quality improvement strategy described in subsection (g)(1); and

(F) utilize a uniform enrollment form that qualified issuers of qualified health plans may use (either electronically or on paper) in enrolling in qualified health plans offered through such Exchange, and that takes into account the applicable standards of the Accreditation Association of Insurance Commissioners develops and submits to the Secretary; and

(G) utilize the standard format established for presenting health benefits plan options; and

(H) provide information to enrollees and prospective enrollees, and to each Exchange in which it is offered, on any quality measures for health plan performance endorsed under section 398J of the Public Health Service Act, as applicable.

(2) RULES.—Nothing in paragraph (1)(C) shall be construed to require a qualified health plan to contract with a provider described in such paragraph if such provision requirement is generally applicable payment rates of such plan.

(3) RATING SYSTEM.—The Secretary shall develop a rating system that would rate qualified health plans that are offered through an Exchange in each benefit level on the basis of the relative quality and price. The Exchange shall include the quality rating in the information provided to enrollees through the Internet portal established under paragraph (4).

(4) INTERNET PORTALS.—The Secretary shall—

(A) continue to operate, maintain, and update the Internet portal developed under section 1302(b) and to assist in developing and maintaining their own such portal; and

(B) make available for use by Exchanges a model portal for an Internet portal that may be used to direct qualified individuals and qualified employers to qualified health plans, to assist such individuals and employers in determining whether they are eligible to participate in an Exchange or eligible for a premium tax credit or cost-sharing reduction; and to present standardized information (including quality ratings) regarding qualified health plans offered through an Exchange to assist consumers in making easy health plan comparisons.

Such template shall include, with respect to each qualified health plan offered through the Exchange in each rating area, access to the uniform outline of coverage the plan is required to provide under section 1302(b) of the Public Health Service Act and to a copy of the plan’s written policy.

(5) ENROLLMENT PERIODS.—The Secretary shall require an Exchange to provide for—

(A) an initial open enrollment period, as determined by the Secretary (such determination to be made not later than July 1, 2015),

(B) annual open enrollment periods, as determined by the Secretary for calendar years after the initial enrollment period;

(C) a special enrollment period specified in section 9801 of the Internal Revenue Code of 1986 and other special enrollment periods under circumstances similar to such periods under D of title XVIII of the Social Security Act; and

(D) special monthly enrollment periods for Indians (as defined in section 4 of the Indian Health Care Improvement Act).

(6) REQUIREMENTS.—

(A) IN GENERAL.—An Exchange shall be a governmental agency or nonprofit entity that is established by a State.

(B) OFFERING OF COVERAGE.—

(A) IN GENERAL.—An Exchange shall make available any health plan that is not a qualified health plan.

(B) OFFERING OF STAND-ALONE DENTAL BENEFITS.—Each Exchange within a State shall allow an issuer of a plan that only provides limited scope dental benefits meeting the requirements of section 9821(c)(2)(A) of the Internal Revenue Code of 1986 to offer the plan through the Exchange (either separately or in conjunction with a qualified health plan) if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J).

(C) RULES RELATING TO ADDITIONAL REQUIRED BENEFITS.—

(A) IN GENERAL.—Except as provided in subparagraph (B), an Exchange may make available a qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 1302(b).

(B) STATES MAY REQUIRE ADDITIONAL BENEFITS.—

(i) IN GENERAL.—Subject to the requirements of clause (ii), a State may require that a qualified health plan offered in such State include benefits in addition to the essential health benefits specified under section 1302(b).

(ii) STATE MUST ASSUME COST.—A State shall make payments to or on behalf of an individual eligible for the premium tax credit under section 36B of the Internal Revenue
Code of 1986 and any cost-sharing reduction under section 1402 to defray the cost to the individual of any additional benefits described in clause (i) which are not eligible for such cost-sharing reduction section 36B(b)(3)(D) of such Code and section 1402(c)4.

(4) FUNCTIONS.—An Exchange shall, at a minimum:

(A) implement procedures for the certification, recertification, and decertification, consistent with guidelines developed by the Secretary under subsection (c), of health plans as qualified health plans;

(B) provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

(C) maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

(D) assign a rating to each qualified health plan offered through such Exchange in accordance with the criteria developed by the Secretary under subsection (c)(3);

(E) utilize a standardized format for presenting health benefits plan options in the Exchange, the Exchange determines that such health plan meets the requirements of section 2715 of the Public Health Service Act;

(F) in accordance with section 1413, inform individuals of eligibility requirements for the medicare program under title XIX of the Social Security Act, the CHIP program under title XXI of such Act, or any applicable State public program, if through screening of the application by the Exchange, the Exchange determines that such individuals are eligible for any such program, enroll such individuals in such program;

(G) establish and make available by electronic means the ability to determine the actual cost of coverage after the application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402;

(H) subject to section 411, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual requirement or from the penalty imposed by such section if—

(i) there is no affordable qualified health plan available through the Exchange, or the individual’s employer, covering the individual;

(ii) the individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

(iii) transfer to the Secretary of the Treasury—

(1) a list of the individuals who are issued a certification under subparagraph (H), including the name and taxpayer identification number of each individual;

(2) the name and taxpayer identification number of each individual who was an employee of the Exchange and who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because—

(i) the employer did not provide minimum essential coverage; or

(ii) the employer provided such minimum essential coverage but it was determined under section 36B(c)(1)(C) of such Code to neither be affordable to the employee nor to provide the required minimum actuarial value; and

(iii) the individual was not an employer of the Exchange under section 1411(b)(4) that they have changed employers and of each individual who received a premium tax credit under a qualified health plan during a plan year (and the effective date of such cessation); and

(iv) provide to each employer the name of each employee of the employer described in subparagraph (I)(ii) who ceases coverage under a qualified health plan during a plan year (and the effective date of such cessation); and

(K) establish the Navigator program described in subsection (i).

(5) PROHIBITION AGAINST WASTEFUL USE OF FUNDS.—In carrying out subsection (c), an Exchange shall not utilize any funds intended for the administrative and operational expenses of the Exchange for staff temper, promotional giveaways, excessive executive compensation, or promotion of Federal or State legislative and regulatory modifications.

(6) CONSIDERATION.—An Exchange shall consult with stakeholders relevant to carrying out the activities under this section, including—

(A) health care consumers who are enrollees in qualified health plans;

(B) individuals and entities with experience in facilitating enrollment in qualified health plans;

(C) representatives of small businesses and self-employed individuals;

(D) State Medicaid offices; and

(E) advocates for enrolling hard to reach populations.

(7) PUBLICATION OF COSTS.—An Exchange shall publish on the Exchange website to educate consumers on such costs. Such information shall also include monies lost to waste, fraud, and abuse.

(e) Unfair or Deceptive Acts or Practices.—

(1) IN GENERAL.—An Exchange may certify a health plan as a qualified health plan if—

(A) such health plan meets the requirements for a plan or coverage if the Exchange determines, in accordance with the guidelines provided under section 1411, that it meets the requirements for certification as a qualified health plan under section 1446; and

(B) the Exchange determines that making available such health plan through such Exchange, the Exchange determines that such health plan meets the requirements for a plan or coverage;

(2) PREMISE CONSIDERATIONS.—The Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. Such plans shall prominently post such information on their websites. The Exchange may make such information and the information and the recommendations provided to the Exchange by the State under section 2794(b)(3) of the Public Health Service Act available to the public through the use of the Internet.

(f) FLEXIBILITY.—

(1) REGIONAL OR OTHER INTERSTATE EXCHANGES.—An Exchange may operate in more than one State if—

(A) each State in which such Exchange operates permits such operation; and

(B) the Secretary approves such regional or interstate Exchange.

(2) SUBSIDIARY EXCHANGES.—A State may establish one or more subsidiary Exchanges if—

(A) each such Exchange serves a geographically distinct area; and

(B) the area served by such Exchange is at least as large as a rating area described in section 2701(a) of the Public Health Service Act.

(3) AUTHORITY TO CONTRACT.—

(A) IN GENERAL.—A State may elect to authorize an Exchange established by the State under this section to enter into an agreement with an eligible entity to carry out 1 or more responsibilities of the Exchange.

(B) ELIGIBLE ENTITY.—In this paragraph, the term "eligible entity" means—

(i) a person—

(I) incorporated under, and subject to the laws of, 1 or more States;

(ii) that has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and

(iii) that is not a health insurance issuer or that is treated under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or

(iv) the State medical assistance agency under title XIX of the Social Security Act.

(g) REWARDING QUALITY THROUGH MARKET-BASED INCENTIVES.—

(1) STRATEGY DESCRIBED.—A strategy described in this paragraph is a payment structure that provides increased reimbursement or other incentives for—

(A) improving health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage;

(B) the implementation of initiatives to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional;

(C) the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage; and

(D) the implementation of wellness and health promotion activities.

(2) GUIDELINES.—The Secretary, in consultation with experts in health care quality and stakeholders, shall develop guidelines concerning the matters described in paragraph (1).

(3) REQUIREMENTS.—The guidelines developed under paragraph (2) shall require the periodic reporting to the applicable Exchange of the activities that a qualified health plan has conducted to implement a strategy described in paragraph (1).

(h) QUALITY IMPROVEMENT.—

(1) GENERAL.—Beginning on January 1, 2015, a qualified health plan may contract with—
(A) a hospital with greater than 50 beds only if such hospital—
(i) utilizes a patient safety evaluation system as described in section 1862(o) of the Act;
(ii) conducts public education activities to raise awareness of the availability of qualified health plans;
(iii) distribute fair and impartial information about qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402.
(iv) provide information consistent with the standards described in paragraph (5);
(v) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges.

(2) ELIGIBILITY.—
(i) IN GENERAL.—To be eligible to receive a grant under paragraph (1), an entity shall—
(A) meet the requirements described in paragraph (5); and
(B) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges.

(3) DUTIES.—An entity that serves as a navigator under a grant under this paragraph shall—
(A) conduct public education activities to raise awareness of the availability of qualified health plans;
(B) distribute fair and impartial information about qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402;
(C) facilitate enrollment in qualified health plans;
(D) provide referrals to any applicable office or agency of a qualified health plan or to participate in an Exchange.

(4) QUALIFIED INDIVIDUALS.—A qualified individual enrolled in a qualified health plan may pay any applicable premium owed by such individual to the health insurance issuer issuing such qualified health plan.

(5) EMPLOYER.—
(A) INDIVIDUAL MARKET.—A health insurance issuer shall treat an individual enrolled in a qualified health plan by selecting any level of coverage under section 1302(d) to be made available to individuals through an Exchange.
(B) EMPLOYER MAY CHOOSE PLANS WITHIN A LEVEL.—Each employee of a qualified employer that elects a level of coverage under subparagraph (A) may choose to enroll in a qualified health plan that offers coverage at that level.
(C) PREMIUM RISK POOL.—
(i) REQUIREMENT.—Notwithstanding any other provision of law, after the effective date of this subtitle, the only health plans available to Members of Congress and congressional staff with respect to their service as a Member of Congress or congressional staff shall be health plans that are—
(A) created under this Act (or an amendment made by this Act); or
(B) offered through an Exchange established under this Act (or an amendment made by this Act).

(ii) DEFINITIONS.—In this section:
(A) MEMBER OF CONGRESS.—The term "Member of Congress" means any member of the House of Representatives or the Senate.
(B) CONGRESSIONAL STAFF.—The term "congressional staff" means all full-time and part-time employees employed by the official office of a Member of Congress, whether in Washington, DC or outside of Washington, DC.

(6) NO PENALTY FOR TRANSFERRING TO MINIMUM ESSENTIAL COVERAGE OUTSIDE EXCHANGE.—An Exchange, or a qualified health plan offered through such Exchange, shall not apply any penalty or other fee on an individual who cancels enrollment in a plan because the individual becomes eligible for minimum essential coverage (as defined in section 1301(6)(A) of the Internal Revenue Code of 1986 without regard to paragraph (1)(C) or (D) thereof) or such coverage becomes affordable (within the meaning of section 36B(c)(2)(C) of such Code).

(7) ENROLLMENT THROUGH AGENTS OR BROKERS.—The Secretary shall establish procedures under which a State may allow agents or brokers to—
(i) enroll individuals in any qualified health plans in the individual or small group market as soon as the plan is offered through an Exchange in the State; and
(ii) assist individuals in applying for premium tax credits and cost-sharing reductions for plans sold through an Exchange.

(8) QUALIFIED INDIVIDUALS AND EMPLOYERS; ACCESS LIMITED TO CITIZENS AND LAWFUL RESIDENTS.—
(A) QUALIFIED INDIVIDUALS.—In this title:
(A) the term "qualified individual" means, with respect to an Exchange, an individual who—

(B) qualified individual from enrolling in, or a qualified employer from selecting for its employees, a health plan offered outside of an Exchange.

(2) CONTINUED OPERATION OF STATE BENEFIT REQUIREMENTS.—Nothing in this title shall be construed to term qualified individual to enroll or not to enroll in a qualified health plan or to participate in an Exchange.

(3) VOLUNTARY NATURE OF AN EXCHANGE.—
(A) CHOICE TO ENROLL OR NOT TO ENROLL.—Nothing in this title shall be construed to re-
(i) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and
(ii) resides in the State that established the Exchange (except with respect to territorial agreements under section 1312(c).

(3) INCARCERATED INDIVIDUALS EXCLUDED.—An individual shall not be treated as a qualified individual if, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges.

(2) QUALIFIED EMPLOYER.—In this title:
(A) IN GENERAL.—The term "qualified employer" means a small employer that elects to make all full-time employees of such employer eligible for, or enrolled in, qualified health plans offered through the small group market through an Exchange that offers qualified health plans.

(B) EXTENSION TO LARGE GROUPS.—
(1) IN GENERAL.—Beginning in 2017, each State may allow issuers of health insurance coverage in the large group market in the State to offer qualified health plans in such market through an Exchange. Nothing in this subparagraph shall be construed as requiring the issuer to offer such plans through an Exchange.

(ii) LARGE EMPLOYERS ELIGIBLE.—If a State under clause (i) allows issuers to offer qualified health plans in the large group market through an Exchange that is not also described in paragraph (1), a parliament of qualified employer shall include a large employer that elects to make all full-time employees of such employer eligible for 1 or more qualified health plans offered in the large group market through the Exchange.

(3) ACCESS LIMITED TO LAWFUL RESIDENTS.—If an individual is not, or is not reasonably expected to be present in the United States, the individual is not a qualified health plan is eligible to enroll in a plan through Exchange.

SEC. 1113. FINANCIAL INTEGRITY.

(a) ACCOUNTING FOR EXPENDITURES.—
(1) IN GENERAL.—An Exchange shall keep an accurate accounting of all receipts, and expenditures and shall annually submit to the Secretary a report concerning such accounting.

(2) INVESTIGATIONS.—The Secretary, in coordination with the Inspector General of the Department of Health and Human Services, may investigate the affairs of an Exchange, the Department of Health and Human Services, or the Inspector General of the Department of Health and Human Services, and may not be covered under a qualified health plan in the individual market that is offered through an Exchange.

(b) GAO OVERSIGHT.—Not later than 5 years after the first date on which Exchanges are required to be operational under this title, the Comptroller General shall conduct an ongoing study of Exchange activities and the enrollees in qualified health plans offered through Exchanges. Such study shall review—

SEC. 1321. STATE FLEXIBILITY RELATING TO EXCHANGES.

(a) ESTABLISHMENT OF STANDARDS.—
(1) IN GENERAL.—The Secretary shall, as soon as practicable after the date of enactment of this Act, issue regulations setting forth reporting and risk adjustment requirements under paragraph (2) of such section, the civil penalty assessed under the False Claims Act on any person liable for such Act as described in subparagraph (A) shall be increased by not less than 3 times and not more than 6 times the amount of damages which the Government sustains because of the act of that person.

(b) GAO REPORT.—Not later than 5 years after the first date on which Exchanges are required to be operational under this title, the Comptroller General shall conduct an ongoing study of Exchange activities and the enrollees in qualified health plans offered through Exchanges. Such study shall review—

(1) the operations and administration of Exchanges, including surveys and reports of qualified health plans offered through Exchanges and on the experience of such plans (including plans offered through an Exchange and individuals purchasing health insurance coverage outside of Exchanges), the expenses of Exchanges, claims statistics relating to such plans, and the experience of patients enrolling in such plans, and the manner in which Exchanges meet their goals;

(2) any significant observations regarding the utilization and adoption of Exchanges;

(3) where appropriate, recommendations for improvements in the operations or policies of such plans; and

(4) how many physicians, by area and specialty, are not taking or accepting new patients enrolled in Federal Government health care programs and the adequacy of provider networks of Federal Government health care programs.

PART III—STATE FLEXIBILITY RELATING TO EXCHANGES.

SEC. 1321. STATE FLEXIBILITY RELATING TO EXCHANGES.

(a) ESTABLISHMENT OF STANDARDS.—
(1) IN GENERAL.—The Secretary shall, as soon as practicable after the date of enactment of this Act, issue regulations setting forth the requirements of section 2736(b) of the Public Health Service Act, that seeks to operate an Exchange under this section, the Secretary shall presume that such Exchange meets the standards under this section unless the Secretary determines, after completion of the process established under subparagraph (2), that the Exchange does not comply with such standards.

(2) PROCESS.—The Secretary shall establish a process to work with a State described in paragraph (1) that is not operational by January 1, 2014, and which has insured a percentage of its eligible population that does not prevent the application of the standards of this Act, that seeks to operate an Exchange under this section, the Secretary shall presume that such Exchange meets the standards under this section unless the Secretary determines, after completion of the process established under paragraph (2), that the Exchange does not comply with such standards.

SEC. 1322. FEDERAL PROGRAM TO ASSIST ESTABLISHMENT AND OPERATION OF NON-PROFIT, MEMBER-RUN HEALTH INSURANCE ISSUERS.

(a) ESTABLISHMENT OF PROGRAM.—
(1) IN GENERAL.—The Secretary shall establish a program to carry out the purposes of this section as to be the Consumer Operated and Oriented Plan (CO-OP) program.

(2) PURPOSE.—It is the purpose of the CO-OP program to foster the creation of non-profit, member-owned health insurance issuers to offer qualified health plans in the individual and small group markets in the States in
which the issuers are licensed to offer such plans.

(b) LOANS AND GRANTS UNDER THE CO-OP PROGRAM.—

(1) IN GENERAL.—The Secretary shall provide through the CO-OP program for the awarding of loans and grants to one or more qualified nonprofit health insurance issuers of—

(A) loans to provide assistance to such person in meeting its start-up costs; and

(B) grants to provide assistance to such person in meeting any solvency requirements of States in which the person seeks to be licensed to issue qualified health plans.

(2) REQUIREMENTS FOR AWARDING LOANS AND GRANTS.—

(A) IN GENERAL.—In awarding loans and grants under the CO-OP program, the Secretary shall—

(i) take into account the recommendations of the advisory board established under paragraph (3);

(ii) give priority to applicants that will offer qualified health plans on a Statewide basis, will utilize integrated care models, and have a private supporter;

(iii) ensure that there is sufficient funding to establish at least 1 qualified nonprofit health insurance issuer in each State, except that not more than 2 such issuers will be established if the Secretary from funding the establishment of multiple qualified nonprofit health insurance issuers in any State if the funding is sufficient to do so.

(B) STATES WITHOUT ISSUERS IN PROGRAM.—

If no health insurance issuer applies to be a qualified nonprofit health insurance issuer within the State, the Secretary may use amounts appropriated under this section for the awarding of grants to encourage the establishment of a qualified nonprofit health insurance issuer within the State or the expansion of a qualified nonprofit health insurance issuer from another State to the State.

(C) AGREEMENT.—

(i) IN GENERAL.—The Secretary shall require any person receiving a loan or grant under the CO-OP program to enter into an agreement with the Secretary which requires such person to meet (and to continue to meet) each of the following:

(A) any requirement under this section for such person to be treated as a qualified nonprofit health insurance issuer; and

(B) any requirements contained in the agreement for such person to receive such loan or grant.

(ii) RESTRICTIONS ON USE OF FEDERAL FUNDS.—The agreement shall include a requirement that no portion of the funds made available by any loan or grant under this section may be used—

(I) for carrying on propaganda, or otherwise attempting, to influence legislation; or

(II) for marketing.

Nothing in this clause shall be construed to allow the Secretary to take any action prohibited by section 501(c)(29) of the Internal Revenue Code of 1986.

(iii) FAILURE TO MEET REQUIREMENTS.—If the Secretary determines that a person has failed to meet any requirement described in clause (i) or (ii) and has failed to correct such failure within a reasonable period of time after the person has been notified (reasonably should have known) of such failure, such person shall repay to the Secretary an amount equal to the sum of—

(I) the aggregate amount of loans and grants received under this section; plus

(II) interest on the aggregate amount of loans and grants received under this section, for the period the loans or grants were outstanding.

The Secretary shall notify the Secretary of the Treasury of any determination under this section of a failure that results in the termination of an issuer’s tax-exempt status under section 501(c) of the Internal Revenue Code of 1986.

(D) TIME FOR AWARDING LOANS AND GRANTS.—The Secretary shall not later than July 1, 2013, award the loans and grants under this subsection to begin the distribution of amounts awarded under such loans and grants.

(3) ADVISORY BOARD.—

(A) IN GENERAL.—The advisory board under this paragraph shall consist of 15 members appointed by the Comptroller General of the United States and 10 individuals with qualifications described in section 1805(c)(2) of the Social Security Act.

(B) RULES RELATING TO APPOINTMENTS.—

(i) STANDARDS FOR APPOINTMENTS.—Any individual appointed under subparagraph (A) shall meet the following standards:

(I) I N GENERAL.—The individual shall be an individual with experience in the health care field or an individual with a background in public administration.

(ii) FOR THE PURPOSE OF SUBPARAGRAPH (I) —

(I) 110 percent of the aggregate amount of—

(A) loans to provide assistance to such person in meeting its start-up costs; and

(B) grants to provide assistance to such person in meeting any solvency requirements of States in which the person seeks to be licensed to issue qualified health plans.

shall be treated as a qualified nonprofit health insurance issuer unless the organization meets all the requirements under subsection (d) of section 205 of the Federal Trade Commission Act (15 U.S.C. 41). Such term also includes an organization established by the Comptroller General of the United States from among individuals with qualifications described in section 1805(c)(2) of the Social Security Act.

(D) PAY AND REIMBURSEMENT.—

(i) NO COMPENSATION FOR MEMBERS OF ADVISORY BOARD.— Except as provided in clause (ii), a member of the advisory board shall not receive pay, allowances, or benefits by reason of their service on the board.

(ii) EXPENSES.—Each member shall receive travel expenses, including per diem in lieu of subsistence under subchapter I of chapter 57 of title 5, United States Code.

(E) APPLICATION OF FEDERAL ADVISORY COMMITTEE ACT (5 U.S.C. APP.)—

The provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the advisory board, except that section 14 of such Act shall not apply.

(F) TERMINATION.—The advisory board shall terminate on the earlier of the date that it completes its duties under this section or December 31, 2015.

(G) QUALIFIED NONPROFIT HEALTH INSURANCE ISSUER.—For purposes of this section—

(1) IN GENERAL.—The term “qualified nonprofit health insurance issuer” means a health insurance issuer that is an organization—

(A) that is organized under State law as a nonprofit, member corporation; (B) that is organized under State law as a nonprofit health insurance issuer that is an organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization meets all the requirements under subsection (d) of section 205 of the Federal Trade Commission Act (15 U.S.C. 41). Such term also includes an organization established by the Comptroller General of the United States from among individuals with qualifications described in section 1805(c)(2) of the Social Security Act.

(C) QUALIFIED NONPROFIT HEALTH INSURANCE ISSUER.—For purposes of this section—

(1) IN GENERAL.—The term “qualified nonprofit health insurance issuer” means a health insurance issuer that is an organization—

(A) that is organized under State law as a nonprofit, member corporation; (B) that is organized under State law as a nonprofit health insurance issuer that is an organization shall not be treated as a qualified nonprofit health insurance issuer unless the organization meets all the requirements under subsection (d) of section 205 of the Federal Trade Commission Act (15 U.S.C. 41). Such term also includes an organization established by the Comptroller General of the United States from among individuals with qualifications described in section 1805(c)(2) of the Social Security Act.

(C) qualified nonprofit health insurance issuer unless—

(i) the organization is sponsored by a State or local government, any political subdivision thereof, or an instrumentality of such government or political subdivision.

(ii) the organization is a private entity and begins the distribution of amounts awarded under such loans and grants.

(2) COUNCIL MAY NOT SET PAYMENT RATES.—

The private purchasing council established under paragraph (1) shall not set payment rates for health care facilities or providers participating in health insurance coverage provided by qualified nonprofit health insurance issuers.

(3) CONTINUED APPLICATION OF ANTITRUST LAWS.—

(A) IN GENERAL.—Nothing in this section shall be construed to limit the application of the antitrust laws to any private purchasing council (whether or not established under this subsection) or to any qualified nonprofit health insurance issuer participating in such a council.

(B) ANTITRUST LAWS.—For purposes of this subparagraph, the term “antitrust laws” has the meaning given the term in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)). Such term also includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section 5 applies to unfair methods of competition.

(LIMITATION ON PAY AND REIMBURSEMENT.—

If the Secretary determines that a person has failed to meet any requirement described in clause (i) or (ii) and has failed to correct such failure within a reasonable period of time after the person has been notified (reasonably should have known) of such failure, such person shall repay to the Secretary an amount equal to the sum of—

(I) the aggregate amount of loans and grants received under this section; plus

(II) interest on the aggregate amount of loans and grants received under this section, for the period the loans or grants were outstanding.

The Secretary shall notify the Secretary of the Treasury of any determination under this section of a failure that results in the termination of an issuer’s tax-exempt status under section 501(c) of the Internal Revenue Code of 1986.

(D) LIMITATION ON PAY AND REIMBURSEMENT.—

If the Secretary determines that a person has failed to meet any requirement described in clause (i) or (ii) and has failed to correct such failure within a reasonable period of time after the person has been notified (reasonably should have known) of such failure, such person shall repay to the Secretary an amount equal to the sum of—

(I) the aggregate amount of loans and grants received under this section; plus

(II) interest on the aggregate amount of loans and grants received under this section, for the period the loans or grants were outstanding.

The Secretary shall notify the Secretary of the Treasury of any determination under this section of a failure that results in the termination of an issuer’s tax-exempt status under section 501(c) of the Internal Revenue Code of 1986.
(B) establish or maintain a price structure for reimbursement of any health benefits covered by such issuer.

(2) COMPETITION.—Nothing in this section shall be construed as authorizing the Secretary to interfere with the competitive nature of providing health benefits through qualified nonprofit health insurance issuers.

(3) REIMBURSEMENT.—There are hereby appropriated, out of any funds in the Treasury not otherwise appropriated, $6,000,000,000 to carry out this section.

(c) TAX EXEMPTION FOR QUALIFIED NONPROFIT HEALTH INSURER.—

(1) IN GENERAL.—Section 501(c) of the Internal Revenue Code (defining applicable tax-exempt organizations) is amended by adding at the end the following:

''(29) CO-OP HEALTH INSURANCE ISSUERS.—''(A) IN GENERAL.—A qualified nonprofit health insurance issuer (within the meaning of section 1322 of the Patient Protection and Affordable Care Act) which has received a loan or grant under the CO-OP program under such section, but only with respect to periods for which the issuer is in compliance with the requirements of such section and any agreement with respect to the loan or grant.

''(B) CONDITIONS FOR EXEMPTION.—Subparagraph (A) shall apply to an organization only if—

''(i) the organization has given notice to the Secretary, in such manner as the Secretary may require, that it is applying for recognition of its status under this paragraph,

''(ii) except as provided in section 1322(c)(4) of the Patient Protection and Affordable Care Act, no part of the net earnings of which inures to the benefit of any private shareholder or individual,

''(iii) including as part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation, and

''(iv) the organization does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office.

(2) ADDITIONAL REPORTING REQUIREMENT.—Section 6033 of such Code (relating to returns of tax-exempt organizations) is amended by adding at the end the following:

''(m) ADDITIONAL INFORMATION REQUIRED FROM CO-OP INSURERS.—An organization described in section 501(c)(29) shall include on the return required under subsection (a) the following information:

''(1) The amount of the reserves required by each State in which the organization is licensed to issue qualified health plans.

''(2) The amount of reserves on hand.

''(3) Application of tax on excess benefit transactions.—Section 4958(e)(1) of such Code (defining applicable tax-exempt organization) is amended by inserting, after subsection (d), and by inserting after subsection (e) the following:

''(3) Application of tax on excess benefit transactions.

(3) GAO STUDY AND REPORT.

(1) IN GENERAL.—The Comptroller General of the General Accountability Office shall conduct an ongoing study on competition and market concentration in the health insurance market in the United States after the implementation of the reforms in such market under the provisions of, and the amendments made by, this Act. Such study shall include an analysis of new issuers of health insurance in such market.

(2) REPORT.—The Comptroller General shall, not later than December 31 of each even-numbered year, submit a report to the appropriate committees of the Congress the results of the study conducted under paragraph (1), including any recommendations for administrative or legislative changes the Comptroller General determines necessary or appropriate to increase competition in qualified health plans through the health insurance market.

SEC. 1233. COMMUNITY HEALTH INSURANCE OPTION.

(a) Voluntary Nature.—

(1) NO REQUIREMENT FOR HEALTH CARE PROVIDERS TO PARTICIPATE.—Nothing in this section shall be construed to require a health care provider to participate in a community health insurance option, or to impose any penalty for non-participation.

(2) NO REQUIREMENT FOR INDIVIDUALS TO JOIN.—Nothing in this section shall be construed to require an individual to participate in a community health insurance option, or to impose any penalty for non-participation.

(b) Conditions for Participation.—

(1) A STATE MAY OFFER ADDITIONAL BENEFITS.—If—

(A) a State elects to prohibit Exchanges in such State from offering a community health insurance option if such State enacts a law to provide for such prohibition.

(B) TERMINATION OF OPT OUT.—A State may repeal a law described in subparagraph (A) and provide for the offering of such an option through the Exchange.

(c) Establishment of Community Health Insurance Option.—

(1) Establishment.—The Secretary shall establish a community health insurance option to offer, through the Exchanges established under this title, health care coverage that provides value, choice, competition, and affordability in the United States.

(2) Health Insurance Options.—

(A) DEFINITION.—In this section, the term ''community health insurance option'' means health insurance coverage that—

''(i) except as specifically provided for in this section, complies with the requirements for being a qualified health plan;

''(ii) provides high value for the premium charged;

''(iii) reduces administrative costs and promotes administrative simplification for beneficiaries;

''(iv) complies with State laws (if any), except as otherwise provided for in this title, relating to the laws described in section 1324(b);

(B) ESSENTIAL HEALTH BENEFITS.—

''(A) GENERAL RULE.—Except as provided in subparagraph (B), a community health insurance option offered under this section shall provide coverage for the essential health benefits described in section 1322(b).

''(B) STATES MAY OFFER ADDITIONAL BENEFITS.—Nothing in this section shall preclude a State from establishing or allowing as members of a single pool, in addition to the essential health benefits required under subparagraph (A) to be provided to enrollees of a community health insurance option offered in such State.

(C) CREDITS.—

''(1) IN GENERAL.—An individual enrolled in a community health insurance option under this section who is enrolled in a qualified health plan.

''(2) ADDITIONAL FEDERAL COST.—A re-
(C) Consumer Protections.—The consumer protection laws of a State shall apply to a community health insurance option.

(b) Requirements Established in Partnership With States.

(A) In General.—The Secretary, in collaboration with the National Association of Insurance Commissioners (in this paragraph referred to as "NAIC"), may promulgate regulations to establish additional requirements for a community health insurance option.

(B) Applicability.—Any requirement promulgated under subparagraph (A) shall be applicable to such option beginning 90 days after the date on which the regulation involved becomes final.

(c) Start-Up Fund.

(1) Establishment of Fund.

(A) In General.—There is established in the Treasury of the United States a trust fund to be known as the "Health Benefit Plan Start-Up Fund" (referred to in this section as the "Start-Up Fund").

(B) Funding.—There is hereby appropriated to the Start-Up Fund out of any moneys in the Treasury appropriated for payment requirements in paragraph (4) for the purposes described in paragraph (1)B.

(C) Pass Through of Revenues.—The Secretary may establish procedures for reducing the amount of payments to a contracting administrator to take into account any rebates or price concessions.

(d) Contracting Administrator.

(A) In General.—A community health insurance option shall be required to repay the Secretary of the Treasury (on such terms as the Secretary determines) for any payments made under paragraph (1)B by the date that is not later than 9 years after the date on which the payment is made. The Secretary may not include in a contract subject to the repayment requirements at rates that do not exceed the market interest rate (as determined by the Secretary).

(B) Sanctions in Case of For-Profit Conversion.—In any case in which the Secretary elects to opt out as provided for in subsection (a)(3) shall establish or designate an for-profit or non-profit private entity to serve as the State Advisory Council to provide recommendations to the Secretary on the operations and policies of a community health insurance option in the State. Such Council shall provide recommendations on at least the following:

(A) Policies and procedures to integrate quality improvement and cost containment mechanisms into the health care delivery system;

(B) Mechanisms to facilitate public awareness of the availability of a community health insurance option; and

(C) Alternative payment structures under a community health insurance option for health care providers that encourage quality improvement and cost control.

(2) Members.—The members of the State Advisory Council shall be representatives of the public and shall include health care consumers and providers.

(e) Authority to Contract; Terms of Contract.

(1) Authority.—

(A) In General.—The Secretary may enter into a contract or contracts with one or more qualified entities for the purpose of performing administrative functions (including enrollment functions specified in section 1874A of the Social Security Act) with respect to a community health insurance option. The Secretary may enter into contracts under subsection (a)(1) of such section. The Secretary shall have the same authority with respect to a community health insurance option under this section as the Secretary has under subsections (a)(1) and (b) of section 1874A of the Social Security Act with respect to title XVIII of such Act.

(B) Requirements Apply.—If the Secretary enters into a contract with a qualified entity to offer a community health insurance option, under such contract, the Secretary shall—

(i) meet the criteria established under subsection (2); and

(ii) shall receive an administrative fee under paragraph (7).

(2) Limitation.—Contracts under this subsection shall not involve the transfer of insurance risk to the contracting administrator.

(3) Reference.—An entity with which the Secretary has entered into a contract under this paragraph shall be referred to as a "contracting administrator".

(e) Requirements in Case of For-Profit Conversion.

(A) In General.—For any payments received by such entity from the Start-Up Fund; and

(2) Provide for a hearing. The Secretary may conduct a hearing only after notice to the contracting administrator involved and the Inspector General, only after notice to the contracting administrator involved and an opportunity for a hearing. The Secretary may revoke such contract if the Secretary determines that the contracting administrator involved and the Inspector General, only after notice to the contracting administrator involved and an opportunity for a hearing. The Secretary may revoke such contract if the Secretary determines that the contracting administrator involved and the Inspector General, only after notice to the contracting administrator involved and an opportunity for a hearing.

(f) Report by HHS and Insolvency Warning.

(1) In General.—On an annual basis, the Secretary shall conduct a study on the solvency of a community health insurance option and submit to Congress a report describing the results of such study. The report shall include a description of the result of the study under paragraph (1) is that a community health insurance option is insolvent, such result shall be treated as a community health insurance option.

(2) Submission of Plan and Procedure.

(A) In General.—If there is a community health insurance option solvency warning or price concession.

(B) Provision for Timely Recovery of Premiums.—The Secretary, upon the recommendation of the Inspector General, may conduct a competitive bidding process for the purposes of renewing existing contracts or selecting new qualified entities with which to enter into contracts under this section.

(4) Limitation.—A contract may not be renewed under this subsection unless the Secretary determines that the contracting administrator has met the requirements established by the Secretary in the areas described in paragraph (7)B.

(5) Audits.—The Inspector General shall conduct periodic audits of the contracting administrators under this subsection to ensure that the administrator involved is in compliance with this section.

(6) Revocation.—A contract awarded under this subsection shall be revoked by the Secretary, upon the recommendation of the Inspector General, only after notice to the contracting administrator involved and an opportunity for a hearing.

(7) Fee for Administration.

(A) In General.—The Secretary shall pay the contracting administrator a fee for the management, administration, and delivery of the benefits under this section.

(B) Requirement for High Quality Administration.—The Secretary shall review the fee described in subparagraph (A) by not more than 10 percent, or reduce the fee described in subparagraph (A) by not more than 1 percent, based on which the Secretary determines that the contracting administrator, in the determination of the Secretary, meets performance requirements established by the Secretary, in at least the following areas:

(i) Maintaining low premium costs and low administrative costs.

(ii) Reducing administrative costs and promoting administrative simplification for beneficiaries.

(iii) Promoting high quality clinical care.

(iv) Providing high quality customer service to beneficiaries.

(C) Non-Renewal.—The Secretary may not renew a contract to offer a community health insurance option under this section with any contracting entity that has been assessed more than one reduction under subsection (b)(6).

(D) Limitation.—Notwithstanding the terms of a contract under this subsection, the Secretary shall notify the State legislature of the reimbursement rates for purposes of subsection (b)(6).

(E) Report by HHS and Insolvency Warning.

(1) In General.—On an annual basis, the Secretary shall conduct a study on the solvency of a community health insurance option and submit to Congress a report describing the results of such study.

(2) Submission of Plan and Procedure.

(A) In General.—If there is a community health insurance option solvency warning or price concession.

(B) Provision for Timely Recovery of Premiums.—The Secretary, upon the recommendation of the Inspector General, may conduct a competitive bidding process for the purposes of renewing existing contracts or selecting new qualified entities with which to enter into contracts under this section.

(4) Limitation.—A contract may not be renewed under this subsection unless the Secretary determines that the contracting administrator has met the requirements established by the Secretary in the areas described in paragraph (7)B.

(5) Audits.—The Inspector General shall conduct periodic audits of the contracting administrators under this subsection to ensure that the administrator involved is in compliance with this section.

(6) Revocation.—A contract awarded under this subsection shall be revoked by the Secretary, upon the recommendation of the Inspector General, only after notice to the contracting administrator involved and an opportunity for a hearing.

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(A) In General.—The Secretary shall pay the contracting administrator a fee for the management, administration, and delivery of the benefits under this section.

(B) Requirement for High Quality Administration.—The Secretary shall review the fee described in subparagraph (A) by not more than 10 percent, or reduce the fee described in subparagraph (A) by not more than 1 percent, based on which the Secretary determines that the contracting administrator, in the determination of the Secretary, meets performance requirements established by the Secretary, in at least the following areas:

(i) Maintaining low premium costs and low administrative costs.

(ii) Reducing administrative costs and promoting administrative simplification for beneficiaries.

(iii) Promoting high quality clinical care.

(iv) Providing high quality customer service to beneficiaries.

(C) Non-Renewal.—The Secretary may not renew a contract to offer a community health insurance option under this section with any contracting entity that has been assessed more than one reduction under subsection (b)(6).

(D) Limitation.—Notwithstanding the terms of a contract under this subsection, the Secretary shall notify the State legislature of the reimbursement rates for purposes of subsection (b)(6).

(E) Report by HHS and Insolvency Warning.

(1) In General.—On an annual basis, the Secretary shall conduct a study on the solvency of a community health insurance option and submit to Congress a report describing the results of such study.

(2) Submission of Plan and Procedure.

(A) In General.—If there is a community health insurance option solvency warning or price concession.

(B) Provision for Timely Recovery of Premiums.—The Secretary, upon the recommendation of the Inspector General, may conduct a competitive bidding process for the purposes of renewing existing contracts or selecting new qualified entities with which to enter into contracts under this section.

(4) Limitation.—A contract may not be renewed under this subsection unless the Secretary determines that the contracting administrator has met the requirements established by the Secretary in the areas described in paragraph (7)B.

(5) Audits.—The Inspector General shall conduct periodic audits of the contracting administrators under this subsection to ensure that the administrator involved is in compliance with this section.

(6) Revocation.—A contract awarded under this subsection shall be revoked by the Secretary, upon the recommendation of the Inspector General, only after notice to the contracting administrator involved and an opportunity for a hearing.

(7) Fee for Administration.

(A) In General.—The Secretary shall pay the contracting administrator a fee for the management, administration, and delivery of the benefits under this section.

(B) Requirement for High Quality Administration.—The Secretary shall review the fee described in subparagraph (A) by not more than 10 percent, or reduce the fee described in subparagraph (A) by not more than 1 percent, based on which the Secretary determines that the contracting administrator, in the determination of the Secretary, meets performance requirements established by the Secretary, in at least the following areas:

(i) Maintaining low premium costs and low administrative costs.

(ii) Reducing administrative costs and promoting administrative simplification for beneficiaries.

(iii) Promoting high quality clinical care.

(iv) Providing high quality customer service to beneficiaries.

(C) Non-Renewal.—The Secretary may not renew a contract to offer a community health insurance option under this section with any contracting entity that has been assessed more than one reduction under subsection (b)(6).

(D) Limitation.—Notwithstanding the terms of a contract under this subsection, the Secretary shall notify the State legislature of the reimbursement rates for purposes of subsection (b)(6).

(E) Report by HHS and Insolvency Warning.

(1) In General.—On an annual basis, the Secretary shall conduct a study on the solvency of a community health insurance option and submit to Congress a report describing the results of such study.

(2) Submission of Plan and Procedure.

(A) In General.—If there is a community health insurance option solvency warning or price concession.

(B) Provision for Timely Recovery of Premiums.—The Secretary, upon the recommendation of the Inspector General, may conduct a competitive bidding process for the purposes of renewing existing contracts or selecting new qualified entities with which to enter into contracts under this section.

(4) Limitation.—A contract may not be renewed under this subsection unless the Secretary determines that the contracting administrator has met the requirements established by the Secretary in the areas described in paragraph (7)B.

(5) Audits.—The Inspector General shall conduct periodic audits of the contracting administrators under this subsection to ensure that the administrator involved is in compliance with this section.

(6) Revocation.—A contract awarded under this subsection shall be revoked by the Secretary, upon the recommendation of the Inspector General, only after notice to the contracting administrator involved and an opportunity for a hearing.

(7) Fee for Administration.

(A) In General.—The Secretary shall pay the contracting administrator a fee for the management, administration, and delivery of the benefits under this section.

(B) Requirement for High Quality Administration.—The Secretary shall review the fee described in subparagraph (A) by not more than 10 percent, or reduce the fee descript
the budget submission to Congress under section 1105(a) of title 31, United States Code, for the succeeding year, proposed legislation to respond to such warning.

(b) Authorization of Appropriations.—(A) In General.—There is authorized to be appropriated such sums as may be necessary to carry out this section.

(2) SEC. 1324. LEVEL PLAYING FIELD.

(a) In General.—Notwithstanding any other provision of law, any health insurance coverage offered by a private health insurance issuer shall not be subject to any Federal or State law described in subsection (b) if the amount the Secretary determines is necessary to carry out this section.

(b) Standard Health Plan.—In this section, the term “standard health plan” means a health benefit plan described in section 1302(b) of the Improving America’s Health Care Act of 2003.

(c) Health Insurance Coverage.—(1) IN GENERAL.—The Secretary shall establish a competitive process for entering into contracts with standard health plans under subsection (a), including negotiation of premiums and cost-sharing and negotiation of benefits in addition to the essential health benefits described in section 1302(b).

(2) Specific Items to be Considered.—A State shall, as part of its competitive process under paragraph (1), include at least the following:

(A) Innovation.—Negotiation with offerors for contracts for health insurance coverage offered by a health insurance issuer, that has a medical loss ratio of at least 85 percent.

(B) Specific Items to be Considered.—A State shall, as part of its competitive process under paragraph (1), include at least the following:

(i) General.—The Secretary shall establish a basic health program meeting the requirements of this section under section 1322, a community health insurance program under section 1323, a premium reimbursement program under section 1324, or a State plan under section 1331.

(ii) Knoxville.—The Secretary shall make the determination under this subsection (a) if the individual had enrolled in the lowest cost silver plan and such credits and reductions provided to eligible individuals described in clause (i), including the amount the Secretary determines as necessary to carry out this section.

(iii) Knoxville.—The Secretary shall make the determination under this subsection (a) if the individual had enrolled in the lowest cost silver plan and such credits and reductions provided to eligible individuals described in clause (i), including the amount the Secretary determines as necessary to carry out this section.

(2) Certification.—The Secretary shall certify, that—

(A) IN GENERAL.—A State shall establish a basic health program meeting the requirements of this section under section 1322, a community health insurance program under section 1323, a premium reimbursement program under section 1324, or a State plan under section 1331.

(B) Standard Health Plan.—In this section, the term “standard health plan” means a health benefit plan described in section 1302(b) of the Improving America’s Health Care Act of 2003.

(2) Specific Items to be Considered.—A State shall, as part of its competitive process under paragraph (1), include at least the following:

(A) Innovation.—Negotiation with offerors for contracts for health insurance coverage offered by a health insurance issuer, that has a medical loss ratio of at least 85 percent.

(B) Specific Items to be Considered.—A State shall, as part of its competitive process under paragraph (1), include at least the following:

(i) General.—The Secretary shall establish a basic health program meeting the requirements of this section under section 1322, a community health insurance program under section 1323, a premium reimbursement program under section 1324, or a State plan under section 1331.

(ii) Knoxville.—The Secretary shall make the determination under this subsection (a) if the individual had enrolled in the lowest cost silver plan and such credits and reductions provided to eligible individuals described in clause (i), including the amount the Secretary determines as necessary to carry out this section.

(iii) Knoxville.—The Secretary shall make the determination under this subsection (a) if the individual had enrolled in the lowest cost silver plan and such credits and reductions provided to eligible individuals described in clause (i), including the amount the Secretary determines as necessary to carry out this section.
focus on enrollees with income below 200 percent of poverty.

(ii) CERTIFICATION.—The Chief Actuary of the Centers for Medicare & Medicaid Services, in consultation with the Office of Tax Analysis of the Department of the Treasury, shall certify whether the methodology used to make determinations under this subparagraph, and such determinations, meet the requirements of clause (i). Such certifications shall be based on sufficient data from the State and from comparable States about their experience with programs created by this Act.

(b) CORRECTIONS.—The Secretary shall adjust the payment for any fiscal year to reflect any error in the determinations under subparagraph (A) for any preceding fiscal year.

4. APPLICATION OF SPECIAL RULES.—The provisions of section 1303 shall apply to a State basic health program, and to standard health plans offered through such program, in the same manner as such rules apply to qualified health plans.

5. ELIGIBLE INDIVIDUAL.—(1) In general.—In this section, the term “eligible individual” means, with respect to any State, an individual—

(A) who resides in the State who is not a qualified individual under section 1312 who is eligible to be covered by a qualified health plan offered through an Exchange and credits and reductions provided under such provisions to residents of the other States; and

(B) whose household income exceeds 133 percent but does not exceed 200 percent of the poverty line for the size of the family involved.

(c) Definition of poverty line.—The term ‘poverty line’ means the poverty line determined annually by the Secretary, taking into consideration the experience of other States with respect to participation in an Exchange and credits and reductions provided under such provisions to residents of the other States.

(d) Waiver consideration and transparency.—(1) Waiver consideration and transparency.—

(A) IN GENERAL.—An application for a waiver under section 1332, if considered by the Secretary in accordance with the regulations described in subparagraph (B), shall be treated as a waiver under this section, including the implementation of the State plan under subsection (a)(1)(B).

(B) REGULATIONS.—Not later than 180 days after the date of enactment of this Act, the Secretary shall promulgate regulations relating to waivers under this section that provide—

(i) a process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input;

(ii) a process for the submission of an application that ensures the disclosure of—

(I) the provisions of law that the State involved of such determination and

(ii) the specifications for the State to ensure that the waiver will be in compliance with subsection (b); and

(iii) a process for providing public notice and comment after the application is received by the Secretary, that is sufficient to ensure a meaningful level of public input and that does not impose requirements that are in addition to, or exceed, requirements imposed under the Administrative Procedures Act, or requirements that are unreasonable or unnecessarily burdensome with respect to State compliance;

(iv) a process for the submission to the Secretary of periodic reports by the State concerning the implementation of the program under the waiver; and

(v) a process for the periodic evaluation by the Secretary of the program under the waiver.

(C) REPORT.—The Secretary shall annually report to Congress concerning actions taken by the Secretary with respect to applications for waivers under this section.

(D) COORDINATED WAIVER PROCESS.—The Secretary shall develop a process for coordinating and consolidating the State waiver processes applicable under the provisions of this section, and the existing waiver processes applicable under titles XVIII, XIX, and XXI of the Social Security Act, and any other Federal law that provides for the provision of health care items or services. Such process shall permit a State to submit a single application for a waiver under any or all of such provisions.

(E) DEFINITION.—In this section, the term “Secretary” means—

(A) the Secretary of Health and Human Services with respect to waivers relating to the provisions described in subparagraph (A) through (C) of paragraph (2); and

(B) the Secretary of the Treasury with respect to waivers relating to the provisions described in paragraph (2)(D).

6. GRANTING OF WAIVERS.—(1) IN GENERAL.—The Secretary may grant a waiver under this section to the Secretary of the Treasury only if the Secretary determines that the State plan—

(A) will provide coverage that is at least as comprehensive as the coverage described in section 1303(b) and offered through Exchanges established under this title as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States about their experience with programs created by this Act and the provisions of this Act that would be waived;

(B) will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide; and

(C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide; and

(2) REQUIREMENT TO ENACT A LAW.—(A) IN GENERAL.—A law described in this paragraph is a State law that provides for a waiver under this section only if the Secretary determines that the State plan—

(i) is budget neutral for the Federal Government; and

(ii) a 10-year budget plan for such plan that is sufficient to ensure that the waiver will be in compliance with paragraph (2)(D).

(B) TERMINATION OF OPT OUT.—A State may request and the Secretary may toll the authority provided under the waiver with respect to the State.

(c) SCOPE OF WAIVER.—(1) IN GENERAL.—The Secretary shall determine the scope of a waiver of a requirement described in subsection (a)(2) granted to a State under subsection (a)(1).

(2) LIMITATION.—The Secretary may not waive under this section any Federal law or requirement that is not within the authority of the Secretary.

(d) DETERMINATIONS BY SECRETARY.—(1) TIME FOR DETERMINATION.—The Secretary shall make a determination under subsection (a)(1) not later than 180 days after the receipt of an application from a State under such subsection.

(2) EFFECT OF DETERMINATION.—(A) GRANTING OF WAIVERS.—If the Secretary determines to grant a waiver under subsection (a)(1), the Secretary shall notify the State involved of such determination and the terms and effectiveness of such waiver.

(B) TERMINATION OF WAIVER.—If the Secretary determines a waiver should not be granted under subsection (a)(1), the Secretary shall
notify the State involved, and the appropriate committees of Congress of such determination and the reasons therefore.

(e) Term of Waiver.—No waiver under this section shall extend over a period of longer than 5 years unless the State requests continuation of such waiver, and such request shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State in writing, with respect to any additional information which is needed in order to make a final determination with respect to the request.

SEC. 1333. PROVISIONS RELATING TO OFFERING OF PLANS IN MORE THAN ONE STATE.

(a) Health Care Choice Compacts.—

(1) In General.—Not later than July 1, 2013, the Secretary shall, in consultation with the National Association of Insurance Commissioners, issue regulations for the creation of health care choice compacts under which 2 or more States may enter into an agreement under which—

(A) 1 or more qualified health plans could be offered in the individual markets in all such States but, except as provided in subparagraph (B), only be subject to the laws and regulations of the State in which the plan was written or issued;

(B) the issuer of any qualified health plan to which the compact applies—

(i) would be subject to market conduct, unfair trade practices, network adequacy, and consumer protection standards (including standards relating to rating), including but not limited to, the standard applicable to the performance of the contract, of the State in which the purchaser resides;

(ii) would be required to be licensed in each State in the compact or to submit to the jurisdiction of each such State with regard to the standards described in clause (i) (including allowing access to records if the insurer were licensed in the State); and

(iii) must clearly notify consumers that the policy may not be subject to all the laws and regulations of the State in which the purchaser resides;

(2) State Authority.—A State may not enter into an agreement under this paragraph if the State does not adopt or maintain applicable requirements of this标题 in the State in which the plan was written or issued.

(b) Approval of Compacts.—The Secretary may approve interstate health care choice compacts under paragraph (1) only if the Secretary determines that such health care choice compact—

(A) will provide coverage that is at least as comprehensive as the coverage defined in section 1312(b) and offered through Exchanges established under this title;

(B) will provide coverage and cost-sharing protections against excessive out-of-pocket spending, at least as favorable as the provisions of this title would provide;

(C) will provide coverage to at least a comparable number of its residents as the provisions of this title would provide;

(D) will not undermine Federal deficit and

(E) will not weaken enforcement of laws and regulations prescribed in paragraph (1)(B)(i) in any State in which is included in such compact.

(4) Effective Date.—A health care choice compact described in paragraph (1) shall not take effect before January 1, 2016.

(b) Authority for Nationwide Plans.—

(1) In General.—Except as provided in paragraph (b)(2), the Secretary shall, in consultation with the National Association of Insurance Commissioners, issue regulations for the creation of health insurance issuers affiliated either by common ownership and control or by the common use of a nationally licensed service mark of a qualified health plan in the individual or small group market meets the requirements of this subsection (in this subsection, a "nationwide qualified health plan")—

(A) the issuer of the plan may offer the nationwide qualified health plan in the individual or small group market in more than 1 State; and

(B) with respect to State laws mandating benefit coverage by a health plan, only the applicable reinsurance requirements of States in which such plan is written or issued shall apply to the nationwide qualified health plan.

(2) State Opt-Out.—A State may, by specific reincorporated after the date of enactment of this title, provide that this subsection shall not apply to that State. Such opt-out shall be effective until such time as the State by law revokes it.

(3) Plan Requirements.—An issuer meets the requirements of this subsection with respect to a nationwide qualified health plan if, in the determination of the Secretary—

(A) the plan offers a benefits package that is uniform in each State in which the plan is offered and meets the requirements set forth in paragraphs (4) through (6); and

(B) the plan is offered in each State in which it offers the plan and is subject to all requirements of State law not inconsistent with the standards described in this paragraph, including but not limited to, the standards applicable to the performance of the contract, of the State in which the purchaser resides.

(4) Effective Date.—A nationwide qualified health plan may be offered only after such rules have taken effect.

(c) Coverage.—The Secretary shall provide that the health benefits coverage provided to an individual through a nationwide qualified health plan under this subsection shall include at least the essential benefits package described in section 1302.

(d) State Law Mandating Benefit Coverage by a Health Benefits Plan.—For the purposes of this subsection—

(I) a law that mandates health insurance coverage or the offer of health insurance coverage for specific services or specific diseases. A law that mandates health insurance coverage or reimbursement for services by certain entities of health care services, or a law that mandates that certain classes of individuals must be covered as a group or as dependents, is not a law mandating benefit coverage by a health benefits plan.

PART V—REINSURANCE AND RISK ADJUSTMENT

SEC. 1341. TRANSITIONAL REINSURANCE PROGRAM FOR INDIVIDUAL AND SMALL GROUP MARKETS IN EACH STATE.

(a) In General.—Each State shall, not later than January 1, 2014—

(1) include in the Federal standards or State law or regulation the State adopts and has in effect under section 1321(b) the provisions described in subparagraph (A) and (B); and

(2) establish (or enter into a contract with) 1 or more applicable reinsurance entities to carry out the reinsurance program under this section.

(b) Model Regulation.—

(1) In General.—In establishing the Federal standards under section 1321(a), the Secretary, in consultation with the National Association of Insurance Commissioners (the "NAIC"), shall include provisions that allow States to establish and maintain a program under which—

(A) health insurance issuers, and third party administrators on behalf of group health plans, are required to make payments to an applicable reinsurance entity for any plan year beginning in the 3-year period beginning January 1, 2014 (as specified in paragraph (3)); and

(B) the applicable reinsurance entity collects payments under subparagraph (A) and uses amounts so collected to make reinsurance payments to issuers described in subparagraph (A) that cover high-risk individuals in the individual market (including grandfathered health plans) for any plan year beginning in such 3-year period.

(2) High-Risk Individual; Payment Amounts.—The Secretary shall include the following in the provisions under paragraph (1):—

(A) Determination of High-Risk Individuals.—The method by which individuals will be identified as high risk individuals for purposes of the reinsurance program established under this section. Such method shall provide for the identification of high-risk individuals as follows

(i) a list of at least 50 but not more than 100 medical conditions that are identified as high-risk conditions and that may be based on the identification of diagnostic and procedure codes that are indicative of individuals with pre-existing, high-risk conditions; or

(ii) any other comparable objective method of identification recommended by the American Academy of Actuaries.

(B) Payment Amount.—The formula for determining the amount that will be paid to health insurance issuers described in paragraph (1)(A) that issue high-risk individual plans shall provide for the use of funds through reconciliation and may be designed—
(1) to provide a schedule of payments that specifies the amount that will be paid for each of the conditions identified under sub-paragraph (A); or

(ii) reduce or otherwise comparable method for determining payment amounts that is recommended by the American Academy of Actuaries and that encourages the use of care management programs for high risk conditions.

(3) DETERMINATION OF REQUIRED CONTRIBUTIONS.

(A) IN GENERAL.—The Secretary shall include in the provisions under paragraph (1) the method for determining the amount each health plan that administers a public health plan described in paragraph (2)(A) for each plan year beginning in the 36-month period beginning January 1, 2014. The contribution amount for any plan year may be based on the percentage of revenue of each issuer and the total costs of providing benefits to enrollees in self-insured plans or on a specified amount per enrollee and may be required to be paid in advance or periodically throughout the plan year.

(B) SPECIFIC REQUIREMENTS.—The method under this paragraph shall be designed so that—

(i) the contribution amount for each issuer proportionally reflects each issuer’s fully insured commercial book of business for all major medical products and the total value of all applicable costs incurred by the issuer and the costs of coverage administered by the issuer as a third party administrator;

(ii) the aggregate contribution amounts for all States shall, based on the best estimates of the NAIC and without regard to amounts described in clause (ii), equal $10,000,000,000 for plan years beginning in 2014, $6,000,000,000 for plan years beginning in 2015, and $4,000,000,000 for plan years beginning in 2016; and

(iv) in addition to the aggregate contribution amounts under clause (iii), each issuer’s contribution amount for any calendar year under clause (ii) reflects its proportionate share of the $2,000,000,000 for 2014, an additional $2,000,000,000 for 2015, and an additional $1,000,000,000 for 2016.

Nothing in this subparagraph shall be construed to require a State from using additional amounts from issuers on a voluntary basis.

(4) EXPENDITURE OF FUNDS.—The provisions under paragraph (1) shall provide that—

(A) the contribution amounts collected for any calendar year may be allocated and used in any of the three calendar years for which amounts are collected based on the reinsurance needs of an applicable reinsurance entity; and

(B) amounts remaining unexpended as of December 31 shall be used to make payments under any reinsurance program of a State in the individual market in effect in the 2-year period beginning on January 1, 2017.

Notwithstanding the preceding sentence, any contribution amounts described in paragraph (3)(B)(iv) shall be deposited into the general fund of the Treasury of the United States and may not be used for the program established under this section.

III. LOCALLY OPERATED REINSURANCE ENTITY.—For purposes of this section—

(1) IN GENERAL.—The term “applicable reinsurance entity” means a not-for-profit organization that—

(A) the purpose of which is to help stabilize premiums for coverage in the individual and small group markets in a State during the first 3 years of operation of an Exchange for such markets within the State when the risk of adverse selection related to new rating rules and market share is high; and

(B) the duties of which shall be to carry out the reinsurance program under this section by coordinating the funding and operation of such program and in doing so design to implement the reinsurance program.

(2) STATE DISCRETION.—A State may have more than 1 applicable reinsurance entity to carry out the reinsurance program under this section within the State and 2 or more applicable reinsurance entities may provide for an applicable reinsurance entity to carry out such program in all such States.

(3) ENTITIES ARE TAX-EXEMPT.—An applicable reinsurance entity established under this section shall be exempt from taxation under chapter 1 of the Internal Revenue Code of 1986.

(4) ALLOWABLE COSTS.—The expenses that the applicable reinsurance entity may incur shall be limited to carrying out the reinsurance program and activities relating to it.

(5) CONTRIBUTIONS.—The applicable reinsurance entity may receive contributions from an issuer or an issuer’s affiliated organization.

(6) ADMINISTRATION.—The applicable reinsurance entity may establish criteria and methods to be used in determining payment amounts that is consistent with the provisions of this section.

(a) IN GENERAL.—The Secretary shall establish and administer a program a risk corridors for calendar years 2014, 2015, and 2016, under which a qualified health plan offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan’s aggregate premiums.

(b) PAYMENTS.—The Secretary shall make a payment under paragraph (a) to a qualified health plan if the actual costs of the plan for a plan year are more than 108 percent of the target amount.

(c) SCOPE.—The Secretary may carry out the risk adjustment activities described in subsection (b) if the actuarial risk of the enrollees of such plans or coverage for a year is greater than the average actuarial risk of all enrollees in all plans and coverage in such State for such year that are not self-insured group health plans.

Subtitle E—Affordable Coverage Choices for All Americans

PART I—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

Subpart A—Premium Tax Credits and Cost-Sharing Reductions

SEC. 1401. REFUNDABLE TAX CREDIT PROVIDING PREMIUM ASSISTANCE FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.

(a) IN GENERAL.—Subpart C of part IV of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by inserting after section 36B the following new section:

"SEC. 36B. REFUNDABLE CREDIT FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.

(1) IN GENERAL.—In the case of an applicable taxpayer, there shall be allowed as a refundable credit against the tax imposed by this title for any taxable year an amount equal to 20 percent of the total premium assistance credit amount of the taxpayer for the taxable year for which the credit is allowed.

(2) PREMIUM ASSISTANCE CREDIT AMOUNT.—For purposes of this section—

"(a) IN GENERAL.—The term ‘applicable health insurance issuer’ means each issuer of a qualified health plan described in subsection (b) that—

(B) amounts remaining unexpended as of

(C) amounts remaining unexpended as of

(D) amounts remaining unexpended as of

(E) amounts remaining unexpended as of

(F) amounts remaining unexpended as of

(G) amounts remaining unexpended as of

(H) amounts remaining unexpended as of

(I) amounts remaining unexpended as of

(J) amounts remaining unexpended as of

(K) amounts remaining unexpended as of

(L) amounts remaining unexpended as of

(M) amounts remaining unexpended as of

(N) amounts remaining unexpended as of

(O) amounts remaining unexpended as of

(P) amounts remaining unexpended as of

(Q) amounts remaining unexpended as of

(R) amounts remaining unexpended as of

(S) amounts remaining unexpended as of

(T) amounts remaining unexpended as of

(U) amounts remaining unexpended as of

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(W) amounts remaining unexpended as of

(X) amounts remaining unexpended as of

(Y) amounts remaining unexpended as of

(Z) amounts remaining unexpended as of

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“(1) IN GENERAL.—The term ‘premium assistance credit amount’ means, with respect to any taxable year, the sum of the premium assistance amounts determined under paragraph (2) with respect to all coverage months of the taxpayer occurring during the taxable year.

“(2) PREMIUM ASSISTANCE AMOUNT.—The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of—

(A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer and which were enrolled in through an Exchange established by the State under subsection (b) of the Patient Protection and Affordable Care Act, or

(B) the excess (if any) of—

(i) the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer, over

(ii) an amount equal to 1/12 of the product of the applicable percentage and the taxpayer’s household income for the taxable year.

“(3) OTHER TERMS AND RULES RELATING TO PREMIUM ASSISTANCE AMOUNTS.—For purposes of paragraph (2)—

(A) APPLICABLE PERCENTAGE.—

(i) IN GENERAL.—Except as provided in clause (ii), the applicable percentage with respect to any taxpayer for any taxable year is equal to the product of 1.0 minus the number of percentage points (not greater than 7) which bears the same ratio to 7 percentage points as—

(I) the taxpayer’s household income for the taxable year in excess of 100 percent of the poverty line for a family of the size involved, divided by 100, exceeds 133 percent of the poverty line for a family of the size involved, and

(II) the taxpayer’s household income for the taxable year is in excess of 100 percent of the poverty line for a family of the size involved.

(ii) SPECIAL RULE FOR TAXPAYERS UNDER 133 PERCENT OF POVERTY LINE.—If a taxpayer’s household income for the taxable year is in excess of 100 percent, but not more than 133 percent, of the poverty line for a family of the size involved, the taxpayer’s applicable percentage shall be 2 percent.

“(B) INDEXING.—In the case of taxable years beginning after calendar year 2014, the Secretary shall adjust the initial and final applicable percentages under clause (i), and the 2 percent under clause (ii), for the calendar year through which the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for such period.

“(B) APPLICABLE SECOND LOWEST COST SILVER PLAN.—The applicable second lowest cost silver plan with respect to any applicable taxpayer is the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides which—

(i) is offered through the same Exchange through which the qualified health plans taken into account under paragraph (2)(A) were offered, and

(ii) provides—

(A) self-only coverage in the case of an applicable taxpayer

(aa) whose tax for the taxable year is determined under section 1(c) (relating to unmarried individuals other than surviving spouses and heads of households) and who is not allowed a deduction under section 151 for the taxable year with respect to a dependent, or

(bb) who is not described in item (aa) but who purchases only self-only coverage, and

(B) family coverage in the case of any other applicable taxpayer

If a taxpayer files a joint return and no credit is allowed under this section with respect to 1 of the spouses by reason of subsection (e), the taxpayer shall be treated as described in clause (1)(i) unless a deduction is allowed under section 151 for the taxable year with respect to the taxpayer, the taxpayer’s spouse, or any dependent of the taxpayer.

“(C) ADJUSTED MONTHLY PREMIUM.—The adjusted monthly premium for an applicable second lowest cost silver plan is the monthly premium which would have been charged (for purposes of section 151) to the taxpayer, with respect to which the premiums under paragraph (2)(A) were determined, and with respect to which the premiums under paragraph (2)(A) were determined for the plan if each individual covered under a qualified health plan taken into account under paragraph (2)(A) were covered by such sliver plan and the premium was adjusted only for the age of each such individual, the tax year for which the premium was determined, and the calendar year in which the individual was enrolled in the plan.

“(D) DEDUCTION FOR INCOME GROWTH.—The credit shall be allowed under this section with respect to any applicable taxpayer only if the taxpayer’s household income for the taxable year exceeds the taxpayer’s applicable percentage, of the poverty line for a family of the size involved, but not more than 133 percent of such line.

“(E) LIMITATION ON DEDUCTION.—If a taxpayer files a joint return and no credit is allowed under this section to any applicable taxpayer only if the tax payer and the taxpayer’s spouse file a joint return for the taxable year.

“(F) DEDUCTION FOR LOWER INCOME TAXPAYERS.—If a taxpayer files a joint return and no credit is allowed under this section to any applicable taxpayer only if the taxpayer whose income is at least 100 percent, but not more than 133 percent of the poverty line for a family of the size involved, is the second lowest cost silver plan with respect to the taxpayer, the tax year for which the premiums under paragraph (2)(A) were determined, and with respect to which the premiums under paragraph (2)(A) were determined for the plan if each individual covered under a qualified health plan taken into account under paragraph (2)(A) were covered by such plan, the premium was adjusted only for the age of each such individual, the tax year for which the premium was determined, and the calendar year in which the individual was enrolled in the plan.

“(G) DEDUCTION FOR MEDICAID TAXPAYERS.—If a taxpayer (other than an individual described in clause (i)) is covered under the eligible medical assistance program (under title XIX of the Social Security Act) by reason of an alien status, the taxpayer shall, for purposes of the credit under this section, be treated as an applicable taxpayer only if the tax year for which the premium was determined, and with respect to which the premiums under paragraph (2)(A) were determined, is the second lowest cost silver plan with respect to the taxpayer, the tax year for which the premiums under paragraph (2)(A) were determined, and with respect to which the premiums under paragraph (2)(A) were determined for the plan if each individual covered under a qualified health plan taken into account under paragraph (2)(A) were covered by such sliver plan and the premium was adjusted only for the age of each such individual, the tax year for which the premium was determined, and the calendar year in which the individual was enrolled in the plan.

“(H) DEDUCTION FOR MARRIED COUPLES.—If a taxpayer (other than an individual described in clause (i)) is covered under the eligible medical assistance program (under title XIX of the Social Security Act) by reason of the marriage of the individual to another individual described in clause (i), the taxpayer shall be treated as an applicable taxpayer only if the tax year for which the premium was determined, and with respect to which the premiums under paragraph (2)(A) were determined, is the second lowest cost silver plan with respect to the taxpayer, the tax year for which the premiums under paragraph (2)(A) were determined, and with respect to which the premiums under paragraph (2)(A) were determined for the plan if each individual covered under a qualified health plan taken into account under paragraph (2)(A) were covered by such plan, the premium was adjusted only for the age of each such individual, the tax year for which the premium was determined, and the calendar year in which the individual was enrolled in the plan.

“(I) SPECIAL RULE FOR EMPLOYER-SPONSORED MINIMUM ESSENTIAL COVERAGE.—For purposes of paragraph (2)(B)—

(i) COVERAGE MUST BE AFFORDABLE.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage—

(A) consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)), and

(B) the employee’s required contribution (whether through advance payment of the credit under section 36B) exceeds 9.8 percent of the employee’s household income.

This clause shall also apply to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee.

“(II) COVERAGE MUST PROVIDE MINIMUM VALUE.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the plan’s share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.

“(III) EMPLOYEE OR FAMILY MUST NOT BE COVERED UNDER EMPLOYER PLAN.—Clauses (i) and (ii) shall not apply if the employee (or any individual described in the last sentence of clause (i)) is covered under the eligible employer-sponsored plan or the grandfathered health plan.

(iv) INDEXING.—In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.8 percent amount described in clauses (i) and (ii) in the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii).
(3) Definitions and other rules.—

(A) QUALIFIED HEALTH PLAN.—The term ‘qualified health plan’ has the meaning given such term by section 1301(a) of the Patient Protection and Affordable Care Act, except that such term shall not include a qualified health plan which is a catastrophic plan described in section 1302(e) of such Act.

(B) FAMILY SIZE.—The term ‘grandfathered health plan’ has the meaning given such term by section 1251 of the Patient Protection and Affordable Care Act.

(d) Terms relating to income and families.—For purposes of this section—

(1) family size.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

(2) household income.—The term ‘household income’ means, with respect to any taxpayer, an amount equal to the sum of—

(i) the modified gross income of the taxpayer, plus

(ii) aggregate modified gross incomes of all other individuals who—

(I) were taken into account in determining the taxpayer’s family size under paragraph (1), and

(II) were required to file a return of tax imposed by section 1 for the taxable year.

(3) modified gross income.—The term ‘modified gross income’ means gross income—

(i) decreased by the amount of any deduction allowable under paragraph (1), (3), (4), or (18) of section 62, and

(ii) increased by the amount of interest received or accrued during the taxable year which is exempt from tax imposed by this chapter, and

(iii) determined without regard to sections 911, 931, and 933.

(e) poverty line.—The term ‘poverty line’ has the meaning given that term in section 2116(c)(5) of the Social Security Act (42 U.S.C. 1397cc(c)(5)).

(f) Exchange.—In the case of any qualified health plan offered through an Exchange for coverage during a taxable year beginning in a calendar year, the poverty line which most recently published poverty line as of the 1st day of the regular enrollment period for coverage during such calendar year.

(g) rules for individuals not lawfully present.—

(1) in general.—If 1 or more individuals for whom a taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year (including the taxpayer or his spouse) are individuals who are not lawfully present, the aggregate amount of premiums which is attributable to such individuals, and

(b) for purposes of applying this section, the determination as to what percentage a taxpayer’s household income bears to the poverty level for a family of the size involved shall be made under section 151(c)(4) (relating to treatment of such’s income as excluded income).

(1) A method under which—

(i) the denominator of which is the poverty line for the taxpayer’s family size determined under clause (I), and

(ii) the numerator of which is the poverty line for the taxpayer’s family size determined without regard to subclause (I).

(2) LAWFULLY PRESENT.—For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be, for the entire period of enrollment for which the credit under this section is allowed, a citizen or national of the United States or an alien lawfully present in the United States.

(3) secretarial authority.—The Secretary of Health and Human Services, in consultation with the Secretary, shall prescribe rules for determining the amount which is attributable to such individuals for purposes of this section. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange for coverage during a taxable year.

(4) Reconciliation of credit and advance credit.—

(1) in general.—The amount of the credit allowed under this section for any taxable year shall be reduced (but not below zero) by the amount of the credit under section 1412 of the Patient Protection and Affordable Care Act.

(2) excess advance payments.—

(A) in general.—If the advance payments to a taxpayer under section 1412 of the Patient Protection and Affordable Care Act for a taxable year exceed the credit allowed under this section (determined without regard to paragraph (1)), the tax imposed by this chapter on the taxable year shall be increased by the amount of such excess.

(B) limitation on increase where income less than 400 percent of poverty line.—

(i) in general.—In the case of an applicable taxpayer whose household income is less than 400 percent of the poverty level for the family size involved for the taxable year, the amount of the increase under subparagraph (A) shall in no event exceed $400 in excess of the credit under section 1412 for the calendar year corresponding to the taxable year.

(ii) indexing of amount.—In the case of any calendar year beginning after 2014, each of the dollar amounts under clause (i) shall be increased by an amount equal to—

(I) such dollar amount multiplied by—

(aa) the inflation adjustment determined under section 1(f)(3) for the calendar year determined by substituting ‘calendar year 2014’ in section 1(f)(3) for ‘calendar year 2012’ in subparagraph (B) thereof; and

(bb) If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

(3) regulations.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations which provide for—

(i) the coordination of the credit allowed under this section with the program for advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act, and

(ii) the application of subsection (f) where the filing status of the taxpayer for a taxable year is different from such status used for determining the advance payment of the credit.

(4) disallowance of deduction.—Section 280C of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

(g) credit for health insurance premiums.—No deduction shall be allowed for the portion of the premiums paid by the taxpayer for coverage of 1 or more individuals under a qualified health plan which is equal to the amount of the credit determined for the taxable year under section 36B(a) with respect to such premiums.

(c) study on affordable coverage.—

(1) STUDY AND REPORT.—(A) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Commissioner General shall conduct a study on the affordability of health insurance coverage, including—

(i) the impact of the tax credit for qualified health insurance coverage of individuals under section 36B of the Internal Revenue Code of 1986 and the tax credit for employer-provided health insurance expenses of small employers under section 45R of such Code on maintaining and expanding the health insurance coverage of individuals;

(ii) the availability of affordable health benefits plans, including a study of whether the percentage of household income used for the purposes of subsection (c) of the Internal Revenue Code of 1986 (as added by this section) is the appropriate level for determining whether employer-provided coverage is affordable for an individual and whether such level may be lowered without significantly increasing the costs to the Federal Government and reducing employer-provided coverage; and

(iii) the ability of individuals to maintain essential health benefits coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986).

(B) report.—The Commissioner General shall submit to the appropriate committees of Congress a report under subparagraph (A), together with legislative recommendations relating to the matters studied under such subparagraph.

(2) appropriate committeeS.—In this subsection, the term ‘appropriate committees of Congress’ means the Committee on Finance and the Committee on Health, Education, Labor and Pensions of the Senate, and the Committee on Education and Labor, and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance and the Committee on Health, Education, Labor and Pensions of the Senate.

(d) conforming amendments.—

(1) paragraph (2) of section 321(b) of title 31, United States Code, is amended by inserting—

(36B, after ‘36A’.

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 36A the following new item:

‘Sec. 36B. Refundable credit for coverage under a qualified health plan.’.

(e) effective date.—The amendments made by this section shall apply to taxable years ending after December 31, 2013.

SEC. 1402. REDUCED COST-SHARING FOR INDIVIDUALS ENROLLING IN QUALIFIED HEALTH PLANS.

(a) in general.—In the case of an eligible insured enrolled in a qualified health plan—

(i) the Secretary shall notify the issuer of the plan of such eligibility; and

(ii) the issuer shall reduce the cost-sharing under the plan at the level and in the manner specified in subsection (b).

(b) eligible insured.—In this section, the term ‘eligible insured’ means an individual—

who enrolls in a qualified health plan in the silver level of coverage in the individual market offered through an Exchange; and
(2) whose household income exceeds 100 percent but does not exceed 400 percent of the poverty line for a family of the size involved.

In the case of an individual described in section 36B(c)(1)(B) of the Internal Revenue Code of 1986, the individual shall be treated as having household income equal to 100 percent for purposes of applying this section.

(c) TERMINATION OF REDUCTION IN COST-SHARING.—

(1) REDUCTION IN OUT-OF-POCKET LIMIT.—

(A) IN GENERAL.—The reduction in cost-sharing subsection shall be achieved by reducing the applicable out-of-pocket limit under section 1302(c)(1) in the case of—

(i) an eligible insured whose household income is more than 100 percent but not more than 200 percent of the poverty line for a family of the size involved, by one-half; and

(ii) an eligible insured whose household income is more than 300 percent but not more than 400 percent of the poverty line for a family of the size involved, by one-third.

(B) COORDINATION WITH ACTUARIAL VALUE LIMITS.—

(i) IN GENERAL.—The Secretary shall ensure that the out-of-pocket limit under this paragraph shall not result in an increase in the plan’s share of the total allowed costs of benefits provided under the plan above—

(1) 90 percent in the case of an eligible insured described in paragraph (2)(A);

(II) 80 percent in the case of an eligible insured described in paragraph (2)(B); and

(III) 70 percent in the case of an eligible insured described in clause (1) or (II) of subparagraph (A).

(ii) ADJUSTMENT.—The Secretary shall adjust the out-of-pocket limits under paragraph (1) if necessary to ensure that such limits do not cause the respective actuarial values to exceed the levels specified in clause (i).

(2) ADDITIONAL REDUCTION FOR LOWER INCOME INSURED.—The Secretary shall establish procedures under which the issuer of a qualified health plan may elect to which the plan applies shall further reduce cost-sharing under the plan in a manner sufficient to—

(A) in the case of an eligible insured whose household income is less than 100 percent but not more than 150 percent of the poverty line for a family of the size involved, increase the plan’s share of the total allowed costs of benefits provided under the plan to 90 percent of such costs; and

(B) in the case of an eligible insured whose household income is more than 150 percent but not more than 200 percent of the poverty line for a family of the size involved, increase the plan’s share of the total allowed costs of benefits provided under the plan to 80 percent of such costs.

(3) METHODS FOR REDUCING COST-SHARING.—

(A) IN GENERAL.—An issuer of a qualified health plan making reductions under this subsection shall not be required to reduce the plan’s share of the total allowed costs of benefits provided by the Secretary of such reductions and the Secretary shall make periodic and timely payments to the issuer equal to the value of the reductions.

(B) TIMES OF INVOICING.—The Secretary may establish a captivated payment system to carry out the payment of cost-sharing reductions under this subsection. Any such system shall reduce the burden on the Secretary of such reductions and make appropriate risk adjustments to such payments.

(4) ADDITIONAL BENEFITS.—If a qualified health plan provides additional benefits in addition to the essential health benefits required to be provided by the plan, or a State requires a qualified health plan under section 1311(d)(3)(B) to cover benefits in addition to the essential health benefits required to be provided by the plan, the reductions in cost-sharing under this section shall not apply to such additional benefits.

(5) SPECIAL RULE FOR PEDIATRIC DENTAL PLANS.—If an individual enrolls in both a qualified health plan described in section 1311(d)(2)(B)(i)(I) for any plan year, subsection (a) shall not apply to that portion of any reduction in cost-sharing under subsection (a) that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J).

(d) SPECIAL RULES FOR INDIANS.—

(1) INDIVIDUAL RESPONSIBILITY TESTING FOR POVERTY.—If an individual enrolled in any qualified health plan in the individual market through an Exchange is an Indian (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d))) whose household income is more than 300 percent of the poverty line for a family of the size involved, then, for purposes of this section—

(A) such individual shall be treated as an eligible insured; and

(B) the issuer of the plan shall eliminate any cost-sharing under the plan.

(2) ITEMS OR SERVICES FURNISHED THROUGH INDIAN HEALTH PROVIDERS.—If an individual described in paragraph (A) is enrolled in a qualified health plan furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services—

(A) no cost-sharing under the plan shall be imposed under the plan for such item or service; and

(B) the issuer of the plan shall not reduce the payment to any such entity for such item or service by the amount of any cost-sharing that would be due from the Indian Tribe but for subparagraph (A).

(3) PAYMENT.—The Secretary shall pay to—

(A) an issuer of a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of this section;

(e) RULES FOR INDIVIDUALS NOT LAWFULLY PRESENT.—

(1) IN GENERAL.—If an individual who is an eligible insured; and

(B) for purposes of applying this section, the determination as to what percentage a taxpayer’s household income bears to the poverty level for a family of the size involved that is to be covered by the plan shall be made under one of the following methods:

(i) A method under which—

(1) the taxpayer’s family size is determined by not taking such individuals into account; and

(II) the taxpayer’s household income is equal to the product of the taxpayer’s household income (determined without regard to this subsection) and a fraction—

(aa) the numerator of which is the poverty line for the taxpayer’s family size determined without regard to subsection (a); and

(bb) the denominator of which is the poverty line for the taxpayer’s family size determined without regard to subsection (a).

(ii) A method having the same result as the method under clause (i).

(2) LAWFULLY PRESENT.—For purposes of sections 1311(d)(4)(B) and 5000A(e)(2); and

(4) whether to grant a certification under section 1412 and not the taxable year for which the credit under section 36B of such Code is allowed.

Subpart B—Eligibility Determinations

SEC. 1411. PROCEDURES FOR DETERMINING ELIGIBILITY FOR EXCHANGE PARTICIPATION, PREMIUM TAX CREDITS AND REDUCED COST-SHARING, AND INDIVIDUAL RESPONSIBILITY EXEMPTIONS.

(a) ESTABLISHMENT OF PROGRAM.—The Secretary shall establish a program meeting the requirements of this section for determining—

(1) whether an individual who is to be covered in the individual market by a qualified health plan offered through an Exchange, or who is claiming a premium tax credit or reduced cost-sharing, meets the requirements of title II and I of this title and section 36B(e) of the Internal Revenue Code of 1986 that the individual be a citizen or national of the United States or otherwise lawfully present in the United States;

(2) the case of an individual claiming a premium tax credit or reduced cost-sharing under section 36B of such Code or section 1402—

(A) whether the individual meets the income and coverage requirements of such sections; and

(B) the amount of the tax credit or reduced cost-sharing;

(3) whether an individual’s coverage under an employer-sponsored health benefits plan is treated as unaffordable under sections 36B(c)(2)(C) and 5000A(e)(2); and

(4) whether to grant a certification under section 1311(d)(4)(B) attesting that, for purposes of the individual responsibility requirement under section 5000A of the Internal Revenue Code of 1986, an individual is entitled to an exemption from either the individual responsibility requirement or the penalty imposed by such section.

(b) INFORMATION REQUIRED TO BE PROVIDED BY APPLICANTS.—

(1) IN GENERAL.—An applicant for enrollment in a qualified health plan offered through an Exchange in the individual market shall provide—

(A) the name, address, and date of birth of each individual who is to be covered by the
plan (in this subsection referred to as an ‘enrollee’); and
(B) the information required by any of the following paragraphs that is applicable to an enrollee.

(2) CITIZENSHIP OR IMMIGRATION STATUS.—
   The following information shall be provided with respect to every enrollee:
   (A) the name, address, and employer identification number (if available) of the enrollee; or
   (B) the Secretary, after consultation with the Secretary of Homeland Security, determines appropriate.

(3) ELIGIBILITY AND AMOUNT OF TAX CREDIT OR REDUCED COST-SHARING.—In the case of an enrollee with respect to whom a premium tax credit or reduced cost-sharing under section 36B of such Code or section 1402 is being claimed, the following information:
   (A) INFORMATION REGARDING INCOME AND FAMILY SIZE.—The information described in section 6103(l)(2) for the taxable year ending with or within the second calendar year preceding the calendar year in which the plan year begins.
   (B) CHANGES IN CIRCUMSTANCES.—The information described in section 1412(b)(2), including information with respect to individuals who were not required to file an income tax return for the taxable year described in subparagraph (A) or individuals who experienced changes in marital status or family size or significant change in income.

(4) EMPLOYER-SPONSORED COVERAGE.—In the case of an enrollee with respect to whom eligibility for a premium tax credit under section 36B of such Code or cost-sharing reduction under section 1402 is being established on the basis that the enrollee’s (or related individual’s) employer is not treated under section 36B(c)(2)(C) of such Code as providing minimum essential coverage or affordable minimum essential coverage, the following information:
   (A) the employer’s address and employer identification number (if available) of the employer.
   (B) Whether the enrollee or individual is a full-time employee and whether the employer provides such minimum essential coverage.
   (C) If the employer provides such minimum essential coverage, the lowest cost option for the enrollee’s or individual’s enrollment status and the enrollee’s or individual’s required contribution (within the meaning of section 5000A(e)(1)(B) of such Code) under the employer-sponsored plan.
   (D) If an enrollee claims an employer’s minimum essential coverage is unaffordable, the information described in paragraph (3).

If an enrollee changes employment or obtains additional employment while enrolled in a qualified health plan for which such credit or reduction is allowed, the enrollee shall notify the Exchange of such change or additional employment and provide the information described in this paragraph with respect to the new employer.

(5) EXEMPTIONS FROM INDIVIDUAL RESPONSIBILITIES REQUIREMENTS.—In the case of an individual who is seeking an exemption certification under subsection (b)(4)(H) from the requirement or penalty imposed by section 5000A, the following information:
   (A) In the case of an individual seeking exemption based on the lack of affordable coverage, the information described in paragraphs (3) and (4), as applicable.
   (C) VERIFICATION OF INFORMATION CONTAINED IN RECORDS OF SPECIFIC FEDERAL OFFICIALS.—
      (1) INFORMATION TRANSFERRED TO SECRETARY.—An Exchange shall submit the information provided by an applicant under subsection (a)(2) for verification in accordance with the requirements of this subsection and subsection (d).
      (A) COMMISSIONER OF SOCIAL SECURITY.—The Secretary shall submit to the Commissioner of Social Security the following information for a determination as to whether the information provided is consistent with the information in the records of the Commissioner:
         (i) The name, date of birth, and social security number of the individual for whom such information was provided under subsection (b)(2).
         (ii) The attestation of an individual that the individual is a citizen.
      (B) SECRETARY OF HOMELAND SECURITY.—
         (i) IN GENERAL.—In the case of an individual:
            (I) who attests the individual is an alien lawfully present in the United States; or
            (II) who attests the individual is a citizen but with respect to whom the Commissioner of Social Security has notified the Secretary under subsection (e)(3) that the attestation is inconsistent with information in the records maintained by the Commissioner;
         the Secretary shall submit to the Secretary of Homeland Security the information described in clause (ii) for a determination as to whether the information provided is consistent with the information in the records of the Secretary of Homeland Security.
         (ii) INFORMATION.—The information described in clause (i) is the following:
            (I) The name, date of birth, and any identifying information with respect to the individual’s immigration status provided under subsection (b)(2).
            (II) The attestation that the individual is an alien lawfully present in the United States or in the case of an individual described in clause (i)(II), the attestation that the individual is a citizen.
      (3) ELIGIBILITY FOR TAX CREDIT AND COST-SHARING REDUCTION.—The Secretary shall submit the information described in subsection (b)(3)(A) provided under paragraph (3), (4), or (5) of subsection (b) to the Secretary of Homeland Security and establish by regulation the methodology for determining of household income and family size for purposes of eligibility.

(6) METHODS.—
   (A) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall provide that verifications and determinations under this subsection shall be done:
      (i) by determining the consistency of the information submitted with the information maintained in the records of the Secretary of the Treasury, the Secretary of Homeland Security, or the Commissioner of Social Security through such other method as is approved by the Secretary.
   (B) ACTIONS RELATING TO VERIFICATION.—
      (1) EXEMPTION FROM INDIVIDUAL RESPONSIBILITY.—
         (i) Pursuant to this section the Secretary shall submit to the Secretary of Social Security or Secretary of Homeland Security, whichever is applicable, the results of its verification and the Secretary shall notify the Exchange of such results. Each person to whom the Secretary should report in such manner as the Secretary determines appropriate.
      (2) VERIFICATION.—
         (A) ELIGIBILITY FOR ENROLLMENT AND PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.—If information provided by an applicant under subsections (1), (2), (3), and (4) of subsection (b) is verified under subsections (c) and (d): (i) the individual’s eligibility to enroll through the Exchange and to apply for premium tax credits and cost-sharing reductions shall be satisfied; and
         (ii) the Secretary shall, if applicable, notify the Secretary of the Treasury under section 6103 of the Internal Revenue Code of 1986 with respect to the confidentiality, disclosure, maintenance, or use of information will be met.
         (B) EXEMPTION FROM INDIVIDUAL RESPONSIBILITY.—If information provided by an applicant under subsections (1), (2), (3), and (4) of this section is verified under subsections (c) and (d), the Secretary shall issue the certification of exemption described in section 1311(d)(4)(H).

(7) INCONSISTENCIES INVOLVING ATTESTATION OF CITIZENSHIP OR LAWFUL PRESENCE.—If the information provided by any applicant under subsection (b)(2) is inconsistent with information in the records maintained by the Commissioner of Social Security or Secretary of Homeland Security, whichever is applicable, the applicant’s eligibility will be determined in the same manner as an individual’s eligibility under the medicare program is determined under section 1902(ee) of the Social Security Act (as in effect on January 1, 2010).

(8) INCONSISTENCIES INVOLVING OTHER INFORMATIONS.—
   (A) IN GENERAL.—If the information provided by an applicant under subsection (b)(2) is inconsistent with information in the records maintained by persons under subsection (c) is not required under subsection (b), the Secretary shall notify the Exchange and the Exchange shall take the following actions:
(1) Reasonable effort.—The Exchange shall make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors. The Exchange shall notify the person to confirm the accuracy of the information, and by taking such additional actions as the Secretary, through regulation or other guidance, may prescribe.

(2) Notice and Opportunity to Correct.—In the case the inconsistency or inability to verify is not resolved under subparagraph (A), the Exchange shall—

(I) notify the applicant of such fact;

(II) provide the applicant an opportunity to either present satisfactory documentary evidence to resolve the inconsistency with the person verifying the information under subsection (c) or (d) during the 90-day period beginning the date on which the notice required under subclause (I) is sent to the applicant.

The Secretary may extend the 90-day period under clause (II) for enrollments occurring during 2014.

(B) Specific Actions Not Involving Citizenship or Lawful Presence.—

(I) In General.—Except as provided in paragraph (3), the Exchange shall, during any part of the close of the period under subparagraph (A)(i)(II), make any determination under paragraphs (2), (3), and (4) of subsection (b) before the information contained on the application.

(ii) Eligibility or Amount of Credit or Reduction.—If an inconsistency involving the employer is not resolved as of the close of the period under subparagraph (A)(i)(II), the Exchange shall notify the applicant of the amount (if any) of the credit or reduction that is determined to be the extent allowable by law. Such process shall be in addition to any rights of appeal the employer may have under subtitie F of such Code.

(ii) Confidentiality.—Notwithstanding any provision of this title (or the amendments made by this title) or section 6103 of the Internal Revenue Code of 1986, an employer shall not receive any taxpayer return information with respect to an employee for purposes of determining whether the employer is subject to the penalty under section 4980H of the Internal Revenue Code of 1986 with respect to the employee, except that—

(I) the employer may be notified as to the name of an employee and whether or not the employee’s income is above or below the threshold by which the affordability of an employer’s health insurance coverage is measured; and

(ii) such other determinations made by this title and section 4980H of the Internal Revenue Code of 1986 as added by section 1513) that the following rights are protected:

(A) the right of an individual to request the confidentiality of their taxpayer return information and their right to make a claim for the premium tax credit allowable for the amount of the credit or reduction.

(B) Confidentiality of Applicant Information.—In general, the Exchange shall establish a program under which—

(i) confidentiality of applicant information provided by an applicant who provides a waiver (at such time and in such manner as the Secretary may prescribe) shall be maintained by the employer holding such information.

(ii) a plan participant or participant’s employer who receives information provided by an applicant may disclose such information only to the extent necessary in, and to the extent necessary in, the efficient operation of the Exchange.

(iii) Employer Affordability.—In general, the Exchange shall notify the applicant of the amount of the credit or reduction that is determined to be the extent allowable by law. Such process shall be in addition to any rights of appeal the employer may have under subtitie F of such Code.

(C) Employer Affordability.—In general, the Exchange shall notify the applicant of the amount of the credit or reduction that is determined to be the extent allowable by law. Such process shall be in addition to any rights of appeal the employer may have under subtitie F of such Code.

(D) Exchange Assistance.—In general, the Exchange shall establish a separate appeals process for employees who are notified under subsection (e)(4)(C) that the employer may be liable for a tax imposed by section 4980H of the Internal Revenue Code of 1986 with respect to an employee for purposes of this subparagraph, the terms “negligence” and “disregard” shall have the same meanings as when used in section 6662 of the Internal Revenue Code of 1986.

(E) Exchange Assistance.—In general, the Exchange shall—

(I) provide the applicant an opportunity to verify the information contained on the application;

(II) provide the applicant an opportunity to either present satisfactory documentary evidence to resolve the inconsistency with the person verifying the information under subsection (c) or (d) during the 90-day period beginning the date on which the notice required under subclause (I) is sent to the applicant.

(II) Knowledge and Willful Violations.—Any person who knowingly and willfully provides false or fraudulent information under this title and section 4980H of the Internal Revenue Code of 1986 shall be subject to subsection (c) or (d), in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $25,000.

(III) Improper Use or Disclosure of Information.—Any person who negligently or willfully uses or discloses information in violation of subsection (c) or (d), in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $25,000.

(II) Limitations on Liens and Levies.—The Secretary (or, at the request of the Exchange, to a civil penalty of not more than $25,000.2

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(II) Improper Use or Disclosure of Information.—Any person who negligently or willfully uses or discloses information in violation of subsection (c) or (d), in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than $25,000.
(i) the employer did not provide minimum essential coverage; or
(ii) the employer provided such minimum essential coverage but it was determined under subsection (b) of such Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(3) the Secretary of the Treasury makes advance payments of such credit or reductions to the issuers of the qualified health plans in order to reduce, premiums payable by the employer for such credit.

(b) ADVANCE DETERMINATIONS.—

(1) IN GENERAL.—The Secretary shall provide procedures for making advance determinations on the basis of information other than that described in paragraph (1) of subparagraph (A) in cases where information included with an application form demonstrates significant changes in family size or other household circumstances, change in filing status, the filing of an application for unemployment benefits, or other significant changes affecting eligibility, including—

(A) allowing an individual claiming a decrease of 20 percent or more in income, or filing an application for unemployment benefits, to have eligibility for the credit determined on the basis of household income for a later period or on the basis of the individual’s estimate of such income for the taxable year; and

(B) the determination of household income in cases where the taxpayer was not required to file a return of tax imposed by this chapter for the second preceding taxable year.

(c) PAYMENT OF PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS.—

(1) IN GENERAL.—The Secretary shall notify the Secretary of the Treasury and the Exchange through which the individual is enrolling of the advance determination under section 1411.

(2) PREMIUM TAX CREDIT.—

(A) IN GENERAL.—The Secretary shall develop and provide to each State a single, streamlined form that—

(i) may be used to apply for all applicable State health subsidy programs within the State;

(ii) may be filed online, in person, by mail, or by telephone;

(iii) may be filed with an Exchange or with State officials operating one of the other applicable State health subsidy programs, in, and continue participation in, applicable State health subsidy programs.

(B) STATE AUTHORITY TO ESTABLISH FORM.—A State may develop and use its own single, streamlined form that—

(i) is consistent with standards promulgated by the Secretary under this section;

(ii) is structured to maximize an applicant’s ability to complete the form satisfactorily, taking into account the characteristics of individuals eligible for applicable State health subsidy programs.

(C) SUPPLEMENTAL ELIGIBILITY FORMS.—The Secretary may allow a State to use a supplemental or alternative form in the case of individuals who apply for eligibility that is not determined on the basis of the household income (as defined in section 36B of the Internal Revenue Code of 1986).

(D) ADMINISTRATIVE AUTHORITY.—

(A) AGREEMENTS.—Subject to section 1411 and section 6101(1)(21) of the Internal Revenue Code of 1986 and any other requirement provided by applicable State health subsidy programs, promulgate standards governing the timing, contents, and procedures for data matching described in this subsection. Such standards shall take into account administrative and other costs and the value of data matching to the establishment, verification, and updating of eligibility for applicable State health subsidy programs.

(B) BASED ON DATA EXCHANGES.—

(1) DEVELOPMENT OF SECURE INTERFACE.—Each State shall develop for all applicable State health subsidy programs a secure, electronic interface allowing an exchange of data (including information contained in the application forms described in subsection (b) that allows a determination of eligibility and participation in programs based on a single application. Such interface shall be compatible with the method established for data verification under section 1411(c)(4).

(2) DATA MATCHING PROGRAM.—Each applicable State health subsidy program shall participate in a data matching arrangement for determining eligibility for participation in the program under paragraph (3) that—

(A) provides access to data described in paragraph (3); and

(B) applies only to individuals who—

(i) receive assistance through applicable State health subsidy programs; or

(ii) apply for such assistance—

(1) by filing a form described in subsection (b); and

(2) by requesting a determination of eligibility and authorizing disclosure of the information described in paragraph (3) to applicable State health subsidy programs.

(3) DETERMINATION OF ELIGIBILITY.—

(A) IN GENERAL.—Each applicable State health subsidy program shall, to the maximum extent practicable—

(i) establish, verify, and update eligibility for participation in the program using the data matching arrangement under paragraph (2); and

(ii) determine such eligibility on the basis of reliable, third party data, including information described in sections 1137, 453(I), and 1942(a) of the Social Security Act, obtained through such arrangements.

(B) EXCEPTION.—This paragraph shall not apply in circumstances with respect to which the Secretary determines that the administrative and other costs of the data matching arrangement under paragraph (2) outweigh its expected gains in accuracy, efficiency, and program participation.

(4) SECRETARIAL STANDARDS.—The Secretary shall, after consultation with persons in possession of the data to be matched and representatives of applicable State health subsidy programs, promulgate standards governing the timing, contents, and procedures for data matching described in this subsection. Such standards shall take into account administrative and other costs and the value of data matching to the establishment, verification, and updating of eligibility for applicable State health subsidy programs.

(d) ADMINISTRATIVE AUTHORITY.—

(A) AGREEMENTS.—
(A) prohibit contractual arrangements through which a State Medicaid agency determines eligibility for all applicable State health subsidy programs, but only if such agreements with the Secretary of Health and Human Services require ensuring reduced administrative costs, eligibility errors, and disruptions in coverage; and

(b) require any requirement under title XIX that eligibility for participation in a State’s Medicaid program must be determined by a publicly accountable agency.

c) APPLICABLE STATE HEALTH SUBSIDY PROGRAM.—In this section, the term ‘applicable State health subsidy program’ means —

(1) the program under this title for the enrollment in qualified health plans offered through an Exchange, including the premium tax credit under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402;

(2) a State Medicaid program under title XIX of such Act; and

(3) a State children’s health insurance program (CHIP) under title XXI of such Act; and

(4) a State program under section 1331 established as a basic health plan.

SEC. 1414. DISCLOSURES TO CARRY OUT ELIGIBILITY REQUIREMENTS FOR CERTAIN PROGRAMS.

(a) DISCLOSURE OF TAXPAYER RETURN INFORMATION AND SOCIAL SECURITY NUMBERS.—(1) TAXPAYER RETURN INFORMATION.—Such section (1) of section 6103 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 Eligibility Requirements for Certain Programs.—

‘‘(A) IN GENERAL.—The Secretary, upon written request from the Secretary of Health and Human Services, shall disclose to officers, employees, and contractors of the Department of Health and Human Services responsible for the administration of the Program, any taxpayer information relevant in determining any premium tax credit under section 36B or any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act or eligibility for participation in a State Medicaid program under title XIX of the Social Security Act, a State’s children’s health insurance program under title XXI of the Social Security Act, or a basic health program under section 1331 of the Patient Protection and Affordable Care 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 number of individuals from whom a deduction is allowed under section 151 with respect to the taxpayer (including the taxpayer) and the taxpayer’s spouse,

‘‘(iv) the modified gross income as defined in section 36B of such taxpayer and each of the other individuals included under clause (iii) who are required to file a return of tax imposed by chapter 1 for the taxable year,

‘‘(v) such other information as is prescribed by the Secretary by regulation as might indicate whether the taxpayer is eligible for such credit or reduction (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) INFORMATION TO EXCHANGE AND STATE AGENCIES.—The Secretary of Health and Human Services, upon written request from the Secretary of Labor, shall disclose to an Exchange established under the Patient Protection and Affordable Care Act or its contractors, or to a State agency administering a State program under such clause (i) or (ii), any information relating to business-related credits and eligibility for participation in such program. For purposes of paragraph (1)(A), or (B) may be used by the Secretary of Labor, such information relating to business-related credits and eligibility for participation in such program may be used by Federal, State, or local government agencies, and by officers, employees, and contractors of such agencies, to determine eligibility for such program or, at the request of such agencies, to provide guidance as necessary to determine eligibility for such program. The Secretary shall establish procedures to ensure that such information is obtained and used in accordance with applicable Federal, State, and local laws. The Secretary shall not disclose such information to any entity for purposes of conducting an audit of a claim or an audit of a tax return.’’

(b) CONFIDENTIALITY AND DISCLOSURE.—(1) TAxPAYER RETURN INFORMATION.—Subparagraph (4) of section 6102(a)(1) of the Internal Revenue Code of 1986 is amended by striking ‘‘or (20)’’ and inserting ‘‘or (20), (21)’’.

(c) PROCEDURES AND RECORDKEEPING RELATED TO DISCLOSURES.—(1) Such amount multiplied by a fraction the numerator of which is the total number of full-time equivalent employees of the employer in excess of 10 and the denominator of which is 15.

(2) Such amount multiplied by a fraction the numerator of which is the average annual wages of the employer in excess of the dollar amount in effect under subsection (b) and the denominator of which is $29,000.

(d) ELIGIBLE SMALL EMPLOYER.—For purposes of this section—

‘‘(1) ‘eligible small employer’ means, with respect to any taxable year, an employer—

‘‘(A) which has no more than 25 full-time equivalent employees for the taxable year,

‘‘(B) the average annual wages of which do not exceed the dollar amount in effect under subsection (b) for the taxable year, and

‘‘(C) which has in effect an arrangement described in paragraph (4).

‘‘(2) ‘full-time equivalent employees’—

‘‘(A) in general.—The term ‘full-time equivalent employees’ means a number of employees equal to the number determined by dividing—

‘‘(i) the total number of hours of service for which wages were paid by the employer to employees during the taxable year, by

‘‘(ii) the number of hours of service, as determined in accordance with paragraph (3), that would be worked during the same year by full-time employees.

‘‘(B) excess hours not counted.—If an eligible small employer wishes to use the number of hours of service during any taxable year, such excess shall not be taken into account under subparagraph (A).

‘‘(C) hours of service.—The Secretary, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the number of hours of service, including rules for the application of this paragraph to employees who are not compensated on an hourly basis.

‘‘(D) average annual wages.—

‘‘(i) IN GENERAL.—The average annual wages of an eligible small employer for any
taxable year is the amount determined by dividing—

"(i) the aggregate amount of wages which were paid by the employer to employees during the taxable year, by

"(ii) the number of full-time equivalent employees of the employee determined under paragraph (2) for the taxable year.

Such amount shall be rounded to the next lower multiple of $1,000 if not otherwise such a multiple.

"(B) DOLLAR AMOUNT.—For purposes of paragraph (1)(B),

"(i) in 2011, 2012, and 2013, the dollar amount in effect under this paragraph for taxable years beginning in 2011, 2012, or 2013 is $20,000.

"(ii) Subsequent years.—In the case of a taxable year beginning in a calendar year after 2013, the dollar amount in effect under this paragraph shall be equal to $20,000, multiplied by the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting ‘calendar year 2012’ for ‘calendar year 1992’ in subparagraph (B) thereof.

"(C) CONTRIBUTION ARRANGEMENT.—An arrangement is described in this paragraph if it requires an eligible small employer to make a non-elective contribution on behalf of each employee who enrolls in a qualified health plan and requires an eligible small employer to make a non-elective contribution on behalf of each employee determined under this paragraph with respect to such employer, or

"(D) THE AMOUNT OF THE PREMIUM TAKES OF THE EMPLOYER.—For purposes of this subsection—

"(A) IN GENERAL.—The number of hours of service performed by an employee during the calendar year in which the taxable year begins is the number of hours of service performed by the employee during the calendar year in which the employee rendered services. The term 'calendar year' means, with respect to any eligible small employer, the period beginning with the 1st taxable year in which the employer participates therein, and ending with the last taxable year in which the employer participates therein (as determined under section 152(d)(2) to, or is a de minimis limitation contained in such section).

"(B) AGGREGATION AND OTHER RULES MADE APPLICABLE.—

"(1) AGGREGATION RULES.—All employers treated as a single employer under sections 280C, 416(i)(1)(A)(i), and (m), or (o) of section 414 shall be treated as a single employer for purposes of this section.

"(2) OTHER RULES.—Rules similar to the rules of subsections (c), (d), and (e) of section 52 shall apply.

"(E) CREDIT MADE AVAILABLE TO TAX-EXEMPT ELIGIBLE SMALL EMPLOYERS.—

"(A) IN GENERAL.—In the case of a tax-exempt eligible small employer, there shall be treated as a credit allowable under subparagraph C (and not allowable under this subpart) the larger of—

"(i) the amount of the credit determined under this section with respect to such employer, or

"(ii) the amount of the payroll taxes of the employer during the calendar year in which the taxable year begins.

"(B) TAX-EXEMPT ELIGIBLE SMALL EMPLOYERS.—

"(i) an employee within the meaning of section 410(c)(1),

"(ii) the number of full-time equivalent employees of the employer under section 3111(b), and

"(iii) the aggregate amount of wages which the employer, or

"(C) PAYROLL TAXES.—For purposes of this subsection—

"(A) IN GENERAL.—The term 'payroll taxes' means—

"(i) amounts required to be withheld from the wages of the tax-exempt eligible small employer, which is exempt from tax under section 501(a),

"(ii) the amount of taxes imposed on the tax-exempt eligible small employer under section 3111(b).

"(D) SPECIAL RULE.—A rule similar to the rule of section 26(d)(2)(C) shall apply for purposes of subparagraph (A).

"(E) APPLICATION OF SECTION FOR CALENDAR YEARS 2011, 2012, AND 2013.—In the case of any taxable year beginning in 2011, 2012, or 2013, the following modifications to this section shall apply in determining the amount of the credit under subsection (a):

"(1) NO CREDIT PERIOD REQUIRED.—The credit shall be determined without regard to whether the taxable year is in a credit period and for purposes of applying this section to taxable years beginning after 2012, no credit period shall be treated as beginning with a taxable year beginning before 2014.

"(2) AMOUNT OF CREDIT.—The amount of the credit determined under subsection (b) shall be determined—

"(A) by substituting '35 percent (25 percent in the case of a tax-exempt eligible small employer)' for '30 percent (25 percent in the case of a tax-exempt eligible small employer)' in the numerator of formula (3) for section 3401(a),

"(B) by reference to an eligible small employer's nonelective contributions for premiums paid for health insurance coverage (within the meaning of section 9832(b)(1)(b) of an employee, and

"(C) by substituting for the average premium determined under subsection (b)(2) the amount the Secretary of Health and Human Services determines is the average premium for health insurance coverage for the employee, and

"(D) by substituting for the average premium determined under subsection (b)(2) the amount the Secretary of Health and Human Services determines is the average premium for health insurance coverage in each State in which the employer is offering health insurance coverage (or for such area within the State as is specified by the Secretary).

"(E) AN ARRANGEMENT.—An arrangement shall not fail to meet the requirements of subsection (d)(4) solely because it provides for the offering of insurance outside of an Exchange.

"(B) INSURANCE DEFINITIONS.—Any term used in this section which is also used in the Public Health Service Act or subtitle A of title I of the Patient Protection and Affordable Care Act shall have the meaning given such term by such Act or subtitle.

"(C) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations to prevent the avoidance of the 2-year limit on the credit period through the use of successor entities and the avoidance of the limitations under section (c) through the use of multiple entities.

"(D) CREDIT TO BE PART OF GENERAL BUSINESS CREDIT.—Section 38(b) of the Internal Revenue Code of 1986 (relating to current year business credit) is amended by striking ‘plus’ at the end of paragraph (34), by striking the period at the end of paragraph (35) and inserting ‘‘, plus’’, and by inserting after paragraph (35) the following:

"the small employer health insurance credit determined under section 45R,

"(E) CREDIT ALLOWED AGAINST ALTERNATIVE MINIMUM TAX.—Section 38(c)(4)(B) of the Internal Revenue Code of 1986 (defining specified credits) is amended by redesignating clauses (vi), (vii), (viii), and (ix), respectively, and by inserting after clause (v) the following new clause:

"(vi) the credit determined under section 45R,

"(F) DISALLOWANCE OF DEDUCTION FOR CERTAIN EXPENSES FOR WHICH CREDIT ALLOWED.—

"(1) IN GENERAL.—Section 280C of the Internal Revenue Code of 1986 (relating to disallowance of deduction for certain expenses for which credit allowed) is amended by adding at the end of the following new subsection:

"(B) CREDIT FOR EMPLOYEE HEALTH INSURANCE EXPENSES OF SMALL EMPLOYERS.—No deduction shall be allowed for that portion of the premiums for qualified health plans (as defined in section 3301(a) of the Patient Protection and Affordable Care Act), or for health insurance coverage in the case of taxable years beginning in 2011, 2012, or 2013, paid by an employer which is equal to the amount of the credit allowable under section 45R(a) with respect to the premiums.

"(2) DEDUCTION FOR EXPIRING CREDITS.—Section 196(c) of such Code is amended by striking ‘and’ at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting ‘‘, and’’, and by adding at the end the following new paragraph:

"(14) the small employer health insurance credit determined under section 45R(a),

"(G) CLERICAL AMENDMENT.—The table of sections for subpart D of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

"Sec. 45R. Employee health insurance expenses of small employers.''.

"(H) EFFECTIVE DATES.—

"(1) IN GENERAL.—The amendments made by this section shall apply to amounts paid or incurred in taxable years beginning after December 31, 2010.

"(2) MINIMUM TAX.—The amendments made by subsection (c) shall apply to credits determined under section 45R of the Internal Revenue Code of 1986 in taxable years beginning after December 31, 2010, and to carrybacks of such credits.
Subtitle F—Shared Responsibility for Health Care
PART I—INDIVIDUAL RESPONSIBILITY
SEC. 1501. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

(a) Findings.—Congress makes the following findings:

(I) IN GENERAL.—The individual responsibility requirement provided for in this section (as defined in §2709D of title 26, referred to as the "requirement") is commercial and economic in nature, and substantially affects interstate commerce, as a result of the effects described in paragraph (2).

(II) EFFECTS ON THE NATIONAL ECONOMY AND INTERSTATE COMMERCE.—The effects described in this paragraph are the following:

(A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when and how health insurance is purchased.

(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from $2,500,000,000,000 in 2010 to $3,000,000,000,000 in 2019. Private health insurance spending is projected to increase from $784,000,000,000 in 2010 to $854,000,000,000 in 2019 and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is paid by national or international health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services. According to the Congressional Budget Office, the requirement will increase the number and share of Americans who are insured.

(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers 176,000,000 Americans nationwide. In Massachusetts, a similar requirement has been in place for 5 years, and when health care is paid for, and when health insurance is purchased.

(E) Half of all personal bankruptcies are caused by medical expenses. By significantly increasing health insurance coverage and the size of purchasing pools, which in turn reduces the risk pool, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

(F) SUPREME COURT RULING.—In United States v. South-Eastern Underwriters Association (322 U.S. 533 (1944)), the Supreme Court of the United States held that insurance is interstate commerce subject to Federal regulation.

(b) In General.—Subtitle D of the Internal Revenue Code of 1986 is amended by adding at the end the following new chapter:

CHAPTER 48—MAINTENANCE OF MINIMUM ESSENTIAL COVERAGE

Sec. 5000A. Requirement to maintain minimum essential coverage.

Sec. 5000A. REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.

(a) REQUIREMENT TO MAINTAIN MINIMUM ESSENTIAL COVERAGE.—Applicable individuals shall for each year beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, has minimum essential coverage for such year.

(b) Shared Responsibility Payment.—

(1) IN GENERAL.—If an applicable individual fails to meet the requirement of subsection (a) for 1 or more months during any calendar year beginning after 2013, then, except as provided in subsection (c), there is hereby imposed a penalty with respect to the individual in the amount determined under subsection (c).

(1) INCLUSION WITH RETURN.—Any penalty imposed by this section with respect to any month shall be included with a taxpayer's return under chapter 1 for the taxable year which includes such month.

(2) PAYMENT OF PENALTY.—If an individual with respect to whom a penalty is imposed by this section for any month—

(A) A dependent (as defined in section 152) of another taxpayer for the other taxpayer's taxable year during such month, such other taxpayer shall be liable for such penalty.

(B) file a joint return for the taxable year including such month, such individual and the spouse of such individual shall be jointly liable for such penalty.

(c) AMOUNT OF PENALTY.—

(1) IN GENERAL.—The penalty determined under this subsection for any month with respect to any individual is an amount equal to 1/12 of the applicable dollar amount for the calendar year.

(2) DOLLAR LIMITATION.—The amount of the penalty under subsection (a) for any taxable year with respect to all individuals for whom the taxpayer is liable under subsection (b)(3) shall not exceed an amount equal to 300 percent of the applicable dollar amount (determined without regard to paragraph (3)(C) for the calendar year with or within which the taxable year ends.

(3) APPLICABLE DOLLAR AMOUNT.—For purposes of paragraph (1)—

(A) IN GENERAL.—Except as provided in subparagraph (B) and (C), the applicable dollar amount is $750.

(B) PHASE IN.—The applicable dollar amount is $85 for 2014 and $350 for 2015.

(C) Special rule for individuals under age 18.—If an applicable individual has not attained the age of 18 as of the beginning of a month, the applicable dollar amount with respect to such individual for the month shall be equal to one-half of the applicable dollar amount for the calendar year in which the month occurs.

(d) Indexing of Amount.—In the case of any calendar year beginning after 2016, the applicable dollar amount shall be equal to $750 multiplied by the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting ‘calendar year 2015’ for ‘calendar year 1992’ in subparagraph (B) thereof.

(e) Amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the nearest lowest multiple of $50.

(f) Terms relating to income and families.—For purposes of this section—

(1) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deductions for personal exemptions) for the taxable year.

(2) HOUSEHOLD INCOME.—The term ‘household income' means, with respect to any taxpayer for any taxable year, an amount equal to the sum of—

(i) the modified gross income of the taxpayer, plus

(ii) the aggregate modified gross incomes of all other individuals who—

(I) were taken into account in determining the taxpayer’s family size under paragraph (1), and

(II) required to file a return of tax imposed by section 1 for the taxable year.

(3) MODIFIED GROSS INCOME.—The term ‘modified gross income' means gross income—

(i) decreased by the amount of any deduction allowable under section 1, 2, or 4, or 10, of section 62 (a), and

(ii) increased by the amount of interest received or accrued during the taxable year which is exempt from tax imposed by this chapter, and

(iii) determined without regard to sections 911, 912, and 933.

(g) Poverty Line.—

(1) IN GENERAL.—The term ‘poverty line' has the meaning given that term in section 211(c)(5) of the Social Security Act (42 U.S.C. 987(j)(5)).

(2) POVERTY LINE USED.—In the case of any taxable year ending with or within a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of such calendar year.

(d) Applicable Individual.—For purposes of this section—

(1) IN GENERAL.—The term ‘applicable individual' means, with respect to any month, any individual that is—

(I) required to file a return of tax imposed by section 1 for the taxable year, or

(II) a member of a recognized religious sect 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 such section.

(2) Religious Exemptions.—

(A) RELIGIOUS CONSCIENCE EXEMPTION.—Such term shall not include any individual for any month if such individual has in effect an exemption under section 1311(d)(4)(H) of the Patient Protection and Affordable Care Act (42 U.S.C. 18091(d)(4)(H)) that certifies that such individual is a member of a recognized religious sect 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 such section.

(B) Health Care Sharing Ministry.—

(1) IN GENERAL.—Such term shall not include any individual for any month if such individual is a member of a health care sharing ministry for the month.
“(1) HEALTH CARE SHARING MINISTRY.—The term ‘health care sharing ministry’ means an organization—

“(A) which is described in section 501(c)(3) and is exempt from taxation under section 501(a).

“(B) members of which share a common set of ethical or religious beliefs and share medical expenses among members without regard to the State in which a member resides or is employed,

“(C) members of which retain membership even after they develop a medical condition,

“(D) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

“(2) INDIVIDUALS NOT LAWFULLY PRESENT.—Such term shall not include an individual for any month if for the month the individual is not a citizen or national of the United States or an alien lawfully present in the United States.

“(3) INCARCERATED INDIVIDUALS.—Such term shall not include an individual for any month if the month the individual is incarcerated, other than incarceration pending the disposition of charges.

“(4) REQUIRED CONTRIBUTION.—For purposes of this section, the term ‘required contribution’ means—

“(A) for a calendar year, the tax-exempt portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage, or

“(B) for a calendar year, the tax-exempt portion of the annual premium which would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage.

“(5) MINIMUM ESSENTIAL COVERAGE.—For purposes of this section—

“(A) for purposes of title XIX of the Social Security Act, the term ‘minimum essential coverage’ means any of the following:—

“(i) the Medicare program under part A of title XVIII of the Social Security Act,

“(ii) the Medicaid program under title XIX of the Social Security Act,

“(iii) the Children’s Health Insurance Program under title XXI of the Social Security Act,

“(iv) the SCHIP program under title XXI of the Social Security Act,

“(v) the TRICARE for Life program,

“(vi) the health insurance program established under section 254(e) of title 14, United States Code (relating to Peace Corps volunteers),

“(B) the employer-sponsored plan described in subparagraph (B)(i) of paragraph (3) of subsection (a), the term ‘minimum essential coverage’ means any of the following:—

“(i) the health insurance plan or contract described in subparagraph (B)(i) of paragraph (3) of subsection (a) of this section, or

“(ii) the qualified health plan described in section 1412(b)(1)(B) of the Patient Protection and Affordable Care Act less than 100 percent of the poverty line for the size of the family involved (determined in the same manner as under subsection (b)(4)).

“(C) MEMBERS OF INDIAN TRIBES.—Any applicable individual for any month during which the individual is a member of an Indian tribe (as defined in section 45A(a)(6)).

“(4) MONTHS DURING SHORT COVERAGE GAPS.—

“(A) IN GENERAL.—For purposes of this section—

“(i) the length of a continuous period shall be determined without regard to the calendar years in which months in such period occur,

“(ii) if a continuous period is greater than 1 calendar year, the term ‘continuous period’ means any period of less than 12 months.

“(3) EXCEPTED BENEFITS NOT TREATED AS MINIMUM ESSENTIAL COVERAGE.—The term ‘minimum essential coverage’ shall not include health insurance coverage which consists of coverage of excepted benefits.

“(A) described in paragraph (1) of subsection (a) of section 2791(d)(8) of the Public Health Service Act; or

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

“(4) INDIVIDUALS RESIDING OUTSIDE UNITED STATES OR RESIDENTS OF TERRITORIES.—Any applicable individual shall be treated as having minimum essential coverage for any month—

“(A) if such month occurs during any period described in subparagraph (A) or (B) of section 981(d)(1) which is applicable to the individual, or

“(B) if such individual is a bona fide resident of any possession of the United States (as determined under section 997(a)) for such month.

“(5) INSURANCE-RELATED TERMS.—Any term used in this section which is also used in title I of the Patient Protection and Affordable Care Act shall have the same meaning and shall be used in such title.

“(6) ADMINISTRATION AND PROCEDURE.—

“(A) IN GENERAL.—The penalty provided by this section shall be paid upon notice and demand by the Secretary, and except as provided in paragraph (2), shall be assessed and collected in the same manner as an assessable penalty under subchapter C of chapter 68.

“(B) WAIVER OF CRIMINAL PENALTIES.—In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.

“(C) LIMITATIONS ON LIENS ANDLEVIES.—The Secretary shall not—

“(i) file notice of lien with respect to any property of a taxpayer by reason of any failure to pay the penalty imposed by this section,

“(ii) levy on any such property with respect to such failure.

“(7) CLERICAL AMENDMENT.—The table of chapters for subtitle C of the Internal Revenue Code of 1986 is amended by inserting after the table item relating to chapter 47 the following new item:

“Chapter 48—Maintenance of Minimum Essential Coverage.”.

“(e) EFFECTIVE DATE.—The amendments made by this section shall take effect beginning after December 31, 2013.
"Subpart D—Information Regarding Health Insurance Coverage"

"Sec. 6055. Reporting of health insurance coverage"

(a) IN GENERAL.—Every person who provides minimum essential coverage to an individual during a calendar year shall, at such time and in such manner as the Secretary may prescribe, make a return described in subsection (b).

(b) FORM AND MANNER OF RETURN.—

(1) IN GENERAL.—A return is described in this subsection if it—

(A) is in such form as the Secretary may prescribe, and

(B) contains—

(i) the name, address and TIN of the primary insured and the name and TIN of each other individual obtaining coverage under the policy;

(ii) the dates during which such individual was covered under minimum essential coverage during the calendar year;

(iii) in the case of minimum essential coverage which consists of health insurance coverage, information concerning—

(I) whether or not the coverage is a qualified health plan offered through an Exchange established and operating in the State; or

(II) in the case of a qualified health plan, the amount (if any) of any advance payment under section 1412 of the Patient Protection and Affordable Care Act, and

(2) Paragraph (2) of section 6724(d) of such Code is amended by striking "or" at the end of subparagraph (E)

(c) NOTIFICATION OF NONENROLLMENT.—Not later than June 30 of each year, the Secretary shall notify each individual who is required to return described in subsection (b), of information concerning—

(1) whether or not the coverage is a qualified health plan offered through an Exchange established and operating in the State; or

(2) in the case of a qualified health plan, the amount (if any) of any advance payment under section 1412 of the Patient Protection and Affordable Care Act of any cost-sharing reduction under section 1402 of such Act or of any premium tax credit under section 36B with respect to such coverage, and

(iv) such other information as the Secretary may require.

(d) INFORMATION RELATING TO EMPLOYER-PROVIDED COVERAGE.—If minimum essential coverage provided to an individual under subsection (a) consists of health insurance coverage of a health insurance issuer provided through a group health plan of an employer, a return described in this subsection shall include—

(A) the name, address, and employer identification number of the employer maintaining the plan,

(B) the portion of the premium (if any) required to be paid by such employer, and

(C) if the health insurance coverage is a qualified health plan in the small group market offered through an Exchange, such other information as the Secretary may require for administration of the credit under section 45R (relating to credit for employer health insurance expenses of small employers).

(e) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REPORTED.—

(1) IN GENERAL.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

(A) the name, address of the person required to make such return and the phone number of the information contact for such person, and

(B) such information required to be shown on the return with respect to such individual.

(2) TIME FOR FURNISHING STATEMENTS.—The written statement required under paragraph (1) shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

(d) COVERAGE PROVIDED BY GOVERNMENTAL UNITS.—In the case of coverage provided by any governmental unit or any agency or instrumentality thereof, the 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.

(e) MINIMUM ESSENTIAL COVERAGE.—For purposes of paragraph (1), the term ‘‘minimum essential coverage’’ has the meaning given such term by section 5000A(f)(2).

(f) ASSESSABLE PENALTIES.—

(1) Subparagraph (B) of section 6724(d) of the Internal Revenue Code of 1986 (relating to definitions) is amended by striking ‘‘or’’ at the end of the subheading ‘‘and’’ and by adding ‘‘and’’ as a separate entry next to the existing (c) and by inserting after clause (xxiii) the following new clause:

(xxiv) section 6055 (relating to returns relating to information regarding health insurance coverage), and

(2) Paragraph (2) of section 6724(d) of such Code is amended by striking ‘‘or’’ at the end of subparagraph (F), by striking the period at the end of subparagraph (F) and inserting ‘‘, or’’ and by inserting after subparagraph (F) the following new subparagraph:

(GG) section 6055(c) (relating to statements relating to information regarding health insurance coverage).

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to calendar years beginning after 2013.

PART II—EMPLOYER RESPONSIBILITIES

SEC. 1511. AUTOMATIC ENROLLMENT FOR EMPLOYEES OF LARGE EMPLOYERS.

The Fair Labor Standards Act of 1938 is amended by inserting after section 1824 (29 U.S.C. 218) the following:

"Sec. 18A. Automatic Enrollment for Employees of Large Employers.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 is amended by adding after section 5000A(f)(2), there is hereby imposed on the employer an assessable payment, in the amount specified in this paragraph, for each employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and

(b) ASSESSABLE PENALTIES.—

(1) If the employee purchases a qualified health plan through the Exchange, the employee will lose the employer contribution (if any) to any health benefits plan offered by the employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

(2) EFFECTIVE DATE.—Subsection (a) shall take effect with respect to employers in a State beginning on March 1, 2013.

SEC. 1513. SHARED RESPONSIBILITY FOR EMPLOYERS.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986 is amended by adding at the end the following:

"Sec. 4980H. Shared Responsibility for Employers Regarding Health Coverage.

(a) Large Employers Not Offering Health Coverage.—If—

(1) any applicable large employer fails to offer to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) for any month, and

(2) at least one full-time employee of the applicable large employer has been certified by the employer to the employer under section 1411 of the Patient Protection and Affordable Care Act as having enrolled for such month in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the employee, then there is hereby imposed on the employer an assessable payment equal to the product of—

(A) the applicable minimum essential coverage portion of the employer-sponsored plan amount for the month, and

(B) the number of full-time employees of the applicable large employer during the applicable month

and the number of individuals employed by the employer as full-time employees during such month.

(b) Large Employers With Waiting Periods Exceeding 30 Days.—

(1) IN GENERAL.—In the case of any applicable large employer which requires an extended waiting period to obtain minimum essential coverage under an employer-sponsored plan (as defined in section 5000A(f)(2)), there is hereby imposed on the employer an assessable payment, in the amount specified in paragraph (2), for each full-time employee of the employer to whom the extended waiting period applies.

(c) AMOUNT.—For purposes of paragraph (1), the amount specified in this paragraph for a full-time employee is—

(1) In the case of an extended waiting period which extends 90 days or more, $4,000.

(2) In the case of an extended waiting period which exceeds 60 days, $600.

(d) TERMINATION OF REQUIREMENT.—The term ‘‘extended waiting period’’ means any waiting period (as defined in section 271(b)(4) of the
"(3) APPLICABLE PREMIUM TAX CREDIT AND COST-SHARING REDUCTION.—The term ‘applicable premium tax credit and cost-sharing reduction’ means—

"(a) the premium tax credit allowed under section 36B,

"(b) any cost-sharing reduction under section 1402 of the Patient Protection and Affordable Care Act,

"(c) any advance payment of such credit or reduction under section 1412 of such Act.

"(4) FULL-TIME EMPLOYEE.—

"(a) In general.—The term ‘full-time employee’ means an employee who is employed on average at least 30 hours of service per week.

"(b) HOURS OF SERVICE.—The Secretary, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the hours of service of an employee. Including rules for the application of this paragraph to employees who are not compensated on an hourly basis.

"(c) HOURS OF SERVICE.—The Secretary, in consultation with the Secretary of Labor, shall prescribe such regulations, rules, and guidance as may be necessary to determine the hours of service of an employee. Including rules for the application of this paragraph to employees who are not compensated on an hourly basis.

"(d) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) APPLICABLE PAYMENT AMOUNT.—The term ‘applicable payment amount’ means, with respect to any month, 1⁄12 of $750.

"(2) APPLICABLE LARGE EMPLOYER.—

"(A) In general.—The term ‘applicable large employer’ means, with respect to a calendar year, an employer who employed an average of at least 50 full-time employees on business days during the preceding calendar year.

"(B) EXEMPTION FOR CERTAIN EMPLOYERS.—

"(1) In general.—An employer shall not be considered to employ more than 50 full-time employees if—

"(i) the employer’s workforce exceeds 50 full-time employees for 120 days or fewer during the calendar year, and

"(ii) in excess of 50 employed during such 120-day period were seasonal workers.

"(2) DEFINITION OF SEASONAL WORKERS.—The term ‘seasonal worker’ means a worker who performs labor or services on a seasonal basis as defined by the Secretary of Labor, including workers covered by section 502(b)(3) of the Federal Nondiscrimination in Health Insurance Coverage Act of 1986.

"(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was required to furnish a return under subsection (b)(3) for the calendar year 1986 shall be treated as 1 employer.

"(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was required to furnish a return under subsection (b)(3) for the calendar year 1986 shall be treated as 1 employer.

"(C) RULES FOR DETERMINING EMPLOYER SIZE.—For purposes of this paragraph—

"(1) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as 1 employer.

"(2) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was required to furnish a return under subsection (b)(3) for the calendar year 1986 shall be treated as 1 employer.

"(3) PREDECESSORS.—Any reference in this subparagraph to any predecessor of such employer shall be a reference to any predecessor of such employer.
(d) COORDINATION WITH OTHER REQUIREMENTS.—To the maximum extent feasible, the Secretary may provide that—

(1) any return or statement required to be provided under this section may be provided as part of any return or statement required under section 6051 or 6055, and

(2) in the case of an applicable large employer which is a governmental unit or any agency or instrumentality thereof, the person appropriately designated for purposes of this section shall make the returns and statements required by this section.

(d) Definitions.—For purposes of this section, any term used in this section which is also used in section 4980H shall have the meaning given such term by section 4980H."

(b) Assessable Penalties.—

(1) In general.—Subparagraph (d)(1) of the Internal Revenue Code of 1986 (relating to definitions, as amended by section 1516, is amended by striking "or" at the end of clause (xxiv) and at the end of clause (xix) and inserting "and", and by inserting after clause (xxiv) the following new clause:

"(xxv) section 6056 (relating to returns relating to large employers required to report on health insurance coverage), and"

(2) Paragraph (2) of section 6724(d) of such Code, as so amended, is amended by striking "or" at the end of subparagraph (FF), by striking the period at the end of subparagraph (FF), by striking the period at the end of subparagraph (GG), and by inserting "or" at the end of subparagraph (GG), by striking the period at the end of subparagraph (HH), and by striking the period at the end of subparagraph (II), by striking the period at the end of subparagraph (JJ), by striking the period at the end of subparagraph (JJ) and inserting ", and", and by striking the period at the end of subparagraph (KK) and inserting ", or", and by inserting after paragraph (KK) the following new paragraph:

"(HH) section 6056(c) (relating to statements relating to large employers to report on health insurance coverage)."

(c) Conforming Amendment.—The table of sections for subpart D of part III of subchapter A of chapter 61 of such Code, as added by section 1502, is amended by adding at the end of the following new item:

"Sec. 6056. Large employers required to report on health insurance coverage."

(d) Effective Date.—The amendments made by this section shall apply to periods beginning after December 31, 2013.

SEC. 1515. OFFERING OF EXCHANGE-PARTICI-

PATING QUALIFIED HEALTH PLANS THROUGH CAFETERIA PLANS.

(a) In General.—The Federal Government, and any State or local government or health care provider that receives Federal financial assistance under this Act (or an amendment made by this Act) may offer to any eligible individuals a choice between—

(1) a health insurance coverage plan (as defined in section 1301(a) of the Patient Protection and Affordable Care Act) offered through an Exchange established under section 1311 of such Act; and

(2) any other health insurance coverage plan created under this Act (or any amendments made by this Act), or in any Federal health insurance program expanded by this Act (or any amendments made by this Act), that is not prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794 et seq.), and any other program or activity that is administered by an Executive agency or any other Federal program or activity that is not prohibited under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection.

(b) Conforming Application of Laws.—Nothing in this title (or an amendment made by this title) shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or the Age Discrimination Act of 1975 (29 U.S.C. 611 et seq.), to supersede or preclude any other Federal law that provide additional or different protections against discrimination on any basis described in subsection (a).

(c) Regulations.—The Secretary may promulgate regulations to implement this section.

SEC. 1556. PROTECTIONS FOR EMPLOYEES.

(a) In General.—As otherwise provided in this title (or an amendment made by this title), an employee shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794 et seq.), be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which receives Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive agency or any other Federal program or activity that is not prohibited under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection.

(b) Conforming Application of Laws.—Nothing in this title (or an amendment made by this title) shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or the Age Discrimination Act of 1975 (29 U.S.C. 611 et seq.), to supersede or preclude any other Federal law that provide additional or different protections against discrimination on any basis described in subsection (a).

(c) Regulations.—The Secretary may promulgate regulations to implement this section.

SEC. 1557. NONDISCRIMINATION.

(a) In General.—As otherwise provided in this title (or an amendment made by this title), an employee shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), or section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794 et seq.), be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which receives Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive agency or any other Federal program or activity that is not prohibited under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of this subsection.

(b) Conforming Application of Laws.—Nothing in this title (or an amendment made by this title) shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), or the Age Discrimination Act of 1975 (29 U.S.C. 611 et seq.), to supersede or preclude any other Federal law that provide additional or different protections against discrimination on any basis described in subsection (a).

(c) Regulations.—The Secretary may promulgate regulations to implement this section.
SEC. 1560. RULES OF CONSTRUCTION.

(1) under section 36B of the Internal Revenue Code of 1986 or a subsidiary under section 1402 of this Act;

(2) provided, caused to be provided, or is about to be provided or caused to be provided by the employer, the Federal Government, or the attorney general of a State information relating to any violation of, or any act or omission reasonably believed to be a violation of, any provision of this title (or an amendment made by this title);

(3) testified or is about to testify in a proceeding concerning such violation;

(4) assisted or participated, or is about to assist or participate, in such a proceeding; or

(5) 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 title (or amendment), or any regulation, standard, or ban under this title (or amendment).

‘‘(b) COMPLAINT PROCEDURE.—

‘‘(1) IX. TERMINATION.—An employee who believes that the complaint, or that such requirement is otherwise permitted by (A), by striking ‘‘1 through 3 shall not apply to any individual coverage or any group’’; and

‘‘(2) Simplification and submission of electronic documentation, digitization of documents, and systems verification of eligibility.

‘‘(4) Reuse of stored eligibility information (including documentation) to assist with retention of eligible individuals.

‘‘(5) Ability to expand the enrollment system to integrate new programs, rules, and functionalities, to operate at increased volumes, to apply streamlined verification and eligibility processes to other Federal and State programs, as appropriate.

‘‘(6) Notification of eligibility, recertification, and other needed communication regarding eligibility, which may include communication via email and cellular phones.

‘‘(7) Other functionalities necessary to provide eligibles with streamlined enrollment process.

‘‘(c) APPROVAL AND NOTIFICATION.—With respect to any standard or protocol developed under this subpart, the HIT Policy Committee and the HIT Standards Committee, the Secretary—

‘‘(1) shall notify States of such standards or protocols and shall determine what entities are qualified to receive HIT enrollment under subparagraph (A), taking into consideration the recommendations of the HIT Policy Committee and the HIT Standards Committee.

SEC. 1562. CONFORMING AMENDMENTS.

(a) APPLICABILITY.—Section 2735 of the Public Health Service Act (42 U.S.C. 300gg-21) is amended by redesignating section 1001(d)(4) as—

(1) by striking subsection (a);

(2) in subsection (b)—

(A) in paragraph (1), by striking ‘‘1 through 3’’ and inserting ‘‘1 and 2’’; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking ‘‘subparagraph (C)’’ and inserting ‘‘subparagraph (D) or (E)’’;

(ii) in striking ‘‘1 through 3’’ and inserting ‘‘1 and 2’’; and

(iii) by adding at the end the following:

‘‘(E) ELECTION NOT APPLICABLE.—The election described in subparagraph (A) shall not be available with respect to the provisions of subsection (a)(3);’’

(3) in subsection (c), by striking ‘‘1 through 3 shall not apply to any group’’ and inserting ‘‘1 and 2 shall not apply to any group or any individual coverage or any group’’; and

(4) in subsection (d)—

(A) in paragraph (1), by striking ‘‘1 through 3 shall not apply to any group’’ and inserting ‘‘1 through 3 shall not apply to any group or any individual coverage or any group’’;

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by striking ‘‘1 through 3 shall not apply to any group’’ and inserting ‘‘1 and 2 shall not apply to any individual coverage or any group’’;

(ii) in subparagraph (B), by striking ‘any group’’ and inserting ‘‘any individual coverage or any group’’.

(b) DEFINITIONS.—Section 1001(d)(9) of the Public Health Service Act (42 U.S.C. 300gg-91(d)) is amended by adding at the end the following:
(20) QUALIFIED HEALTH PLAN.—The term ‘‘qualified health plan’’ has the meaning given such term in section 1301(a) of the Patient Protection and Affordable Care Act.

(21) TECHNICAL AND CONFORMING AMENDMENTS.—The term ‘‘Exchange’’ means an American Health Benefit Exchange established under section 1311 of the Patient Protection and Affordable Care Act.

(22) T ECHNICAL AND CONFORMING AMENDMENTS.—In subsection (b), by striking ‘‘(or group health plan)’’ each place that such term appears and inserting ‘‘group or individual health plan’’;

(ii) in paragraph (2), by striking ‘‘(or health insurance coverage offered in connection with such a plan)’’ each place that such term appears and inserting ‘‘or a health insurance issuer offering group or individual health insurance coverage’’;

(iii) in section 2727 (42 U.S.C. 300gg-6), as so redesignated by section 1001(2), by striking ‘‘health insurance issuers providing health insurance coverage’’ and inserting ‘‘or an individual health insurance issuer offering group or individual health insurance coverage’’;

(iv) in subsection (a), by striking ‘‘health insurance coverage’’ and inserting ‘‘individual health insurance coverage’’;

(v) in subsection (b), by striking ‘‘health insurance coverage offered in connection with such a plan’’ and inserting ‘‘individual health insurance coverage’’;

(vi) in paragraph (2), by striking ‘‘health insurance issuer that provides health insurance coverage’’;

(vii) in the matter preceding paragraph (1), by striking ‘‘group health insurance coverage’’ and inserting ‘‘individual health insurance coverage’’;

(viii) in paragraph (1), by striking ‘‘(or health insurance coverage offered in connection with such a plan)’’ each place that such term appears and inserting ‘‘or a health insurance issuer offering group or individual health insurance coverage’’;

(ix) in paragraph (2), by striking ‘‘(or health insurance coverage offered in connection with such a plan)’’ each place that such term appears and inserting ‘‘or a health insurance issuer offering group or individual health insurance coverage’’;

(x) in section 2727 (42 U.S.C. 300gg-6), as so redesignated by section 1001(2), by striking ‘‘health insurance issuers providing health insurance coverage’’ and inserting ‘‘or a health insurance issuer offering group or individual health insurance coverage’’;

(xi) in subsection (b), by striking ‘‘health insurance issuer offering health insurance coverage in connection with a group health plan’’ and inserting ‘‘or a health insurance issuer that offers group or individual health insurance coverage’’;

(xii) in paragraph (2), by striking ‘‘health insurance coverage offered in connection with the plan’’ and inserting ‘‘individual health insurance coverage offered by an issuer in connection with such a plan’’;

(xiii) in paragraph (3), by striking ‘‘health insurance issuer offering health insurance coverage in connection with a group health plan’’ and inserting ‘‘individual health insurance issuer that offers group or individual health insurance coverage’’;

(xiv) in subsection (a), by striking ‘‘(or health insurance issuer providing health insurance coverage in connection with a group health plan)’’ and inserting ‘‘(or an individual health insurance issuer providing health insurance coverage in connection with a group health plan)’’;

(xv) in section 2731 (42 U.S.C. 300gg-11), as so redesignated by section 1001(3), by striking ‘‘health insurance issuer offering group or individual health insurance coverage’’;

(xvi) in paragraph (2), by striking ‘‘small employer’’ and inserting ‘‘employer, or individual, as applicable’’;

(xvii) in the matter preceding paragraph (1), by striking ‘‘small group market or the large group market’’ and inserting ‘‘individual or group market, or all markets’’;

(xviii) in paragraph (1), by inserting ‘‘(or individual, as applicable, after ‘‘plan sponsor’’; and

(xix) in subsection (B), by inserting ‘‘(or individual, as applicable, after ‘‘plan sponsor’’; and

(xx) in the matter preceding clause (i), by striking ‘‘small group market or the large group market, or both markets,’’ and inserting ‘‘individual or group market, or all markets,’’ and

(xxi) in clause (i), by inserting ‘‘or individual, as applicable, after ‘‘plan sponsor’’; and

(xxii) in paragraph (2)(A)—

(i) in the matter preceding clause (i), by striking ‘‘small group market’’ and inserting ‘‘small employer or individual’’;

(ii) in paragraph (1), by inserting ‘‘(or individual, as applicable, after ‘‘employer’’’’ each place that such term appears and inserting ‘‘small employer or individual’’;

(iii) in paragraph (1), by inserting ‘‘(or individual, as applicable, after ‘‘employer’’’’ each place that such term appears and inserting ‘‘small employer or individual’’;

(iv) in paragraph (1), by inserting ‘‘(or individual, as applicable, after ‘‘employer’’’’ each place that such term appears and inserting ‘‘small employer or individual’’;

(v) in paragraph (1), by inserting ‘‘(or individual, as applicable, after ‘‘employer’’’’ each place that such term appears and inserting ‘‘small employer or individual’’;

(vi) in paragraph (1), by inserting ‘‘(or individual, as applicable, after ‘‘employer’’’’ each place that such term appears and inserting ‘‘small employer or individual’’;
employers, or individuals, as applicable."; and
(II) by striking "small employer" and inserting "employee, or individual, as applicable.";
(C) by redesigning such section (as amended by this paragraph) as section 2709 and transferring such section to appear after section 2716 by redesigning subsection (a)(3) as section 2716 and redesigning such section (as amended by this paragraph) as section 2722 and transferring such section to appear after section 2716;
(11) by redesigning subsection 4 as part 2;
(12) in section 2735 (42 U.S.C. 300gg-21), as so redesignated by section 1001(4)—
(A) by striking subsection (a);
(B) by striking "subparts 1 through 3" each place that such appears and inserting "subpart 1";
(C) by redesigning subsections (b) through (e) as subsections (a) through (d), respectively; and
(D) by redesigning such section (as amended by this paragraph) as section 2722;
(13) in section 2736 (42 U.S.C. 300gg-22), as so redesignated by section 1001(4)—
(A) by inserting "(a)" before "group health insurance" and inserting "or health insurance coverage" after "group health plans";
(B) in subsection (b)(1)(B), by inserting "individual or" before "group health insurance coverage or" after "respect to"; and
(C) by redesigning such section (as amended by this paragraph) as section 2722;
(14) in section 2737 (42 U.S.C. 300gg-23), as so redesignated by section 1001(4)—
(A) by inserting "individual or" before "group health insurance"; and
(B) by redesigning such sections (as amended by this paragraph) as section 2724;
(15) in section 2762 (42 U.S.C. 300gg-62)—
(A) in the section heading by inserting "and application" before the period; and
(B) by adding at the end the following:
"(c) APPLICATION OF PART A PROVISIONS.—
"(1) IN GENERAL.—The provisions of part A shall apply to health insurance issuers providing health insurance coverage in the individual market in a State as provided for in such part.
"(2) CLARIFICATION.—To the extent that any provision of this part conflicts with a provision of part A with respect to health insurance issuers providing health insurance coverage in the individual market in a State, the provisions of such part A shall apply; and
"(3) FEDERAL FUNDING FOR COST OF COVERING NEWLY ELIGIBLE INDIVIDUALS.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), is amended—
(A) in subsection (b), in the first sentence, by inserting "subsection (y) and" before "section 1933(d)"; and
(B) by adding at the end the following:
"(y) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR NEWLY ELIGIBLE MANDATORY INDIVIDUALS.—
"(1) AMOUNT OF INCREASE.—
"(2) PERCENTAGE OF FMAP.—During the period that begins on January 1, 2014, and ends on December 31, 2016, notwithstanding subsection (b), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subsection (a)(10)(A)(i) other than medical assistance provided through benchmark II, the Federal medical assistance percentage determined in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2).

CONFORMING AMENDMENT.—Section 1903(i) of the Social Security Act, as amended by section 6402(c), is amended—
(A) in subsection (b), in the first sentence, by inserting "subsection (y) and" before "section 1933(d)"; and
(B) by adding at the end the following:
"(y) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR NEWLY ELIGIBLE MANDATORY INDIVIDUALS.—
"(1) AMOUNT OF INCREASE.—
"(2) PERCENTAGE OF FMAP.—During the period that begins on January 1, 2017, and ends on December 31, 2018, subject to subparagraph (D), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subsection (a)(10)(A)(i) other than medical assistance provided through benchmark II, the Federal medical assistance percentage determined in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2).

SEC. 9815. ADDITIONAL MARKET REFORMS.-(a) GENERAL RULE.—Except as provided in subsection (b)—
"(1) the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart; and
"(2) to the extent that any provision of this part conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.
"(b) EXCEPTION.—Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this part shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.

TECHNICAL AMENDMENT TO THE INTERNAL REVENUE CODE OF 1986.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by adding at the end the following:
"SEC. 9815. ADDITIONAL MARKET REFORMS.-(a) GENERAL RULE.—Except as provided in subsection (b)—
""(1) the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart; and
""(2) to the extent that any provision of this part conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.
""(b) EXCEPTION.—Notwithstanding subsection (a), the provisions of sections 2716 and 2718 of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall not apply with respect to self-insured group health plans, and the provisions of this part shall continue to apply to such plans as if such sections of the Public Health Service Act (as so amended) had not been enacted.

TITLE II—ROLE OF PUBLIC PROGRAMS Subtitle A—Improved Access to Medicaid SEC. 2001. MEDICAL COVERAGE FOR THE LOW-EST INCOME POPULATIONS.-(a) COVERAGE FOR INDIVIDUALS WITH INCOME AT OR BELOW 133 PERCENT OF THE POVERTY LINE.—
"(1) BEGINNING 2014.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a) is amended—
"(A) by striking "or" at the end of subsection (a)(10)(A)(i) shall consist of an individual described in subclause (VIII) of section 1933(d); and
"(B) by adding at the end the following:
"(y) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR NEWLY ELIGIBLE MANDATORY INDIVIDUALS.—
"(1) AMOUNT OF INCREASE.—
"(2) PERCENTAGE OF FMAP.—During the period that begins on January 1, 2014, and ends on December 31, 2016, notwithstanding subsection (b), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subsection (a)(10)(A)(i) other than medical assistance provided through benchmark II, the Federal medical assistance percentage determined in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2).

(b) 2017 AND 2018.—
"(I) IN GENERAL.—For purposes of clause (y) of subsection (a), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subsection (a)(10)(A)(i) shall be equal to 100 percent.
"(B) 2017 AND 2018.—
"(I) IN GENERAL.—During the period that begins on January 1, 2017, and ends on December 31, 2018, notwithstanding subsection (b) and subject to subparagraph (D), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subsection (a)(10)(A)(i) shall be equal to 100 percent.

(1) SEC. 2001. MEDICAL COVERAGE FOR THE LOW-

"(I) AMOUNT OF INCREASE.—
"(II) PERCENTAGE OF FMAP.—During the period that begins on January 1, 2014, and ends on December 31, 2016, notwithstanding subsection (b), the Federal medical assistance percentage determined for a State that is one of the 50 States or the District of Columbia for each fiscal year occurring during that period with respect to amounts expended for medical assistance for newly eligible individuals described in subsection (a)(10)(A)(i) other than medical assistance provided through benchmark II, the Federal medical assistance percentage determined in section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2).
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‘‘For any fiscal year quarter occurring in the
calendar year:

If the State is an expansion State, the applicable percentage point increase is:

If the State is not an expansion State, the applicable percentage point increase is:

2017

30.3

34.3

2018

31.3

33.3

‘‘(II) EXPANSION STATE DEFINED.—For purposes of the table in subclause (I), a State is
an expansion State if, on the date of the enactment of the Patient Protection and Affordable Care Act, the State offers health
benefits coverage statewide to parents and
nonpregnant, childless adults whose income
is at least 100 percent of the poverty line,
that is not dependent on access to employer
coverage, employer contribution, or employment and is not limited to premium assistance, hospital-only benefits, a high deductible health plan, or alternative benefits
under a demonstration program authorized
under section 1938. A State that offers health
benefits coverage to only parents or only
nonpregnant childless adults described in the
preceding sentence shall not be considered to
be an expansion State.
‘‘(C) 2019 AND SUCCEEDING YEARS.—Beginning January 1, 2019, notwithstanding subsection (b) but subject to subparagraph (D),
the Federal medical assistance percentage
determined for a State that is one of the 50
States or the District of Columbia for each
fiscal year quarter occurring during that period with respect to amounts expended for
medical assistance for newly eligible individuals described in subclause (VIII) of section
1902(a)(10)(A)(i), shall be increased by 32.3
percentage points.
‘‘(D) LIMITATION.—The Federal medical assistance percentage determined for a State
under subparagraph (B) or (C) shall in no
case be more than 95 percent.
‘‘(2) DEFINITIONS.—In this subsection:
‘‘(A) NEWLY ELIGIBLE.—The term ‘newly eligible’ means, with respect to an individual
described in subclause (VIII) of section
1902(a)(10)(A)(i), an individual who is not
under 19 years of age (or such higher age as
the State may have elected) and who, on the
date of enactment of the Patient Protection
and Affordable Care Act, is not eligible under
the State plan or under a waiver of the plan
for full benefits or for benchmark coverage
described in subparagraph (A), (B), or (C) of
section 1937(b)(1) or benchmark equivalent
coverage described in section 1937(b)(2) that
has an aggregate actuarial value that is at
least actuarially equivalent to benchmark
coverage described in subparagraph (A), (B),
or (C) of section 1937(b)(1), or is eligible but
not enrolled (or is on a waiting list) for such
benefits or coverage through a waiver under
the plan that has a capped or limited enrollment that is full.
‘‘(B) FULL BENEFITS.—The term ‘full benefits’ means, with respect to an individual,
medical assistance for all services covered
under the State plan under this title that is
not less in amount, duration, or scope, or is
determined by the Secretary to be substantially equivalent, to the medical assistance
available for an individual described in section 1902(a)(10)(A)(i).’’.
(4) STATE OPTIONS TO OFFER COVERAGE EARLIER AND PRESUMPTIVE ELIGIBILITY; CHILDREN
jbell on DSKDVH8Z91PROD with SENATE

November 19, 2009

CONGRESSIONAL RECORD — SENATE

REQUIRED TO HAVE COVERAGE FOR PARENTS TO
BE ELIGIBLE.—
(A) IN GENERAL.—Subsection (k) of section

1902 of the Social Security Act (as added by
paragraph (2)), is amended by inserting after
paragraph (1) the following:
‘‘(2) Beginning with the first day of any fiscal year quarter that begins on or after January 1, 2011, and before January 1, 2014, a

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State may elect through a State plan amendment to provide medical assistance to individuals who would be described in subclause
(VIII) of subsection (a)(10)(A)(i) if that subclause were effective before January 1, 2014.
A State may elect to phase-in the extension
of eligibility for medical assistance to such
individuals based on income, so long as the
State does not extend such eligibility to individuals described in such subclause with
higher income before making individuals described in such subclause with lower income
eligible for medical assistance.
‘‘(3) If an individual described in subclause
(VIII) of subsection (a)(10)(A)(i) is the parent
of a child who is under 19 years of age (or
such higher age as the State may have elected) who is eligible for medical assistance
under the State plan or under a waiver of
such plan (under that subclause or under a
State plan amendment under paragraph (2),
the individual may not be enrolled under the
State plan unless the individual’s child is enrolled under the State plan or under a waiver
of the plan or is enrolled in other health insurance coverage. For purposes of the preceding sentence, the term ‘parent’ includes
an individual treated as a caretaker relative
for purposes of carrying out section 1931.’’.
(B) PRESUMPTIVE ELIGIBILITY.—Section 1920
of the Social Security Act (42 U.S.C. 1396r–1)
is amended by adding at the end the following:
‘‘(e) If the State has elected the option to
provide a presumptive eligibility period
under this section or section 1920A, the State
may elect to provide a presumptive eligibility period (as defined in subsection (b)(1))
for individuals who are eligible for medical
assistance under clause (i)(VIII) of subsection (a)(10)(A) or section 1931 in the same
manner as the State provides for such a period under this section or section 1920A, subject to such guidance as the Secretary shall
establish.’’.
(5) CONFORMING AMENDMENTS.—
(A) Section 1902(a)(10) of such Act (42
U.S.C. 1396a(a)(10)) is amended in the matter
following subparagraph (G), by striking ‘‘and
(XIV)’’ and inserting ‘‘(XIV)’’ and by inserting ‘‘and (XV) the medical assistance made
available to an individual described in subparagraph (A)(i)(VIII) shall be limited to
medical assistance described in subsection
(k)(1)’’ before the semicolon.
(B) Section 1902(l)(2)(C) of such Act (42
U.S.C. 1396a(l)(2)(C)) is amended by striking
‘‘100’’ and inserting ‘‘133’’.
(C) Section 1905(a) of such Act (42 U.S.C.
1396d(a)) is amended in the matter preceding
paragraph (1)—
(i) by striking ‘‘or’’ at the end of clause
(xii);
(ii) by inserting ‘‘or’’ at the end of clause
(xiii); and
(iii) by inserting after clause (xiii) the following:
‘‘(xiv) individuals described in section
1902(a)(10)(A)(i)(VIII),’’.
(D) Section 1903(f)(4) of such Act (42 U.S.C.
1396b(f)(4))
is
amended
by
inserting
‘‘1902(a)(10)(A)(i)(VIII),’’
after
‘‘1902(a)(10)(A)(i)(VII),’’.
(E) Section 1937(a)(1)(B) of such Act (42
U.S.C. 1396u–7(a)(1)(B)) is amended by inserting
‘‘subclause
(VIII)
of
section
1902(a)(10)(A)(i) or under’’ after ‘‘eligible
under’’.

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(b) MAINTENANCE OF MEDICAID INCOME ELIGIBILITY.—Section 1902 of the Social Security
Act (42 U.S.C. 1396a) is amended—
(1) in subsection (a)—
(A) by striking ‘‘and’’ at the end of paragraph (72);
(B) by striking the period at the end of
paragraph (73) and inserting ‘‘; and’’; and
(C) by inserting after paragraph (73) the
following new paragraph:
‘‘(74) provide for maintenance of effort
under the State plan or under any waiver of
the plan in accordance with subsection
(gg).’’; and
(2) by adding at the end the following new
subsection:
‘‘(gg) MAINTENANCE OF EFFORT.—
‘‘(1) GENERAL REQUIREMENT TO MAINTAIN
ELIGIBILITY STANDARDS UNTIL STATE EXCHANGE IS FULLY OPERATIONAL.—Subject to
the succeeding paragraphs of this subsection,
during the period that begins on the date of
enactment of the Patient Protection and Affordable Care Act and ends on the date on
which the Secretary determines that an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act is fully operational, as a
condition for receiving any Federal payments under section 1903(a) for calendar
quarters occurring during such period, a
State shall not have in effect eligibility
standards, methodologies, or procedures
under the State plan under this title or
under any waiver of such plan that is in effect during that period, that are more restrictive than the eligibility standards,
methodologies, or procedures, respectively,
under the plan or waiver that are in effect on
the date of enactment of the Patient Protection and Affordable Care Act.
‘‘(2) CONTINUATION OF ELIGIBILITY STANDARDS FOR CHILDREN UNTIL OCTOBER 1, 2019.—
The requirement under paragraph (1) shall
continue to apply to a State through September 30, 2019, with respect to the eligibility standards, methodologies, and procedures under the State plan under this title or
under any waiver of such plan that are applicable to determining the eligibility for medical assistance of any child who is under 19
years of age (or such higher age as the State
may have elected).
‘‘(3) NONAPPLICATION.—During the period
that begins on January 1, 2011, and ends on
December 31, 2013, the requirement under
paragraph (1) shall not apply to a State with
respect to nonpregnant, nondisabled adults
who are eligible for medical assistance under
the State plan or under a waiver of the plan
at the option of the State and whose income
exceeds 133 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a
family of the size involved if, on or after December 31, 2010, the State certifies to the
Secretary that, with respect to the State fiscal year during which the certification is
made, the State has a budget deficit, or with
respect to the succeeding State fiscal year,
the State is projected to have a budget deficit. Upon submission of such a certification
to the Secretary, the requirement under
paragraph (1) shall not apply to the State
with respect to any remaining portion of the
period described in the preceding sentence.
‘‘(4) DETERMINATION OF COMPLIANCE.—
‘‘(A) STATES SHALL APPLY MODIFIED GROSS
INCOME.—A State’s determination of income

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in accordance with subsection (e)(14) shall not be considered to be eligibility standards, methodologies, or procedures that are more restrictive than the standards, methodologies, or procedures applicable under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

"(B) STATES MAY EXPAND ELIGIBILITY OR MOVE WAVERED POPULATIONS INTO COVERAGE UNDER PARAGRAPH (1) OR (2) DURING THE TRANSITION PERIOD—With respect to the transition period applicable under paragraph (1), (2), or (3), a State that applies eligibility standards, methodologies, or procedures in procedures, applied under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, or that makes individuals who, on such date of enactment, are eligible for medical assistance under a waiver of the State plan, after such date of enactment eligible for medical assistance through a State plan or under a waiver of the plan with an income eligibility level that is not less than the income eligibility level that applied under the waiver, or as a result of the application of subclause (XXIV) of section 1902(a)(10)(A)(ii)(XIX), shall not be considered to have in effect eligibility standards, methodologies, or procedures in effect under the State plan or under a waiver of the plan on the date of enactment of the Patient Protection and Affordable Care Act, or that makes individuals who, on such date of enactment, are eligible for medical assistance under a waiver of the State plan, after such date of enactment eligible for medical assistance through a State plan or under a waiver of the plan, for purposes of determining compliance with the requirements of paragraph (1), (2), or (3).

"(c) MEDICAID BENCHMARK BENEFITS MUST CONSIST OF AT LEAST MINIMUM ESSENTIAL COVERAGE.—Section 1937(b) of such Act (42 U.S.C. 1396a(q)(b)) is amended—

(1) in paragraph (3), in the matter preceding subparagraph (A), by inserting "subject to paragraphs (5) and (6)," before "each horizontal baseline,"

(2) in paragraph (2)—

(A) in the matter preceding subparagraph (A), by inserting "subject to paragraphs (5) and (6)," before "each horizontal baseline,"

(B) in subparagraph (A)—

(i) by redesignating clauses (iv) and (v) as clauses (vi) and (vii), respectively; and

(ii) by inserting after clause (ii), the following:

"(iv) Coverage of prescription drugs.

"(v) Mental health services.

"(vi) Substance use disorder services.

(C) in subparagraph (B)—

(i) by striking clauses (i) and (ii); and

(ii) by redesignating clauses (iii), (iv) and (v) as clauses (i) and (ii), respectively; and

(D) in subsection (a)—

(5) MINIMUM STANDARDS.—Effective January 1, 2014, any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) must provide at least essential health benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.

"(6) MENTAL HEALTH SERVICES PARITY.—

"(A) IN GENERAL.—In the case of any benchmark benefit package under paragraph (1) or benchmark equivalent coverage under paragraph (2) that is offered by an entity that is not a Medicaid managed care organization and that provides both medical and surgical, mental health or substance use disorder benefits, the entity shall ensure that the financial requirements and treatment limitations applicable to such mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act.

in the same manner as such requirements apply to a group health plan.

"(B) DEEMED COMPLIANCE.—Coverage provided with respect to an individual described in subparagraph (A) and provided under the State plan or under a waiver of the State plan under section 1902(a)(10)(A) of the services described in section 1905(a)(4)(B) (relating to early and periodic screening, diagnostic, and preventive health services defined in section 1905(r)) and provided in accordance with section 1902(a)(4) shall be deemed to satisfy the requirements of subparagraph (A)

"(d) ANNUAL REPORTS ON MEDICAID ENROLLMENT.—

(1) STATE REPORTS.—Section 1902(a)(2) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by subsection (b), is amended—

(A) by striking "and" at the end of paragraph (73);

(B) by striking the period at the end of paragraph (74) and inserting "and"; and

(C) by inserting after paragraph (74) the following new paragraph:

"(75) provide that, beginning January 2015, and annually thereafter, the State shall submit a report to the Secretary that contains—

"(A) the total number of enrolled and newly enrolled individuals in the State plan or under a waiver of the plan for the fiscal year ending on September 30 of the preceding calendar year, segregated by population, including children, parents, nonpregnant childless adults, disabled individuals, elderly individuals, and such other categories or subgroups as the Secretary may determine, eligible for medical assistance under the State plan or under a waiver of the plan as the Secretary may require;

"(B) a description, which may be specified in the report, of the outreach and enrollment processes used by the State during such fiscal year; and

"(C) any other data determined necessary by the Secretary to monitor enrollment and retention of individuals eligible for medical assistance under the State plan or under a waiver of the plan as the Secretary may require.

"(2) REPORTS TO CONGRESS.—Beginning April 2015, and annually thereafter, the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress on the total enrollment and new enrollment in Medicaid for the fiscal year ending on September 30 of the preceding calendar year on a State-by-State basis and shall include in each such report such recommendations for administrative or legislative changes to improve enrollment in the Medicaid program as the Secretary determines appropriate.

"(e) STATE OPTION FOR COVERAGE FOR INDIVIDUALS WHO HAVE INCOME THAT EXCEEDS 133 PER CENT OF THE POVERTY LINE.—

"(1) COVERAGE AS OPTIONAL CATACLYSMIC NEED GROUP.—Section 1902 of the Social Security Act (42 U.S.C. 1396a(o)) is amended—

(A) in subsection (a)(10)(A)

(i) in clause (XVIII), by striking "or" at the end of clause (XVIII);

(ii) in clause (XIX), by adding "or" at the end of clause (XIX); and

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

"(XX) beginning January 1, 2014, who are under 65 years of age and are not described in or enrolled under a previous subclause of this clause, and whose income (as determined under subparagraph (C)) is not more than 100 percent of the poverty line (as defined in section 211(c)(5)) applicable to a family of the size involved but does not exceed the highest income eligibility level established under the State plan or under a waiver of the plan as subject to subsection (hh);" and

(B) by adding at the end the following new subparagraph:

"(hh)(1) A State may elect to phase-in the extension of eligibility for medical assist-

ance to individuals described in subclause (XX) of subsection (a)(10)(A)(ii) based on the categorical group (including nonpregnant childless adults) or income, so long as the State does not elect to extend eligibility to in-

dividuals described in such subclause with higher income before making individuals de-

scribed in such subclause with lower income eligible for medical assistance.

"(2) If an individual described in subclause (XX) of subsection (a)(10)(A)(ii) is the parent of a child who is under 19 years of age (or, in the case of a parent with such higher age as the State may have elect-

ed) who is eligible for medical assistance under the State plan or under a waiver of the plan under the State plan unless the individual's child is enrolled under the State plan or under a waiver of the plan or is enrolled in other health insurance or coverage. For pur-

poses of the preceding sentence, the term ‘parent’ includes an individual treated as a caretaker relative, for purposes of carrying out section 1931.

"(2) CONFORMING AMENDMENTS.—

(A) Section 1906(a) of such Act (42 U.S.C. 1396a(o)), as amended by subsection (a)(5)(C), is amended in the matter preceding para-

graph (1)—

(i) by striking "or" at the end of clause (xiii); and

(ii) by inserting "or" at the end of clause (xiv); and

(iii) by inserting after clause (xiii) the fol-

lowing:

"(xvii) individuals described in section 1902(a)(10)(A)(ii)(XX),";

(B) Section 1903(d) of such Act (42 U.S.C. 1396a(l)), as amended by inserting "1902(a)(10)(A)(ii)(XX)," after "1902(a)(10)(A)(ii)(X),"; and

(C) Section 1920(e) of such Act (42 U.S.C. 1396l(e)), as amended by inserting "or clause (ii)(XX)" after "clause (ii)(VIII),".

"(b) IN GENERAL.—Notwithstanding subsection (r) or any other provision of this title, except as provided in subparagraph (D), for purposes of determining income eligi-

bility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under the plan or waiver for which a determination of in-

come eligibility is required, including with respect to the imposition of premiums and cost-sharing, a State shall use the modified gross in-

come of an individual and, in the case of an individual in a family greater than one, the household income of such family. A State shall establish income eligibility thresholds for populations to be eligible for medical as-

sistance under the State plan or under a waiver of the plan under modified gross income and household income that are not less than the effective income eligibility levels that ap-

ply to the State plan or waiver for which a determination of income eligibility is required, including with respect to the imposition of premiums and cost-sharing.

"(2) INCOME DETERMINED USING MODIFIED GROSS INCOME.—

(A) IN GENERAL.—Section 1902(e) of the So-

cial Security Act (42 U.S.C. 1396a(e)), is amended by adding at the end the following:

"(xxiv) individuals described in section 1902(a)(10)(A)(ii)(XX),";

(B) Section 1903(d) of such Act (42 U.S.C. 1396a(l)), as amended by inserting "1902(a)(10)(A)(ii)(XX)," after "1902(a)(10)(A)(ii)(X),"; and

(C) Section 1920(e) of such Act (42 U.S.C. 1396l(e)), as amended by inserting "or clause (ii)(XX)" after "clause (ii)(VIII),".

"(c) IN GENERAL.—With respect to the purposes of this section, the term ‘individual’ means an individual described in subsection (b)(1) who is eligible for medical assistance under the State plan or under a waiver of the plan.

"(d) EFFECTIVE DATE.—This section shall take effect on the first day of the first full calendar month beginning after the date of the enactment of this Act.
this title and title XXI as are necessary to ensure that States establish income and eligibility determination systems that protect beneficiaries.

(b) NO CONCOME OR EXPENSE DISREGARDS.—No type of expense, block, or other income disregard shall be applied by a State to determine income eligibility for medical assistance under the State plan or under any waiver of such plan or for any other purpose applicable under the plan or waiver for which a determination of income is required.

(C) NO ASSET TEST.—A State shall not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under a waiver of the plan.

(D) EXCEPTIONS.—

(1) INDIVIDUALS ELIGIBLE BECAUSE OF OTHER SOURCES OF MEDICAL ASSISTANCE.—In paragraph (1), the State plan, or a waiver of the plan, may not require any individual to satisfy a result of eligibility determination made by, or under, a Federal or State program for medical assistance, and an individual is eligible for medical assistance for the following:

(A) Individuals who are eligible for medical assistance under the State plan, or any waiver of the plan, may be determined as eligible for medical assistance under the State plan or under any waiver of the plan for the purposes of being blind or disabled and incurring costs for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XX) on the date of enactment of the Patient Protection and Affordable Care Act. The Secretary shall ensure that the use of eligibility determination systems that protect confidentiality that are used to determine eligibility for medical assistance under the State plan or under any waiver of the plan (and subject to the determinations of income eligibility under subsection (a)(10)(A)(ii)(XX)) are carried out in a manner consistent with section 1935(a)(2).

(B) The Secretary may not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under any waiver of the plan for the purpose of determining the income eligibility of individuals for purposes of determining eligibility for medical assistance under the State plan or under any waiver of the plan.

(C) NO ASSET TEST.—A State shall not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under any waiver of the plan for the purpose of determining the income eligibility of individuals for purposes of determining eligibility for medical assistance under the State plan or under any waiver of the plan.

(D) CONFORMING AMENDMENT.—Section 1906A of such Act (42 U.S.C. 1396i–1) is amended—

(1) in subsection (a) (and in subsection (b) insofar as it relates to individuals who were in foster care under the State plan or the State plan or waiver is amended to allow the State plan or waiver to apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under any waiver of the plan), by striking “(1)” and inserting “(1)”, “and” and inserting “(2)”.

(2) in subsection (b) (and in subsection (a) to the extent necessary to permit a State to coordinate eligibility requirements for dual eligible individuals (as defined in section 1915(h)(2)(B) under the State plan or under any waiver of the plan and under title XVIII and title XIX who were in foster care under the State plan or under any waiver of such plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under title XVI, and individuals who are eligible as a result of being or being deemed to be a child in foster care under the responsibility of the State."

(II) Individuals who have attained age 65.

(III) Individuals who qualify for medical assistance under the State plan or under any waiver of such plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under title XVI, and including an individual who is eligible for medical assistance on the basis of section 1902(e)(3).

(IV) Individuals described in subsection (a)(10)(B)(vii) (including any individual described in paragraph (a)(10)(B)(vii) as a result of a change in status occurring after the date of enactment of the Patient Protection and Affordable Care Act)."

(V) Individuals described in any clause of subparagraph (A), (B), or (C) shall not apply to an individual who is being blind or disabled and incurring costs for medical assistance on the basis of section 1902(a)(10)(A)(ii)(XX) on the date of enactment of the Patient Protection and Affordable Care Act.

(G) LIMITATION ON SECRETARIAL AUTHORITY.—The Secretary shall not waive compliance with the requirements of this paragraph except to the extent necessary to permit a State to coordinate eligibility requirements for dual eligible individuals (as defined in section 1915(h)(2)(B) under the State plan or under any waiver of the plan and under title XVIII and title XIX who were in foster care under the State plan or under any waiver of such plan on the basis of being blind or disabled (or being treated as being blind or disabled) without regard to whether the individual is eligible for supplemental security income benefits under title XVI, and individuals who are eligible as a result of being or being deemed to be a child in foster care under the responsibility of the State."

(2) EXPRESS LANE AGENCY FINDINGS.—In paragraph (2), the term ‘express lane agency’ means an agency that, in compliance with the methodologies and procedures proposed to be established under paragraph (1), is able to determine income eligibility under subparagraphs (A), (B), or (C) of this paragraph on the date of enactment of the Patient Protection and Affordable Care Act."

(H) DEFINITIONS OF MODIFIED GROSS INCOME AND HOUSEHOLD INCOME.—In this paragraph, the term ‘modified gross income’ and ‘household income’ have the meanings given in sections 1902(a)(10)(A)(i)(IX), 1903(f)(4), and subsection (f)(4) of the Internal Revenue Code of 1986.

(I) CONTINUED APPLICATION OF MEDICAID RULES REGARDING POINT-IN-TIME INCOME AND SOURCES OF INCOME.—The requirement under this paragraph for States to use modified gross income and household income to determine income eligibility for medical assistance under the State plan or under any waiver of such plan and for any other purpose applicable under this section for which determination of income is required shall not be construed as affecting or limiting the application of the requirement under this paragraph.

(J) NO ASSET TEST.—A State may not apply any assets or resources test for purposes of determining eligibility for medical assistance under the State plan or under any waiver of the plan, for purposes of determining the income eligibility of individuals for purposes of determining eligibility for medical assistance under the State plan or under any waiver of the plan.

(2) The requirement under this paragraph shall not apply to the determination of income eligibility for medical assistance under the State plan or under any waiver of the plan for purposes of determining the income eligibility of an individual under age 19.

(3) in paragraph (2), by striking “the parent of an individual under age 19” and inserting “an individual or the parent of an individual under age 19”.

(4) in subsection (e), by striking “under age 19” each place it appears.

(b) CONFORMING AMENDMENT.—The heading for section 1937(a)(10)(A)(i) of such Act (42 U.S.C. 1396i–1) is amended by striking “OPTION FOR CHILDREN”.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2014.

SEC. 2004. MEDICAID COVERAGE FOR FORMER FOSTER CARE CHILDREN.

(a) IN GENERAL.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a), as amended by section 2001(a)(1), is amended—

(1) by striking “or” at the end of subclause (VII);

(2) by adding “or” at the end of subclause (VIII); and

(3) by inserting after subclause (VIII) the following:

“(IX) who were in foster care under the responsibility of a State for more than 6 months (whether or not consecutive) but are no longer in such care, who are not described in any of subclauses (I) through (VII) of this clause, and who are under 25 years of age.”

(b) CONFORMING AMENDMENT.—Section 1936b–4 of the Social Security Act (42 U.S.C. 1396b–4), as amended by section 2001(a)(4)(B) and amended by section 2001(a)(5)(D), is amended by inserting “or”, clause (I)(IX), after “clause (I)(VIII).”

(c) CONFORMING AMENDMENTS.—

(1) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)), as amended by section 2001(a)(5)(D), is amended by inserting “or”, after “(A)”, “(B)”, and inserting “or”, “or”, “or”.

(2) Section 1902(a)(10)(A)(i)(IX) of such Act (42 U.S.C. 1396a–1(i)(IX)), as amended by section 1938rr, is amended by inserting “or”, “or”, “or”.

(3) Section 1902(a)(10)(A)(i)(IX) of such Act (42 U.S.C. 1396a–1(i)(IX) before the period “or”.

(d) EFFECTIVE DATE.—The amendments made by this section take effect on January 1, 2014.

SEC. 2005. PAYMENTS TO TERRITORIES.

(a) IN GENERAL.—Section 1909(g) of such Act (42 U.S.C. 1396g) is amended—

(1) in paragraph (2), in the matter preceding subparagraph (A), by striking “paragraph (3)” and inserting “paragraphs (3) and (5)”; and

(2) in paragraph (4), by striking “and (3)” and inserting “(3) and (4)”;

and
(3) by adding at the end the following paragraph:

"(5) FISCAL YEAR 2011 AND THEREAFTER.—The amounts otherwise determined under this section for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for the second, third, and fourth quarters of fiscal year 2011, and for each fiscal year after fiscal year 2011 (after the application of subsection (f) and the preceding paragraphs of this subsection), shall be increased by 50 percent.

(b) DISREGARD OF PAYMENTS FOR MANDATORY EXPANDED ENROLLMENT.—Section 1108(b)(4) of such Act (42 U.S.C. 1396d(g)(4)) is amended by striking "(A) fiscal years beginning" and inserting "into the:";

"(A) fiscal years beginning;"

(2) by striking the period at the end and inserting "; and;"; and

(3) by adding at the end the following:

"(B) fiscal years beginning with fiscal year 2014, payments made to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa with respect to amounts expended for medical assistance for newly eligible individuals under section 1905(y)(2) of the Social Security Act (42 U.S.C. 1396d(y)(2)) nonpregnant childless adults who are eligible under subsection (a)(2) of the Social Security Act (42 U.S.C. 1396a(a)(2)) and whose income (as determined under the Social Security Act (42 U.S.C. 1396a(a)(2))) does not exceed (in the case of each such Commonwealth and territory respectively) the income eligibility level in effect for that population under the Commonwealth or territory, plus the amount of the Federal medical assistance percentage for a fiscal year without regard to this subsection and subsection (y), is less than the Federal medical assistance percentage determined for the State for the preceding fiscal year under this subsection.

(2) INCREASED FMAP.—

(1) IN GENERAL.—The first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended by striking "shall be 50 per centum" and inserting "shall be 55 per centum".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) takes effect on January 1, 2011.

SEC. 2006. SPECIAL ADJUSTMENT TO FMAP DETERMINATION FOR CERTAIN STATES RECOVERING FROM A MAJOR DISASTER.

Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a), 2002(b), and 2003(a) of this Act, is amended—

(1) in subsection (b), in the first sentence, by striking "subsection (y)" and inserting "subsections (y) and (aa)"; and

(2) by adding at the end the following new subsection:

"(aa) Notwithstanding subsection (b), beginning January 1, 2011, the Federal medical assistance percentage for a fiscal year for a disaster-recovery FMAP adjustment State shall be equal to the following:

(A) in the case of the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, the Federal medical assistance percentage determined for the fiscal year without regard to this subsection and subsection (y), increased by 50 percent of the number of percentage points by which the Federal medical assistance percentage determined for the fiscal year without regard to this subsection and subsection (y), increased by 50 percent of the number of percentage points by which the Federal medical assistance percentage determined for the first fiscal year (or part of a fiscal year) for which this subsection applies to the State, Federal medical assistance percentage determined for the fiscal year (other than with respect to disproportionate share hospital payments described in section 1923 and payments under this title that are based on the enhanced payments under section 2105(b)) and shall not apply with respect to payments under title IV (other than under part E of title IV) or payments under title XXI.

SEC. 2007. MEDICAID IMPROVEMENT FUND RESTATEMENT.

(a) RESCISSION.—Any amounts available to the Medicaid Improvement Fund established under section 1905(b) of the Social Security Act (42 U.S.C. 1396d) for any fiscal years 2004 through 2013 for which the Federal medical assistance percentage for the fiscal year (other than under part E of title IV) or payments under title XXI.

(b) CONFORMING AMENDMENTS.—Section 1911(b)(1) of the Social Security Act (42 U.S.C. 1396l(b)(1)) is amended—

(1) in subparagraph (A), by striking "$100,000,000" and inserting "$150,000,000"; and

(2) in subparagraph (B), by striking "$150,000,000" and inserting "$200,000,000".

Subtitle B—Enhanced Support for the Children's Health Insurance Program

SEC. 2101. ADDITIONAL FEDERAL FINANCIAL PARTICIPATION FOR CHIP.

(a) IN GENERAL.—Section 1902(a)(10)(A)(i) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)) is amended by adding at the end the following:

"Notwithstanding the preceding sentence, during the period that begins on October 1, 2013, and ends on September 30, 2019, the enhanced FMAP determined for a State for a fiscal year (or for any portion of a fiscal year occurring during such period) shall be increased by 25 percentage points, but in no case may the enhanced FMAP under the preceding sentence not apply with respect to determining the payment to a State under subsection (y) for expenditures described in subparagraph (A)(v), paragraphs (8), (9), (11) of subsection (c), or clause (4) of the first sentence of section 1905(b)."

(b) MAINTENANCE OF EFFORT.—

(1) IN GENERAL.—Section 2105(d) of the Social Security Act (42 U.S.C. 1397eed(d)) is amended by adding at the end the following:

"Continuation of Eligibility Standards for Children Until October 1, 2019.—

"(A) IN GENERAL.—During the period that begins on the date of enactment of the Patient Protection and Affordable Care Act and ends on September 30, 2019, a State shall not have in effect eligibility standards, methodologies, or procedures under its State child health plan (including any waiver under such plan) for children (including children provided medical assistance for which payment is made under section 1902(a)(10)(A)(i) and whose income (as determined under the Social Security Act (42 U.S.C. 1396a(a)(2))) does not exceed 3 percentage points; and

"(B) IN GENERAL.—The first sentence of section 1905(b) is amended by striking "shall be 50 per centum" and inserting "shall be 55 per centum".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) takes effect on January 1, 2011.
(C) by adding at the end the following:

“(v) shall, beginning January 1, 2014, use modified gross income and household income (as defined in section 36B(d)(2) of the Internal Revenue Code of 1986) to determine eligibility for child health assistance under the State child health plan or under any waiver of such plan and for any other purpose applicable for which a determination of income is required, including with respect to the imposition of premiums and cost-sharing, consistent with section 1902(e)(14)."

SEC. 2102. TECHNICAL CORRECTIONS.

(a) CHIPRA.—Effective as if included in the enactment of the Children’s Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3) (in this section referred to as “CHIPRA”):

(1) Section 2104(m) of the Social Security Act, as added by section 102 of CHIPRA, is amended—

(A) in subparagraphs (E) through (L) as subparagraphs (F) through (M), respectively; and

(B) by inserting after subparagraph (D), the following:

“(E) Section 1902(e)(14) (relating to income determined using modified gross income and household income)."

(e) APPLICATION OF STREAMLINED ENROLLMENT SYSTEM.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)), as amended by subsection (d)(2), is amended by adding at the end the following:

“(N) Section 1943(b) (relating to coordination with State Exchanges and the State Medicaid agency)."

(f) ELIGIBILITY FOR CHILDREN INELIGIBLE FOR MEDICAID AS A RESULT OF ELIMINATION OF DISREGARDS.—Notwithstanding any other provision of law, a State shall treat any child who is determined to be ineligible for medical assistance under the State Medicaid plan or under a waiver of the plan as a result of the elimination of the application of the income disregard based on expense or type of income, as required under section 1902(e)(14) of the Social Security Act (as added by this Act), as a targeted low-income child under section 1902(a)(10) (unless the child is excluded under paragraph (2) of that section) and shall provide child health assistance to the child under the State child health plan (whether implemented under title XIX or XXI, or both, of the Social Security Act).

SEC. 2102. TECHNICAL CORRECTIONS.

(a) CHIPRA.—Effective as if included in the enactment of the Children’s Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3) (in this section referred to as “CHIPRA”):

(1) Section 2104(m) of the Social Security Act, as added by section 102 of CHIPRA, is amended—

(A) by redesignating paragraph (7) as paragraph (8); and

(B) by inserting after paragraph (6), the following:

“(7) ADJUSTMENT OF FISCAL YEAR 2010 ALLOTMENTS TO ACCOUNT FOR CHANGES IN PROJECTED SPENDING FOR CERTAIN PREVIOUSLY APPROVED EXPANSION PROGRAMS.—For purposes of the fiscal year 2010 allotment, in the case of one of the 50 States or the District of Columbia that has an approved State plan amendment effective January 1, 2006, to provide child health assistance through the provision of benefits under the State plan under title XIX for children from birth through age 5 whose family income does not exceed 200 percent of the poverty line, the Secretary shall increase the allotment by an amount that would be equal to the Federal share of expenditures that would have occurred under the Federal Medical Assistance Percentage (FMAP) rate rather than the Federal medical assistance percentage matching rate for such population.

(2) Section 1902(e)(14) of CHIPRA is amended by striking “legal residents” and inserting “lawfully residing in the United States”.

(3) Subclauses (I) and (II) of paragraph (3)(C)(i) of section 2105(a) of the Social Security Act (42 U.S.C. 1396a(a)(3)(i)), as added by section 104 of CHIPRA, are each amended by striking “—”.

(4) Section 2105(a)(3)(E)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(3)(E)(ii)), as added by section 104 of CHIPRA, is amended by striking “—” and inserting “Poverty guidelines”.

(5) Section 2105(c)(9)(B) of the Social Security Act (42 U.S.C. 1397c(c)(9)(B)), as added by section 211(c)(1) of CHIPRA, is amended by striking “section 1903(a)(3)(G)” and inserting “section 1903(a)(3)(G)”.

(6) Section 2109(b)(2)(B) of the Social Security Act (42 U.S.C. 1397l(b)(2)(B)), as added by section 104 of CHIPRA, is amended by inserting “the thing population growth factor under section 2104(b)(9)” and “a high-performing State under section 211(b)(3)(B)”.

(7) Section 2110(c)(9)(B)(v) of the Social Security Act (42 U.S.C. 1397l(c)(9)(B)(v)), as added by section 568(b) of CHIPRA, is amended by striking “is amended” and all that follows through “and inserting” and “is amended by”.

(b) CHIP E LIGIBILITY FOR CHILDREN INELIGIBLE FOR MEDICAID AS A RESULT OF ELIMINATION OF DISREGARDS.—Notwithstanding any other provision of law, a State shall treat any child who is determined to be ineligible for medical assistance under the State Medicaid plan or under a waiver of the plan as a result of the elimination of the application of the income disregard based on expense or type of income, as required under section 1902(e)(14) of the Social Security Act (as added by this Act), as a targeted low-income child under section 1902(a)(10) (unless the child is excluded under paragraph (2) of that section) and shall provide child health assistance to the child under the State child health plan (whether implemented under title XIX or XXI, or both, of the Social Security Act).

sec. 2102. ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES.

Subtitle C—Medicaid and CHIP Enrollment Simplification

SEC. 2201. ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES.

Title XIX of the Social Security Act (42 U.S.C. 1396a et seq.) is amended by adding at the end the following:

“Subtitle C—Medicaid and CHIP Enrollment Simplification

SEC. 2201. ENROLLMENT SIMPLIFICATION AND COORDINATION WITH STATE HEALTH INSURANCE EXCHANGES.

‘(a) Combining Eligibility Determination in Medicaid.—As a condition of the State plan under this title and receipt of any Federal financial assistance under section 1902(a) for a fiscal year beginning after January 1, 2014, a State shall ensure that the requirements of subsections (b) and (c) are met.

‘(b) Enrollment Simplification and Coordination With State Health Insurance Exchanges and CHIP.—

‘(1) IN GENERAL.—A State shall establish procedures for—

‘(A) enrolling individuals, through an Internet website that meets the requirements of paragraph (4), to apply for medical assistance under the State plan or under a waiver of the plan, to be enrolled in the State plan or waiver, to renew their enrollment in the plan or waiver, and to consent to enrollment or reenrollment in the State plan through electronic signature;

‘(B) enrolling, without any further determination by the State and through such website, individuals who are identified by an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act as being eligible for—

‘(i) medical assistance under the State plan or waiver;

‘(ii) child health assistance under the State child health plan under title XXI;

‘(iii) dental coverage.

‘(C) ensuring that individuals who apply for but are determined to be ineligible for medical assistance under the State plan or a waiver or ineligible for child health assistance under the State Medicaid plan or waiver, for which a determination of eligibility errors and disruptions in coverage.

‘(D) ensuring that the State agency responsible for administering the State plan under this title (in this section referred to as the ‘State Medicaid agency’), the State agency responsible for administering the State child health plan under title XXI (in this section referred to as the ‘State CHIP agency’), and an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act, establish an electronic interface sufficient to allow for a determination of an individual’s eligibility for such medical assistance, child health assistance, or both, under the State Medicaid plan or waiver, the State child health plan under title XXI, and a qualified health plan, as appropriate; and

‘(E) coordinating, for individuals who are enrolled in the State plan or waiver or ineligible for medical assistance under the State Medicaid plan or waiver, the State child health plan under title XXI and who are also enrolled in a qualified health plan offered through such an Exchange, and for individuals who are enrolled in the State child health plan under title XXI and who are also enrolled in a qualified health plan, the provision of medical assistance or child health assistance to such individuals with the coverage provided under the qualified health plan in which they are enrolled, including services described in section 1905(a)(9)(B) (relating to early and periodic screening, diagnosis, and treatment services defined in section 1905(r)) and provided in accordance with the requirements of section 1902(a)(43); and

‘(F) conducting outreach, enrollment, and enrolling vulnerable and underserved populations eligible for medical assistance under this title XIX or for child health assistance under title XXI, including homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.

‘(2) AGREEMENTS WITH STATE HEALTH INSURANCE EXCHANGES.—The State Medicaid agency and the State CHIP agency may enter into an agreement with an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act under which the State Medicaid agency or State CHIP agency may determine whether a State resident is eligible for premium assistance for the purchase of a qualified health plan under section 36B of the Internal Revenue Code of 1986 (and, if applicable, advance payment of such assistance under section 1322 of the Patient Protection and Affordable Care Act), and, if eligible, enrolled in such a plan without having to submit an additional or separate application, and for the exchange of information regarding reduced cost-sharing for eligible individuals under section 1402 of the Patient Protection and Affordable Care Act, and any other assistance or subsidies available for coverage obtained through the Exchange.

‘(3) Use of National Exchange.—Notwithstanding any other provision of law, the Secretary shall ensure that information obtained through the Exchange system is made available to the Exchange established by the State and the State CHIP agency for use in determining eligibility under this title for medical assistance, child health assistance, or both, under the State Medicaid plan or waiver, the State child health plan under title XXI, or a qualified health plan, as appropriate; and

‘(4) Coordination.—Any State plan or waiver that is approved under this title and that is not designated as a qualified plan (as defined in section 1311(f)) shall not be required to include the provisions described in paragraphs (1) and (2).’’.
"(3) STREAMLINED ENROLLMENT SYSTEM.— The State Medicaid agency and State CHIP agency shall participate in and comply with the requirements for the system established under section 1902(a)(47)(B) of the Social Security Act (relating to streamlining procedures for enrollment through an Exchange, Medicaid, and CHIP)."

(4) DEFINITION REQUIREMENTS.— The procedures established by State under paragraph (1) shall include establishing and having in operation, not later than January 1, 2014, a procedure for the State to provide services furnished on or after that date.

SEC. 2301. COVERAGE FOR FREESTANDING BIRTH CENTER SERVICES.

(a) IN GENERAL.—Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)) is amended—

(1) in subsection (a) by inserting at the end the following new paragraph:

"(28) freestanding birth center services (as defined in subsection (1)(S)(A)) and other ambulatory services that are offered by a freestanding birth center (as defined in subsection (1)(S)(B)) and that are otherwise included in the plan; and"

(2) in subsection (b)(l), by adding at the end the following new paragraph:

"(ii) The term ‘freestanding birth center’ means a health facility—

(A) that is not a hospital;

(B) where childbirth is planned to occur away from the pregnant woman’s residence;

(C) that is not a hospital that elects under section 1902(a)(47)(B) to be a qualified entity for such purpose."
U.S.C. 1396a(a)(10), as amended by section 2001(a)(5)(A), is amended in the matter following subparagraph (G)—

(A) by striking “and XV” and inserting “XV” and;

(B) by inserting “, and XVII” and

(C) by striking “as are necessary for an application to be made by an individual described in subparagraph (A) to be eligible for medical assistance under a State plan; and

(D) information on how to assist such individuals in completing and filing such forms.

(2) NOTIFICATION REQUIREMENTS.—A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is eligible for medical assistance under a State plan shall—

(A) notify the State agency of the determination made to the individual; and

(B) inform such individual at the time the determination is made that an application for medical assistance is required to be made by not later than the last day of the month following the month during which the determination is made.

(3) 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 under a State plan, shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b)."

(4) CONFORMING AMENDMENTS.—

(A) Section 1905(a) of the Social Security Act (42 U.S.C. 1396a(a)(4)(C)) is amended by inserting “November 19, 2009” in the matter preceding paragraph (1) in clause (xv), by striking “or” at the end of (ii) in clause (xv), by adding “or” at the end of, and by inserting after clause (xiv) the following:

“(xvi) individuals described in section 1902(l),”.

(B) Section 1905(a)(8) of such Act (42 U.S.C. 1396a(a)(4)(C)) is amended by inserting “November 19, 2009” in the matter preceding subsection (b) in subsection (a)(10)(A)(ii)(XXI), after “1902(a)(10)(A)(ii)(XX)”,.

(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:

“PRESumptive Eligibility for Family Planning Services—

‘‘Sec. 1920c. (a) State Option.—State plan approved under section 1902 may provide for making medical assistance available to an individual described in section 1902(l)(2) (relating to individuals who meet certain income eligibility standard) during a presumptive eligibility period. In the case of an individual described in section 1902(l)(2), such medical assistance shall be limited to family planning services and supplies described in 1905(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—

‘‘(I)Presumptive Eligibility Period.—The term ‘presumptive eligibility period’ means, with respect to an individual described in subsection (a), the period that—

‘‘(I) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(l); and

‘‘(II) 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.—Subject to subparagraph (B), the term ‘qualified entity’ means any entity that—

‘‘(I) is eligible for payments under a State plan and such title; and

‘‘(II) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

‘‘(B) In general.—Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities in order to prevent fraud and abuse.

‘‘(c) Administration.—

‘‘(I) IN GENERAL.—The State agency shall provide qualified entities with—

‘‘(II) such forms as are necessary for an application to be made by an individual described in subparagraph (A) to be eligible for medical assistance under a State plan; and

‘‘(III) information on how to assist such individuals in completing and filing such forms.

‘‘(d) Effective Date.—The amendments made by this section take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date.

SEC. 2904. CLARIFICATION OF DEFINITION OF MEDICAL ASSISTANCE

Section 1905(a)(5) of the Social Security Act (42 U.S.C. 1396a(a)(5)) is amended by inserting ‘‘or the care and services themselves, or both before (‘‘if provided by an individual who is qualified to provide such services, including family members (as defined by the Secretary).”

Subtitle E—New Options for States to Provide Long-Term Services and Supports

SEC. 2401. COMMUNITY FIRST CHOICE OPTION.

Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended by adding at the end the following:

“(k) State Plan Option to Provide Home and Community-based Attendant Services and Supports.—

“(I) In General.—Subject to the succeeding provisions of this subsection, beginning

November 1, 2010, a State may provide through a State plan amendment for the provision of medical assistance for home and community-based attendant services and supports for individuals who are eligible for medical assistance under the State plan whose income does not exceed 150 percent of the poverty line (as defined in section 211(c)(1)(B) or, if greater, the income level appropriate under an individual’s eligibility status) has been determined to require an institutional level of care to be eligible for nursing facility services in accordance with section 1919(b)(1) then such State may provide such home and community-based attendant services and supports, and, in addition, shall provide to qualified entities—

“(ii) assistance in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks through hands-on assistance, supervision, or cueing—

“(I) under a person-centered plan of services and supports that is based on an assessment of functional need and that is agreed to by the individual or, where appropriate, the individual’s representative;

“(II) in a home or community setting, which does not include a nursing facility, individual or intermediate care facility for the mentally retarded, or an institution for mental diseases, the cost of which could be reimbursed under the State plan, but only if the individual chooses to receive such services, and

“(III) under an agency-provider model or other model (as defined in paragraph (5)(C));

“(iv) the furnishing of which—

“(I) is selected, managed, and, as appropriate, with assistance from the individual’s representative;

“(II) is controlled, to the maximum extent possible, by the individual or, where appropriate, the individual’s representative, regardless of who may act as the employer of record; and

“(v) provided by an individual who is qualified to provide such services, including family members (as defined by the Secretary).”

“Providing Long-Term Services and Supports—

Sec. 2401. COMMUNITY FIRST CHOICE OPTION.—

In addition to assistance in accomplishing activities of daily living, instrumental activities of daily living, and health-related tasks, the State plan amendment for the provision of medical assistance for home and community-based attendant services and supports made available include—
(i) the acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and household duties;

(ii) back-up systems or mechanisms (such as the use of beepers or other electronic devices) to ensure continuity of services and supports provided under this subsection for each fiscal year for which such services and supports are provided;

(iii) voluntary training on how to select, manage, and dismiss attendants.

(C) EXCLUDED SERVICES AND SUPPORTS.—Subject to paragraph (D), the home and community-based attendant services and supports made available do not include—

(i) homemaker services and board and care for the individual;

(ii) medical supplies and equipment; or

(iii) home modifications.

(D) HOME AND COMMUNITY-BASED ATTENDANT SERVICES AND SUPPORTS.—The home and community-based attendant services and supports may include—

(i) expenditures for transition costs such as moving and nonrecurring and utilities, bedding, basic kitchen supplies, and other necessities required for an individual to make the transition from a nursing facility to an independent living setting or group setting, or intermediate care facility for the mentally retarded to a community-based home setting where the individual resides; and

(ii) expenditures relating to a need identified in an individual’s person-centered plan of services and supports that is expected to substitute for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

(2) INCREASED FEDERAL FINANCIAL PARTICIPATION.—For purposes of payments to a State under section 1902(a)(1), with respect to amounts expended by the State to provide medical assistance under the State plan for home and community-based attendant services and supports to eligible individuals in accordance with this subsection during a fiscal year, the Federal medical assistance percentage applicable to the State under section 1902(a)(2)(B) shall be increased by 6 percentage points.

(3) STATE REQUIREMENTS.—In order for a State plan amendment to be approved under this subsection, the State shall—

(A) develop and implement such amendments to the State plan as are necessary to provide medical assistance under the plan that is provided to individuals who receive home and community-based attendant services and supports under this subsection and those provided under other home and community-based services and supports under this subsection for each fiscal year for which such services and supports are provided;

(B) the provision of unemployment and any other services and supports provided in accordance with the requirements of section 1938 and applicable Federal and State laws regarding—

(i) the withholding and payment of Federal and State income and payroll taxes; and

(ii) the provision of unemployment and workers compensation insurance; and

(C) the maintenance of general liability insurance and

(D) occupational health and safety.

(4) EVALUATION, DATA COLLECTION, AND REPORT TO CONGRESS

(A) EVALUATION.—The Secretary shall conduct an evaluation of the provision of home and community-based attendant services and supports under this subsection and those provided under other home and community-based services and supports under this subsection for each fiscal year for which such services and supports are provided.

(B) DATA COLLECTION.—The Secretary shall—

(i) provide for the collection of data and information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year for which such services and supports are provided;

(ii) make available to the public an interim report on the findings of the evaluation under subparagraph (A); and

(iii) make available to the public a final report on the findings of the evaluation under subparagraph (A).

(5) COMPLIANCE WITH CERTAIN LAWS.—A State shall ensure that, regardless of whether the State uses an agency-provider model or other models to provide home and community-based attendant services and supports under a State plan amendment under this subsection, such services and supports are provided in accordance with the requirements of section 1902 and applicable Federal and State laws regarding—

(A) the withholding and payment of Federal and State income and payroll taxes;

(B) the provision of unemployment and workers compensation insurance; and

(C) the maintenance of general liability insurance and

(D) occupational health and safety.

(6) INSTRUMENTAL ACTIVITIES OF DAILY LIVING.—The term ‘instrumental activities of daily living’ includes—

(A) the activities necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and household duties;

(B) the activities necessary to allow the individual to receive health care, including—

(i) such activities as are necessary for an individual to become oriented to the community, and others and maximizes consumer independence and consumer control;

(ii) the specific number of individuals served by the State under the State plan or under a waiver; and

(iii) the comparative analysis of the costs of services and supports provided under the State plan or under a waiver.

(C) DATA COLLECTION.—The Secretary shall provide to Congress and make available to the public an interim report on the findings of the evaluation under subparagraph (A); and

(D) REPORTS.—Not later than—

(i) December 31, 2013, the Secretary shall submit to Congress an interim report on the findings of the evaluation under subparagraph (A); and

(ii) December 31, 2015, the Secretary shall submit to Congress and make available to the public a final report on the findings of the evaluation under subparagraph (A).

(E) DISCUSSION.—In this subsection—

(A) ACTIVITIES OF DAILY LIVING.—The term ‘activities of daily living’ includes tasks such as eating, toileting, grooming, dressing, bathing, and housekeeping.

(B) CONSUMER CONTROLLED.—The term ‘consumer controlled’ means a method of selecting and providing services and supports where the individual, or the individual’s representative, exercises control over the delivery of services and supports, regardless of who acts as the employer of record.

(C) DELIVERY MODELS.—The term ‘agency-provider model’ means, with respect to the provision of home and community-based attendant services and supports for an individual, subject to paragraph (4), a method of providing consumer controlled services and supports under which entities contract for the provision of such services and supports.

(D) OTHER MODELS.—The term ‘other models’ means, subject to paragraph (4), methods, other than an agency-provider model, of providing consumer controlled services and supports. Such models may include the provision of vouchers, direct cash payments, or use of a fiscal agent to assist in obtaining services.

(E) HEALTH-RELATED TASKS.—The term ‘health-related tasks’ means specific tasks related to the needs of an individual, which can be delegated or assigned by licensed health-care professionals under State law to be performed by an attendant.

(F) INDIVIDUAL’S REPRESENTATIVE.—The term ‘individual’s representative’ means a parent, family member, guardian, advocate, or other authorized representative of an individual.

(G) INSTRUMENTAL ACTIVITIES OF DAILY LIVING.—The term ‘instrumental activities of daily living’ includes—

(A) the daily activities necessary for the individual to accomplish activities of daily living, instrumental activities of daily living, and household duties;

(B) the activities necessary to allow the individual to receive health care, including—

(i) such activities as are necessary for an individual to become oriented to the community, and others and maximizes consumer independence and consumer control;
(1) allocate resources for services in a manner that is responsive to the changing needs and choices of beneficiaries receiving non-institutionally-based long-term services and supports that are provided under programs other than the State Medicaid program, and that provides strategies for beneficiaries receiving these services to maximize their independence, including through the use of client-employed providers;

(2) provide the support and coordination needed to achieve full availability of such services and supports that are provided under programs other than the State Medicaid program, and that provides strategies for beneficiaries receiving these services to maximize their independence, including through the use of client-employed providers;

(3) improve coordination among, and the regulation of, all providers of such services under locally and State-funded programs in order to—

(A) achieve a more consistent administration of policies and procedures across programs in relation to the provision of such services; and

(B) oversee and monitor all service system functions to assure—

(i) coordination of, and effectiveness of, eligibility determinations and individual assessments;

(ii) development and service monitoring of a comprehensive system, a management system, a system to qualify and monitor providers, and systems for role-setting and individual budget determinations; and

(B) increase the number of qualified direct care workers to provide self-directed personal assistance services.

(b) ADDITIONAL STATE OPTIONS.—Section 1915(i) of the Social Security Act (42 U.S.C. 1396n(i)) is amended by adding at the end the following new paragraphs:

"(1) AMENDMENT.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by section 2904(a)(1), is amended—

(A) in subclause (XX), by adding 'or' at the end; and

(B) in subclause (XXII), by adding 'or' at the end; and

(C) by inserting after subclause (XXII), the following new subclause:

"'(XXIII) individuals who are eligible for home and community-based services under a waiver for a period of not less than 6 months or for such longer minimum period, not to exceed 2 years, as may be specified by the Secretary, that will receive home and community-based services pursuant to a State plan amendment under such subsection,'.

(2) CONFORMING AMENDMENTS.—

(A) Section 1903(f)(4) of the Social Security Act (42 U.S.C. 1396a(f)(4)), as amended by section 3005(a) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a(a)(10)(A)(ii)), is amended—

(1) in clause (xv), by striking "or" at the end; and

(2) in clause (xvi), by adding "or" at the end; and

(B) in section 1115 of the Social Security Act (42 U.S.C. 1316), as amended by section 1115 of the Deficit Reduction Act of 2005 (42 U.S.C. 1316), is amended—

(1) by striking subparagraph (C) and inserting—

"'(C) AUTHORITY TO OFFER DIFFERENT TYPE, AMOUNT, DURATION, OR SCOPE OF HOME AND COMMUNITY-BASED SERVICES.—A State may offer home and community-based services to individuals under this paragraph that differ in type, amount, duration, or scope from the home and community-based services offered for individuals who satisfy the needs-based criteria established under paragraph (1)(A), and so long as such services are within the scope of services described in paragraph (4)(B) of subsection (a) of this section for individuals who satisfy the needs-based criteria established under paragraph (1)(A),".

(2) by adding at the end the following new clauses:

"(xvii) individuals who are eligible for home and community-based services under a waiver for a period of not less than 6 months or for such longer minimum period, not to exceed 2 years, as may be specified by the Secretary, that will receive home and community-based services pursuant to a State plan amendment under such subsection,'.

(3) by inserting after subparagraph (A) the following new subparagraphs:

"(A) Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by section 2904(a)(1), is amended—

(1) in subsection (a), by striking "or" at the end; and

(2) in subsection (b)(3), by adding at the end the following:

"'(B) a State may elect to provide home and community-based services in accordance with this subsection to individuals who satisfy the needs-based criteria for the receipt of such services established under paragraph (1)(A) that in addition to continuing to provide such services to such individuals, elect to provide home and community-based services in accordance with the requirements of this paragraph to individuals who are eligible for home and community-based services under a waiver approved for the individuals pursuant to a State plan amendment under this subsection,'.

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

"(B) Section 6071(h) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a(h)), is amended—

(A) in paragraph (1), by striking "and" at the end of clause (i) and inserting "or"; and

(B) in paragraph (2), by striking "2011" and inserting "2016; and"

(5) by striking subparagraph (C) and inserting—

"'(C) AUTHORITY TO OFFER DIFFERENT TYPE, AMOUNT, DURATION, OR SCOPE OF HOME AND COMMUNITY-BASED SERVICES.—A State may offer home and community-based services to individuals under this paragraph that differ in type, amount, duration, or scope from the home and community-based services offered for individuals who satisfy the needs-based criteria established under paragraph (1)(A), and so long as such services are within the scope of services described in paragraph (4)(B) of subsection (a) of this section for individuals who satisfy the needs-based criteria established under paragraph (1)(A),".

(6) by striking "or" at the end of clause (i) and inserting "or"; and

(7) by adding at the end the following:

"'(B) a State may elect to provide home and community-based services in accordance with this subsection to individuals who satisfy the needs-based criteria for the receipt of such services established under paragraph (1)(A) that in addition to continuing to provide such services to such individuals, elect to provide home and community-based services in accordance with the requirements of this paragraph to individuals who are eligible for home and community-based services under a waiver approved for the individuals pursuant to a State plan amendment under this subsection, and so long as all eligible individuals in the State for such services are enrolled, and all such services are provided under such election before the end of the initial 5-year period.

"(C) RENEWAL.—An election by a State under this paragraph may be renewed for additional 5-year terms if the Secretary determines, prior to beginning of each such renewal period, that the State has—

(i) adhered to the requirements of this subsection with respect to quality improvement and beneficiary outcomes; and

(ii) met the State's objectives with respect to quality improvement and beneficiary outcomes.

"(D) REMOVAL OF LIMITATION ON SCOPE OF SERVICES.—(Paraphrase (1) of section 1915(i) of the Social Security Act (42 U.S.C. 1396n(i)), as amended by subsection (a), is amended by striking 'or such other services requested by the State as the Secretary may approve'.

"(E) OPTIONAL ELIGIBILITY CATEGORY TO PROVIDE HOME AND COMMUNITY-BASED SERVICES.—The State submits to the Secretary for approval a State plan amendment to provide home and community-based services for beneficiaries receiving home and community-based services against spousal impoverishment.

During the 5-year period that begins on January 1, 2014, section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396n(i)) is amended—

(1) by striking paragraph (C) and inserting the following:

"'(C) PROJECTION OF NUMBER OF INDIVIDUALS TO BE PROVIDED HOME AND COMMUNITY-BASED SERVICES.—The State submits to the Secretary, in such form and manner, and upon such frequency as the Secretary shall specify, the projected number of individuals to be provided home and community-based services;'

and

(2) in subclause (ii) of subparagraph (D)(i), by striking "to be eligible for such services for a period of at least 12 months beginning on the date the individual first received medical assistance for such services" and inserting "to continue to be eligible for such services after the effective date of the modification and until such time as the individual no longer meets the standards of such services under such pre-modified criteria".

"(F) ELIMINATION OF OPTION TO WAIVE STATEWIDENESS; ADDITION OF OPTION TO WAIVE COMPARABILITY.—(Paragraph (3) of section 1915(i) of such Act (42 U.S.C. 1396n(i)) is amended by striking '1902(a)(1) (relating to statewideness)' and inserting '1902(a)(10)(B) (relating to comparability)'.

"(G) EFFECTIVE DATE.—The amendments made by subsections (b) through (f) take effect on the first day of the first fiscal year quarter that begins after the date of enactment of this Act.

SEC. 2403. MONEY FLOWS THE PERSON REHABILITATING AGAINST SPONUS IMPOVERISHMENT.

(a) EXTENSION OF DEMONSTRATION.—

(1) IN GENERAL.—Section 6071(h) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a(h)), as amended by section 2904(a)(1), is amended—

(A) in paragraph (1)(E), by striking "fiscal year 2011" and inserting "each of fiscal years 2011 through 2016"; and

(B) in paragraph (2), by striking "2011" and inserting "2016".

(2) EVALUATION.—(Paragraphs (2) and (3) of section 6071(g) of such Act is amended by inserting at the end the following:

"'(B) REDUCTION OF INSTITUTIONAL RESIDENCY PERIOD.—

(1) IN GENERAL.—Section 6071(b)(2) of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a(b)), as amended by section 2904(a)(1), is amended—

(A) in subparagraph (A)(i), by striking "for a period of not less than 6 months or for such longer minimum period, not to exceed 2 years, as may be specified by the Secretary," and inserting "for a period of not less than 90 consecutive days,"; and

(B) by adding at the end the following:

"‘Any days that an individual resides in an institution on the basis of having been admitted solely for purposes of receiving short-term rehabilitative services for a period for which payment for such services is limited under title XVIII shall not be taken into account for purposes of determining the 90-day period required under subparagraph (A)(i).'

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect 30 days after the date of enactment of this Act.

SEC. 2404. PROHIBITION OF HOME AND COMMUNITY-BASED SERVICES AGAINST SPONUS IMPOVERISHMENT.
services for elderly individuals and adults with physical disabilities. (a) In 2007, 69 percent of Medicaid long-term care spending for elderly individuals and adults with physical disabilities paid for home and community-based care dollars on home and community-based percent or more of their Medicaid long-term care spending for elderly individuals.

Olmstead

The United States Bipartisan Commission on Comprehensive Health Care, also known as the "Pepper Commission," released its "Call for Action" blueprint for health reform in September 1990. In the 20 years since those recommendations were made, Congress has never acted on the report.

In 1999, under the United States Supreme Court’s decision in Olmstead v. L.C., 527 U.S. 566 (1999), individuals with disabilities have the right to choose to receive their long-term services and supports in the community, rather than in an institutional setting.

Despite the Pepper Commission and Olmstead decision, the long-term care provided to our Nation’s elderly and disabled has not improved. In fact, for many, it has gotten far worse.

In 2007, 69 percent of Medicaid long-term care spending for elderly individuals and adults with physical disabilities was paid for institutional services. Only 6 states spent 50 percent or more of their Medicaid long-term care dollars on home and community-based services for elderly individuals and adults with physical disabilities while 1/2 of the States spent less than 25 percent. This disparity continues even though, on average, it is estimated that Medicaid dollars can support nearly 3 elderly individuals and adults with physical disabilities in home and community-based services for every individual in a nursing home. Although every State has chosen to provide certain services under home and community-based waivers, these services are unevenly available within and across States, and reach a small percentage of eligible individuals.

(b) In 2007, 69 percent of Medicaid long-term care spending for elderly individuals and adults with physical disabilities was paid for institutional services. Only 6 states spent 50 percent or more of their Medicaid long-term care dollars on home and community-based services for elderly individuals and adults with physical disabilities while 1/2 of the States spent less than 25 percent. This disparity continues even though, on average, it is estimated that Medicaid dollars can support nearly 3 elderly individuals and adults with physical disabilities in home and community-based services for every individual in a nursing home. Although every State has chosen to provide certain services under home and community-based waivers, these services are unevenly available within and across States, and reach a small percentage of eligible individuals.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) Nearly 2 decades have passed since Congress seriously considered long-term care reform. The United States Bipartisan Commission on Comprehensive Health Care, also known as the "Pepper Commission," released its "Call for Action" blueprint for health reform in September 1990. In the 20 years since those recommendations were made, Congress has never acted on the report.

(2) In 1999, under the United States Supreme Court’s decision in Olmstead v. L.C., 527 U.S. 566 (1999), individuals with disabilities have the right to choose to receive their long-term services and supports in the community, rather than in an institutional setting.

(3) Despite the Pepper Commission and Olmstead decision, the long-term care provided to our Nation’s elderly and disabled has not improved. In fact, for many, it has gotten far worse.

(4) In 2007, 69 percent of Medicaid long-term care spending for elderly individuals and adults with physical disabilities was paid for institutional services. Only 6 states spent 50 percent or more of their Medicaid long-term care dollars on home and community-based services for elderly individuals and adults with physical disabilities while 1/2 of the States spent less than 25 percent. This disparity continues even though, on average, it is estimated that Medicaid dollars can support nearly 3 elderly individuals and adults with physical disabilities in home and community-based services for every individual in a nursing home. Although every State has chosen to provide certain services under home and community-based waivers, these services are unevenly available within and across States, and reach a small percentage of eligible individuals.

(b) INCREASE IN REBATE FOR OTHER DRUGS.—Section 1927(c)(3)(B) of such Act (42 U.S.C. 1396r–8(c)(3)(B)) is amended—

(i) in clause (i), by striking "and" at the end of clause (i); and

(ii) by striking the period at the end and inserting "and"; and

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

"(i) the amount of payment reduction, if any, that—

(A) is not subject to a reconsideration under section 1116(d); and

(B) in subsection (b) of section 2405 of title 42, as added by section 903 of the Patient Protection and Affordable Care Act (42 U.S.C. 1902(a)(10)(A)(ii)(VI)) is amended—

(A) in clause (i)—

(1) by inserting "and before January 1, 2010," after "December 31, 1995," and

(2) by striking the period at the end and inserting "and"; and

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

"(II) by striking the period at the end and inserting "and"; and

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

"(xvii) a drug that the Secretary determines is subject to and that the State shall collect, on or after January 1, 2010, during a fiscal year beginning after December 31, 2009, is 13 percent.".
“(1) IN GENERAL.—Except as provided in clause (ii), in the case of a drug that is a new formulation, such as an extended-release formulation, of a single source drug or an innovator multiple source drug, the rebate obligation with respect to the drug under this section shall be the amount computed under this section for the new formulation of the drug so defined:

“(I) the average manufacturer price for each dosage form and strength of the new formulation of the single source drug or innovator multiple source drug;

“(II) the highest additional rebate (calculated as a percentage of average manufacturer price) under this section for any strength of a single source drug or innovator multiple source drug; and

“(III) the total number of units of each dosage form and strength of the new formulation paid for under the State plan in the rebate period (as reported by the State).

“(ii) NO APPLICATION TO NEW FORMULATIONS OF ORPHAN DRUGS.—Clause (i) shall not apply to a new formulation of a covered outpatient drug that is or has been designated under section 526 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360b) for a rare disease or condition notwithstanding whether or not the period of market exclusivity for the drug under section 527 of such Act has expired or the specific indication for use of the drug.

“(b) EFFECTIVE DATE.—The amendments made by paragraph (a) shall apply to drugs that are paid for by a State after December 31, 2010.

“(c) MAXIMUM REBATE AMOUNT.—Section 1927(c)(2) of such Act (42 U.S.C. 1396r–8(c)(2)), as amended by subsection (d), is amended by adding at the end the following new subparagraph:

“(D) MAXIMUM REBATE AMOUNT.—In no case shall the sum of the amounts applied under paragraph (1)(A)(ii) and this paragraph with respect to each dosage form and strength of a single source drug or an innovator multiple source drug for a rebate period beginning after December 31, 2009, exceed 100 percent of the average manufacturer price of the drug.

“(i) CONFORMING AMENDMENTS.—

“(1) IN GENERAL.—Section 310B of the Public Health Service Act (22 U.S.C. 256b) is amended—

“(A) in subparagraph (a)(2)(B)(ii) and inserting “1927(c)(4)” and inserting “1927(c)(3)”;

“(B) by redesignating subparagraphs (G), (H), and (K) as subparagraphs (E), (F), and (J), respectively; and

“(C) redesignating subsection (d) as subsection (c).

“(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on January 1, 2010.

“SEC. 2502. ELIMINATION OF EXCLUSION OF COVERAGE OF CERTAIN DRUGS.

“(a) IN GENERAL.—Section 1927(d) of the Social Security Act (42 U.S.C. 1397r–8(d)) is amended—

“(1) in paragraph (2)—

“(A) striking subparagraphs (E), (I), and (J), respectively; and

“(B) by redesigning subparagraphs (F), (G), (H), and (K) as subparagraphs (E), (F), (G), and (H), respectively; and

“(2) by adding at the end the following new paragraph:

“(7) NON-EXCLUDABLE DRUGS.—The following drugs or classes of drugs, or their medical uses, shall not be excluded from coverage:

“(A) Agents when used to promote smoking cessation with agents approved by the Food and Drug Administration under the over-the-counter monograph process for purposes of promoting, and when used to promote, tobacco cessation.

“(B) Barbiturates.

“(C) Benzodiazepines.

“(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2014.

“SEC. 2503. PROVIDING ADEQUATE PHARMACY REIMBURSEMENT.

“(a) PHARMACY REIMBURSEMENT LIMITS.—

“(1) IN GENERAL.—Section 1927(e) of the Social Security Act (42 U.S.C. 1396r–8(e)) is amended—

“(A) in paragraph (4), by striking “(or, effective January 1, 2007, two or more)”;

“and

“(B) 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 not less than 175 percent of the average sales price paid by a State for a drug in a rebate period, determined on the basis of utilization of the most recently reported monthly average manufacturer prices for pharmaceutically and therapeutically equivalent multiple source drug products that are available for purchase by retail community pharmacies on a nationwide basis. The Secretary shall implement a smoothing process for average manufacturer prices. Such process shall be similar to the smoothing process used in determining the average sales price of a drug or biological under section 127A.

“(2) DEFINITION OF AMP.—Section 1927(k)(1) of such Act (42 U.S.C. 1396r–8(k)(1)) is amended—

“(A) in subparagraph (A), by striking “by” and all that follows through the period and inserting “by”;

“(B) by striking subparagraph (B) and inserting the following:

“(B) EXCLUSION OF CUSTOMARY PROMPT PAY DISCOUNTS AND OTHER PAYMENTS.—

“(i) IN GENERAL.—The average manufacturer price for a covered outpatient drug shall exclude—

“(I) customary prompt pay discounts extended to wholesalers;

“(II) bona fide service fees paid by manufacturers to wholesalers or retail community pharmacies for services related to distribution service fees, inventory management fees, product stocking allowances, and fees associated with administrative services agreements and patient education programs (such as medication compliance programs and patient education programs);

“(III) reimbursement by manufacturers for recalls, layoffs, or other unsalable returned goods, including (but not limited to) reimbursement for the cost of the goods and any reimbursement of costs associated with return goods handling and processing, reverse logistics, and drug destruction; and

“(IV) payments received from, and rebates or discounts paid to, benefit managers, managed care organizations, health maintenance organizations, insurers, hospitals, clinics, mail order pharmacies, long-term care facilities, government agencies, manufacturers, or any other entity that does not conduct business as a wholesaler or a retail community pharmacy.

“(ii) INCLUSION OF OTHER DISCOUNTS AND PAYMENTS.—Notwithstanding clause (i), any other discounts, rebates, payments, or other financial transactions that are received by, paid by, or on behalf of retail community pharmacies shall be included in the average manufacturer price for a covered outpatient drug;”;

“and

“(C) in subparagraph (C), by striking “the retail pharmacy class of trade” and inserting “retail community pharmacies”.

“(b) DISCLOSURE OF PRICE INFORMATION TO THE PUBLIC.—Section 1927(o)(3) of such Act (42 U.S.C. 1396r–8(b)(3)) is amended—

“(1) in subparagraph (A)—

“(A) in the first sentence, by inserting after clause (i) the following:

“(iv) not later than 30 days after the last day of each month of a rebate period under the agreement, on the manufacturer’s total national units that the manufacturer calculates the monthly average manufacturer price for each covered outpatient drug;”;

“and

“(B) in the second sentence, by inserting “(y) to the extent that the average of the most recently reported monthly average manufacturer prices) after “(D)(y)”;

“(2) in paragraph (D), by striking “average manufacturer prices” and inserting “the weighted average of the most recently reported monthly average manufacturer prices and the average retail survey price determined for each multiple source drug in accordance with subsection (f)”;

“(c) CLARIFICATION OF APPLICATION OF SURVEY OF RETAIL PRICES.—Section 1927(f)(1) of such Act (42 U.S.C. 1396r–8(b)(1)) is amended—

“(1) in subparagraph (A)(i), by inserting “with respect to a retail community pharmacy,” before “the determination”; and

“(2) in subparagraph (C)(ii), by striking “retail pharmacies” and inserting “retail community pharmacies.”

“(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the first day of the first calendar year quarter that begins at least 180 days after the date of enactment of this Act. Notwithstanding the applicability of subsection (a) as to whether or not final regulations to carry out such amendments have been promulgated by such date.
SUBTITLE G—MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS

SEC. 2551. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS.

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

(1) in paragraph (1), by striking “and (3) and inserting “(3)’’;

(2) in paragraph (3)(A), by striking “paragraph (6)” and inserting “paragraphs (6) and (7)”;

(3) by redesignating paragraph (7) as paragraph (8); and

(4) by inserting after paragraph (6) the following new paragraph:

“(ii) No DSH allotment determination for a State for the fiscal year under subparagraph (B)(i) shall be less than the amount equal to 35 percent of the DSH allotment determined for the State for fiscal year 2012 under this subsection (and after the application of this paragraph, if applicable), increased by the percentage change in the consumer price index for all urban consumers (all items, U.S. city average) for each previous fiscal year occurring before the fiscal year.

“(3) DSH allotment determinations for which the Secretary has determined that the percentage determined for a State in accordance with this paragraph for fiscal year 2013 or any succeeding fiscal year shall be less than the amount equal to 35 percent of the DSH allotment determined for the State for fiscal year 2012 under this subsection (and after the application of this paragraph, if applicable), increased by the percentage change in the consumer price index for all urban consumers (all items, U.S. city average) for each previous fiscal year occurring before the fiscal year.

“(4) EXCLUSION OF PORTIONS DIVERTED FOR COVERAGE EXPANSIONS.—For purposes of applying the percentage reduction under subparagraph (A) to the DSH allotment for a State that would be determined under this subsection for the State for the fiscal year without the application of this paragraph (other than a waiver described in subsection (c), or (d), or a waiver under section 1115, which the Secretary has determined for the State for the fiscal year under which non dual eligible individuals are entitled to, or enrolled for, benefits under part A of title XVIII, and is eligible for, and has been extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the conditions for the waiver have not been met or it would no longer be cost-effective and efficient, or consistent with the purposes of this title, to extend the waiver.

“(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the applicable percentage is equal to the product of the percentage reduction in uninsured individuals for the fiscal year under which non dual eligible individuals are entitled to, or enrolled for, benefits under part A of title XVIII, and is eligible for, and has been extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the conditions for the waiver have not been met or it would no longer be cost-effective and efficient, or consistent with the purposes of this title, to extend the waiver.

“(3) Uninsured reduction threshold fiscal year.—In the case of the first fiscal year described in subparagraph (C) with respect to a State—

“(i) if the State is a low DSH State described in paragraph (5)(B), the applicable percentage is equal to 25 percent; and

“(ii) if the State is a low DSH State described in subparagraph (C) with respect to a State, the DSH allotment that would be determined for the State under this subsection, without application of this paragraph, is multiplied by the applicable percentage determined for the State for the fiscal year under which non dual eligible individuals are entitled to, or enrolled for, benefits under part A of title XVIII, and is eligible for, and has been extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the conditions for the waiver have not been met or it would no longer be cost-effective and efficient, or consistent with the purposes of this title, to extend the waiver.

“(D) EXCLUSION OF PORTIONS DIVERTED FOR COVERAGE EXPANSIONS.—For purposes of applying the percentage reduction under subparagraph (A) to the DSH allotment for a State that would be determined under this subsection for the State for the fiscal year without the application of this paragraph (other than a waiver described in subsection (c), or (d), or a waiver under section 1115, which the Secretary has determined for the State for the fiscal year under which non dual eligible individuals are entitled to, or enrolled for, benefits under part A of title XVIII, and is eligible for, and has been extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the conditions for the waiver have not been met or it would no longer be cost-effective and efficient, or consistent with the purposes of this title, to extend the waiver.

“(E) REDUCTION OF STATE DSH ALLOTMENTS ONCE REDUCTION IN UNINSURED THRESHOLD REACHED.—

“(A) IN GENERAL.—Subject to subparagraph (E)(1), the DSH allotment for a State for fiscal years beginning with the fiscal year described in subparagraph (C) with respect to the State, is equal to—

“(i) in the case of the first fiscal year described in subparagraph (C) with respect to a State, the DSH allotment that would be determined for the State for the fiscal year without the application of this paragraph, is multiplied by the applicable percentage determined for the State for the fiscal year under which non dual eligible individuals are entitled to, or enrolled for, benefits under part A of title XVIII, and is eligible for, and has been extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the conditions for the waiver have not been met or it would no longer be cost-effective and efficient, or consistent with the purposes of this title, to extend the waiver.

“(ii) If the State is a low DSH State described in paragraph (5)(B), the DSH allotment determined for the State for the fiscal year under which non dual eligible individuals are entitled to, or enrolled for, benefits under part A of title XVIII, and is eligible for, and has been extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the conditions for the waiver have not been met or it would no longer be cost-effective and efficient, or consistent with the purposes of this title, to extend the waiver.

“(iii) If the State is a low DSH State described in paragraph (5)(B), the DSH allotment determined for the State for the fiscal year described in subparagraph (C) with respect to a State, the DSH allotment that would be determined for the State for the fiscal year without the application of this paragraph, is multiplied by the applicable percentage determined for the State for the fiscal year under which non dual eligible individuals are entitled to, or enrolled for, benefits under part A of title XVIII, and is eligible for, and has been extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the conditions for the waiver have not been met or it would no longer be cost-effective and efficient, or consistent with the purposes of this title, to extend the waiver.

“(B) In this paragraph, the term ‘dual eligible individuals’ means individuals with no health insurance coverage at any time during a year (as determined by the Secretary based on the most recent data available).’’.

(b) Effective Date.—The amendments made by subsection (a) take effect on Oct. 1, 2011.

SUBTITLE H—IMPROVED COORDINATION FOR DUAL ELIGIBLE BENEFICIARIES

SEC. 2552. 5-YEAR PERIOD FOR DEMONSTRATION PROJECTS.

(a) In General.—Section 1915(h) of the Social Security Act (42 U.S.C. 1396n(h)) is amended—

(1) by inserting “(i)” after “(h);”;

(2) by inserting “, or a waiver described in paragraph (2)” after “(e);”;

and

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

“(2)(A) Notwithstanding subsections (c)(3) and (d)(3), any waiver under subsection (b), (c), (d), or (e), or a waiver under section 1115, that provides medical assistance for dual eligible individuals (including any such waivers under which non dual eligible individuals may be enrolled) may be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the conditions for the waiver have not been met or it would no longer be cost-effective and efficient, or consistent with the purposes of this title, to extend the waiver.

“(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the applicable percentage is equal to the product of the percentage reduction in uninsured individuals for the fiscal year under which dual eligible individuals are entitled to, or enrolled for, benefits under part A of title XVIII, and is eligible for, and has been extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the conditions for the waiver have not been met or it would no longer be cost-effective and efficient, or consistent with the purposes of this title, to extend the waiver.

“(3) In this paragraph, the term ‘dual eligible individuals’ means individuals with no health insurance coverage at any time during a year (as determined by the Secretary based on the most recent data available).’’.

(b) Effective Date.—The amendments made by subsection (a) take effect on Oct. 1, 2011.
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(2) Supporting State efforts to coordinate and align acute care and long-term care services for dual eligible individuals with other items and services furnished under the Medicare program.

(3) Providing support for coordination of contracting and oversight by States and the Centers for Medicare & Medicaid Services with respect to the integration of the Medicare and Medicaid programs in a manner that is supportive of the goals described in paragraph (3).

(4) To establish and coordinate with the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) and the Medicaid and CHIP Payment and Access Commission established under section 1900 of such Act (42 U.S.C. 1396) with respect to policies relating to the enrollment in, and provision of, benefits to dual eligible individuals under the Medicare program under title XVIII of the Social Security Act and the Medicaid program under title XIX of such Act.

(5) To study the provision of drug coverage for new full-benefit dual eligible individuals (as defined in section 1933(o)(6) of the Social Security Act) to support the Secretary in as to monitor and report annual total expenditures, health outcomes, and access to benefits for all dual eligible individuals.

(6) To establish and coordinate with the Medicare Payment Advisory Commission established under section 1805 of such Act (42 U.S.C. 1395b–6) information similar to the information required under paragraph (1) to be submitted to Congress under section 1139A(a)(6) information similar to the information required under that section with respect to the measures established under this section.

SEC. 2701. ADULT HEALTH QUALITY MEASURES.

(a) Initial core set of adult health quality measures. —The Secretary shall establish a Medicaid Quality Measurement Program in the same manner as the Secretary establishes the pediatric quality measures program under section 1139A(a). The aggregate amount awarded by the Secretary under the Medicaid Quality Measurement Program, and annually thereafter, the Secretary shall publish recommended changes to the initial core set of adult health quality measures that shall reflect the results of the testing, validation, and consensus process for the development of adult health quality measures.

(b) Reporting. —Nothing in this section shall be construed as supporting the retraction of coverage, under title XIX or XXI or otherwise, to only those services that are evidence-based, or in any way limiting available services.

(c) Annual reports. —Each State with a plan under this title shall annually report separately or as part of the annual report required under section 1109(a), the following:

(1) State-specific adult health quality measures applied by the State under the plan, including measures described in subsection (a)(5); and

(2) State-specific information on the quality of health care furnished to Medicaid eligible adults by entities operating with such a plan, and information collected through external quality reviews of managed care organizations under section 1922 and benchmark plans under section 1902.

(d) Publication. —Not later than September 30, 2014, and annually thereafter, the Secretary shall publish a list of States that provide care to eligible individuals with chronic conditions who select a designated provider (as described in subsection (b)(5)), or a health team for qualification as a designated provider.
section 1902(a), except that, during the first 8 fiscal year quarters that the State plan amendment is in effect, the Federal medical assistance percentage applicable to such payments shall be 90 percent.

(2) METHODOLOGY.—

(A) IN GENERAL.—The State shall specify in the State plan amendment the methodology the State shall use for determining payment for the provision of health home services. Such methodology for determining payment—

(i) may be tiered to reflect, with respect to each eligible individual with chronic conditions provided such services by a designated provider, a team of health care professionals that includes a health team, as well as the severity or number of each such individual’s chronic conditions or the specific capabilities of the provider, team of health care professionals, or health team; and

(ii) shall be established consistent with section 1902(a)(30)(A).

(B) ALTERNATE MODELS OF PAYMENT.—The methodology for determining payment for provision of health home services under this section shall not be limited to a per-member per-month methodology that may be selected by the Secretary to be used as an alternative payment methodology for providing health home services. A planning grant awarded to a State under this section shall remain available until expended.

(C) LIMITATION.—The total amount of payments made to States under this paragraph shall not exceed $25,000,000.

(D) HOSPITAL REFERRALS.—A State shall include in the State plan amendment a requirement for hospitals that are participating providers under the State plan or a waiver of such plan to establish procedures for referring any eligible individuals with chronic conditions on the basis of treatment or care that the hospital itself cannot provide for a Medicaid beneficiary.

(3) PLANNING GRANTS.—

(A) IN GENERAL.—Beginning January 1, 2011, the Secretary may award planning grants to States for purposes of developing a State plan amendment under this section. A planning grant awarded to a State under this paragraph shall remain available until expended.

(B) STATE CONTRIBUTION.—A State awarding a planning grant shall contribute an amount equal to the State percentage determined under section 1905(b) (without regard to section 1131 of the Social Security Act) for each fiscal year for which the grant is awarded.

(C) LIMITATION.—The total amount of planning grants made to States under this subparagraph shall be $200,000,000.

(4) HEALTH HOME SERVICES.—

(A) IN GENERAL.—The term ‘health home services’ means comprehensive and timely high-quality services described in subparagraphs (B), (C), (D), (E), (F), and (G) of this paragraph to a designated provider, a team of health care professionals operating with such a provider, or a health team.

(B) SERVICES DESCRIBED.—The services described in this subparagraph are—

(i) comprehensive care management;

(ii) care coordination and health promotion;

(iii) comprehensive transitional care, including appropriate follow-up, from inpatient to other settings;

(iv) patient and family support (including authorized representatives);

(v) referral to community and social support services, if relevant; and

(vi) use of information technology to link services, as feasible and appropriate.

(5) DESIGNATED PROVIDER.—The term ‘designated provider’ means a physician, clinical practice or clinical group practice, rural clinic, community health center, community mental health center, home health agency, or any other entity or provider (including entities that are determined by the State and approved by the Secretary to be qualified to be a health home for eligible individuals with chronic conditions) that is determined by the Secretary to be qualified to be a health home for eligible individuals with chronic conditions under such option.

(6) TEAM OF HEALTH CARE PROFESSIONALS.—The term ‘team of health care professionals’ means a team of health professionals (as described in the State plan amendment) that may—

(A) include physicians and other professionals, such as a nurse care coordinator, nutritionists, social workers, mental health professionals, or any professionals deemed appropriate by the State; and

(B) be free standing, virtual, or based at a hospital, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary.

(7) HEALTH TEAM.—The term ‘health team’ means the team selected by an eligible individual for purposes of section 3502 of the Patient Protection and Affordable Care Act.

(b) EVALUATION.—

(1) BACKGROUND EVALUATION.—

(A) IN GENERAL.—The Secretary shall enter into a contract with an independent entity or organization to conduct an evaluation and assessment of the States that have elected the option to provide coordinated care through a health home for Medicaid beneficiaries with chronic conditions under such option.

(B) SURVEY AND INTERIM REPORT.—

(A) IN GENERAL.—Not later than January 1, 2014, the Secretary of Health and Human Services shall survey States that have elected the option under section 1945 of the Social Security Act (as added by subsection (a)) and report to Congress on the nature, extent, and utility of such option, particularly as it pertains to—

(i) hospital admission rates;

(ii) chronic disease management;

(iii) coordination of care for individuals with chronic conditions;

(iv) assessment of program implementation; and

(v) processes and lessons learned (as described in subparagraph (B));

(vi) assessment of quality improvements and clinical outcomes under such option; and

(vii) estimates of cost savings.

(B) IMPLEMENTATION REPORT.—A State that has elected the option under section 1945 of the Social Security Act (as added by subsection (a)) shall report to the Secretary, as necessary, on processes that have been developed and lessons learned regarding provision of coordinated care through a health home for Medicaid beneficiaries with chronic conditions under such option.

SEC. 2704. DEMONSTRATION PROJECT TO EVALUATE INTEGRATED CARE AROUND A HOSPITALIZATION.

(a) AUTHORITY TO CONDUCT PROJECT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall establish a demonstration project under title XIX of the Social Security Act to evaluate the use of bundled payments for the provision of integrated care for a Medicaid beneficiary—

(A) with respect to an episode of care that includes a hospitalization; and

(B) for concurrent inpatient and inpatient services provided during a hospitalization.

(2) DURATION.—The demonstration project shall begin on January 1, 2012, and shall end on December 31, 2016.

(b) REQUIREMENTS.—The demonstration project shall be conducted in accordance with the following:

(1) The demonstration project shall be conducted in up to 8 States, determined by the
Secretary based on consideration of the potential to lower costs under the Medicaid program while improving care for Medicaid beneficiaries. A State selected to participate in the demonstration project will submit a demonstration project to particular categories of beneficiaries, beneficiaries with particular diagnoses, or particular geographic regions of the State, but the Secretary shall ensure that, as a whole, the demonstration project is, to the greatest extent possible, representative of the demographic and geographic composition of Medicaid beneficiaries nationally.

(2) The demonstration project shall focus on those States where there is evidence of an opportunity for providers of services and suppliers to improve the quality of care furnished to Medicaid beneficiaries while reducing total expenditures under the State Medicaid programs selected to participate, as determined by the Secretary.

(3) A State selected to participate in the demonstration project shall specify in its application described in subsection (b) the 1 or more episodes of care the State proposes to address in the project, the services to be included in the bundled payments, and the rationalization of such episodes of care and services. The Secretary may modify the episodes of care as well as the services to be included in the bundled payments prior to or after approving the project. The Secretary may also vary such factors among the different States participating in the demonstration project.

(4) The Secretary shall ensure that payments made under the demonstration project are adjusted for severity of illness and other characteristics of Medicaid beneficiaries within a category or having a diagnosis targeted as part of the demonstration project. States shall ensure that Medicaid beneficiaries are not liable for any additional cost associated with care that had not been subject to payment under the demonstration project.

(5) Hospitals participating in the demonstration project shall have or establish robust discharge planning programs to ensure that Medicaid beneficiaries requiring post-acute care are appropriately placed in, or have ready access to, post-acute care settings.

(6) The Secretary and each State selected to participate in the demonstration project shall ensure that the demonstration project does not result in the Medicaid beneficiaries whose care is subject to payment under the demonstration project being provided with less items and services for which medical assistance is provided under the State Medicaid program than the items and services for which medical assistance would have been provided to such beneficiaries under the State Medicaid program in the absence of the demonstration project.

(7) WAIVER PROVISIONS.—Notwithstanding section 1115(a) of the Social Security Act (42 U.S.C. 1315(a)), the Secretary may waive such provisions of titles XIX, XX, and XVIII of such Act as may be necessary to accomplish the goals of the demonstration project, ensure beneficiary access to acute and post-acute care, and maintain quality of care.

(b) EVALUATION AND REPORT.—

(1) DATA.—Each State selected to participate in the demonstration project shall provide to the Secretary, in such form and manner as the Secretary shall specify, relevant data necessary to monitor outcomes, costs, and quality, and evaluate the rationale for selection of the episodes of care and services specified by States under subsection (b)(3).

(2) NOT LESS THAN 1 YEAR AFTER THE COMPLETION OF THE DEMONSTRATION PROJECT, the Secretary shall submit a report to Congress on the results of the demonstration project.

SEC. 2705. MEDICAID GLOBAL PAYMENT SYSTEM DEMONSTRATION PROJECT.

(a) In General.—The Secretary of Health and Human Services (referred to in this section as the “Secretary”) shall, in coordination with the Center for Medicare and Medicaid Services, enter into demonstration project agreements under section 1115A of the Social Security Act, as added by section 3021 of this Act, establish the Medicaid Global Payment System Demonstration Project, and enter into such agreements with States participating in the demonstration project. Such States shall ensure that the demonstration project shall adjust the payments made to an eligible safety net hospital system or network from a fee-for-service payment structure to a global capitated payment model.

(b) DURATION AND SCOPE.—The demonstration project conducted under this section shall operate during a period of fiscal years 2010 through 2012.

(c) REQUIREMENTS.—The demonstration project conducted under this section shall satisfy the requirements described in subparagraph (B) of section 1115(a) of the Social Security Act (as added by section 3021 of this Act), in addition to any other requirements applicable to the demonstration project established under section 1115A of such Act.

(d) REPORT.—The demonstration project conducted under this section shall terminate on December 31, 2016.

(e) DURATION.—The demonstration project conducted under this section shall be in effect for a period of 9 months following the date on which the Secretary begins the demonstration project under which an eligible safety net hospital system or network was selected to participate in the demonstration project.

(f) A UTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.
been selected pursuant to paragraphs (2) and (3).

(2) APPLICATION.—A State seeking to participate in the demonstration project under this section shall submit to the Secretary, at such time and in such format as the Secretary requires, an application that includes such information, provisions, and assurances as the Secretary may require.

(3) SELECTION.—A State shall be determined eligible for the demonstration project by the Secretary on a competitive basis among States with applications meeting the requirements of paragraph (1). In selecting State applications for the demonstration project, the Secretary shall seek to achieve an appropriate balance in the geographic distribution of such projects.

(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) APPROPIATION.—

(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 each of fiscal years 2011, 2012, and 2013.

(B) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—

(iii) In paragraph (3) of section 1902(a) of the Social Security Act (42 U.S.C. 1396a), the term "State plan..." means, with respect to a State and the period from January 1, 2011, to December 31, 2015, the Federal medical assistance percentage determined by the Secretary under section 1905(i) of the Social Security Act (42 U.S.C. 1396i). (ii) In paragraph (3) of section 1902(a) of the Social Security Act (42 U.S.C. 1396a), the term "emergency medical condition" means, with respect to an individual, the medical condition of the individual as determined by the Secretary, for purposes of paragraph (1) of section 1905(i) of the Social Security Act (42 U.S.C. 1396i), to constitute an emergency medical condition for purposes of paragraph (2) of section 1905(i) of the Social Security Act (42 U.S.C. 1396i), and to be treated as a critical condition under that subparagraph.

(2) 5-YEAR AVAILABILITY.—

Funds appropriated under paragraph (1) shall remain available for obligation through December 31, 2015.

(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 made by the Secretary under this section after December 31, 2015.

(4) FUNDS ALLOCATED TO STATES.—

Funds shall be allocated to eligible States on the basis of, including a State's application and the availability of funds, as determined by the Secretary.

(5) PAYMENTS TO STATES.—

The Secretary shall pay to each eligible State, from its allocation, an amount equal to the Federal medical assistance percentage of expenditures in the quarter for medical assistance described in subparagraph (A), for services furnished to individuals for whom the Secretary waives the requirement of subdivision (B) following section 1903(a) of the Social Security Act (42 U.S.C. 1396a). (4) MEDICAL ASSISTANCE.—

The term "medical assistance" has the meaning given that term in section 1905(a) of the Social Security Act (42 U.S.C. 1396a). (5) STABILIZED.—

The term "stabilized" means, with respect to an individual, that the emergency medical condition no longer exists with respect to the individual and the individual is no longer dangerous to self or others.

(6) STATE.—

The term "State" has the meaning given that term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

Subtitle J—Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC)

SEC. 2801. MACPAC ASSESSMENT OF POLICIES AFFECTING ALL MEDICAID BENEFICIARIES.

(a) IN GENERAL.—

(1) REVIEW NATIONAL AND STATE-SPECIFIC DATA.—

The MACPAC shall prepare and submit to the Congress a report that includes a description of—

(A) the impact of Medicaid and CHIP policies, including the performance of health care providers and plans that serve Medicaid and CHIP beneficiaries, and the goals and interact with similar goals established by other purchasers of health care services; and

(B) the extent to which Medicaid and CHIP policies affect access to health care services, and the degree to which Federal and State policies provide access to health care services for vulnerable populations.

(2) STATE-SPECIFIC DATA.—

MACPAC shall—

(A) review national and State-specific Medicaid and CHIP data; and

(B) submit reports and recommendations to the Secretary, the Congress, and States based on such reviews.

(3) RECOMMENDATIONS AND REPORTS OF STATE-SPECIFIC DATA.—

(A) Review national and State-specific Medicaid and CHIP data; and

(B) submit reports and recommendations to the Secretary, the Congress, and States based on such reviews.

(4) REGULATION INTERACTIONS WITH M DICAID AND MEDICARE.—

Consistent with paragraph (1), the compilation of national and State-specific Medicaid and the Medicare program under title XVIII, including with respect to how such interactions affect access to care, payments, and dual eligible individuals, and

(a) by inserting after paragraph (3) (as redesignated by clause (ii) of this subparagraph), the following:

"(G) INTERACTIONS WITH MEDICAID AND MEDICARE.—Consistent with paragraph (1), this section of the program in Medicaid and the Medicare program under title XVIII, including with respect to how such interactions affect access to care, payments, and dual eligible individuals, and

(b) by redesigning paragraphs (3) through (9) as paragraphs (4) through (10), respectively.

(c) by inserting after paragraph (2), the following new paragraph:

"(D) REVIEW NATIONAL AND STATE-SPECIFIC MEDICAID AND CHIP DATA; AND

(E) REGULATION INTERACTIONS WITH MEDICAID AND MEDICARE; and

(F) submit reports and recommendations to the Secretary, the Congress, and States based on such reviews.

(ii) by redesigning subparagraph (C), by striking "or any other programs and all that follows through the period and inserting ", as well as other factors that adversely affect, or have the potential to adversely affect, access to care by, or the affordability of care for, Medicaid and CHIP beneficiaries. MACPAC shall include in the annual report required under paragraph (1)(D) a description of all such areas or programs identified with respect to the period addressed in the report.

(F) in paragraph (5), as so redesignated,
(i) in the paragraph heading, by inserting
“AND REGULATIONS” after “REPORTS”; and
(ii) by striking “II” and inserting the fol-
lowing:
“(A) CERTAIN SECRETARIAL REPORTS.—II;”
and
(iii) in the second sentence, by inserting “and the Secretary” after “appropriate com-
mitees of Congress”.

(iv) by adding at the end the following:
“(B) REGULATIONS.—MACPAC shall review Medicaid and CHIP regulations and may con-
duct rulemaking with respect to MACPAC’s re-
source responsibility to change Medicaid policy regarding Medicaid beneficiaries, including
Medicare beneficiaries who are dually eligible for Medicare and Medicaid, shall rest with
MACPAC.”

(B) INFORMATION SHARING.—MACPAC and MedPAC shall have access to deliberations and
records of the other such entity, respect-
ively, upon the request of the other such en-
tity.

(II) CONSULTATION WITH STATES.—
MACPAC shall regularly consult with States in
carrying out its duties under this section, in-
cluding with respect to developing proc-
eses to gather such data, and ensure that input from States is taken into account and represented in MACPAC’s rec-
ommendations and reports.

(III) PROGRAMMATIC OVERSIGHT VESTED IN THE SECRETARY.—MACPAC’s authority to
make recommendations in accordance with this section shall not affect, or be considered
to duplicate, the Secretary’s authority to
carry out Federal responsibilities with re-
spect to Medicaid and CHIP.”;

(2) in subsection (e)(2)—
(1) by striking subparagraphs (A) and (B)
and inserting the following:
“(A) IN GENERAL.—MACPAC shall consult with the Medicare Payment Advisory Com-
mision (in this paragraph referred to as ‘MedPAC’) established under section 1805 in
carrying out its duties under this section, as
appropriate and particularly with respect to
the issues specified in paragraph (2) as they relate to dually eligible beneficiaries who are dually
eligible for Medicaid and the Medi-
care program under title XVIII, adult
Medicaid beneficiaries who are not dually
eligible for Medicaid and beneficiaries
under Medicare. Responsibility for analysis of
and recommendations to change Medicare
policy regarding Medicare beneficiaries, in-
cluding Medicaid beneficiaries who are dually
eligible for Medicare and Medicaid, shall rest with
MedPAC.

(B) INFORMATION SHARING.—MACPAC and
MedPAC shall have access to deliberations and
records of the other such entity, respect-
ively, upon the request of the other such en-
tity.

(III) CONSULTATION WITH STATES.—
MACPAC shall regularly consult with States in
carrying out its duties under this section, in-
cluding with respect to developing proc-
eses to gather such data, and ensure that input from States is taken into account and represented in MACPAC’s rec-
ommendations and reports.

(IV) The Indian Health Service, an Indian
Health program operated by the Indian Health
Service, shall also include representatives of chil-
dren, pregnant women, the elderly, individ-
uals with disabilities, caregivers, and dual
eligible individuals, current or former re-
presentatives of States or other Federal agencies responsible
for administering Medicaid, and current or
former representatives of State agencies re-
 sponsible for administering CHIP.

(1) in subsection (d)(2), by inserting “and
State” after “Federal”;

(2) in subsection (e)(1), in the first sen-
tence, by inserting for receiving payments under sections 190(a) and 210(a), from any State agency responsible
for administering Medicaid or CHIP,
after “Secretary”;

and

(3) in subsection (f)—
(A) in the subsection heading, by striking “AUTHORIZATION OF APPROPRIATIONS” and in-
serting “Funding”;

(B) in paragraph (1), by inserting “other
than for fiscal year 2010” before “in the
same manner”; and

(C) by adding at the end the following:
“(3) FUNDING FOR FISCAL YEAR 2010.—

(A) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there is
appropriated to MACPAC to carry out the
provisions of this section for fiscal year 2010,
$9,000,000.

(B) TRANSFER OF FUNDS.—With-
standing section 1904(a)(13), from the
amounts appropriated in such section for fis-
cal year 2010, $2,000,000 is hereby transferred
and appropriated to MACPAC to carry out the
provisions of this section for fiscal year 2010,
$9,000,000.

(C) APPLICABILITY.—Amounts made available
under paragraphs (2) and (3) to MACPAC to
carry out the provisions of this section shall remain available until expended.”.

(1) by adding at the end the following:
“INDIAN TRIBES AND TRIBAL ORGANIZATIONS.”

(A) REQUIREMENT FOR ALL STATES TO AS-
SIST IN CLEAN UP.—For purposes of section
10912(e)(1) of the Patient Protection and Affordable Care Act.

(B) FUNDING FOR FISCAL YEAR 2010.—

(A) IN GENERAL.—The purposes of this sec-
tion are—

(1) to strengthen and improve the pro-
grams and activities carried out under this
section; and

(2) to improve coordination of services for at-
risk communities; and

(3) to identify and provide comprehensive
services to improve outcomes for families who reside in at risk communities.

(C) REPORTS TO ASSESS STATEWIDE NEEDS AND IDENTIFY AT RISK COMMUNITIES.

Subtitle K—Protection for American Indians and Alaska Natives

SEC. 2901. SPECIAL RULES RELATING TO INDI-
ANS.

(a) NO COST-SHARING FOR INDIANS WITH
INCOME BELOW THE FEDERAL POVERTY ENROLLED IN COVERAGE THROUGH A STATE
EXCHANGE.—For provisions prohibiting cost
sharing for Indians enrolled in any qualified
health plan in the individual market through
an Exchange, see section 1402(d) of the Pa-

tient Protection and Affordable Care Act.

(b) FAYER OF LAST RESORT.—Health pro-
grams operated by the Indian Health Serv-

ice, Indian tribes, tribal organizations, and
Urban Indian organizations (as those terms are defined in section 108 of the Indian
Health Care Improvement Act (25 U.S.C. 1605)) shall
be the payer of last resort for services pro-
vided by such service, tribes, or organiza-
tions to individuals eligible for services
through such programs, notwithstanding any
Federal, State, or local law to the contrary.

(c) FACILITATING ENROLLEMENT OF INDIANS
UNDER THE EXCHANGE.—For purposes of
section 1220b-9(c) is amended by striking “in this section” and inserting “For purposes of this section, title XIX, and title XXI.”.

SEC. 2902. ELIMINATION OF SUNSET FOR REIM-
BURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.

(a) REIMBURSEMENT FOR ALL MEDICARE PART B SERVICES FURNISHED BY CERTAIN INDIAN HOSPITALS AND CLINICS.—Section 1840(b)(3) of the Social Security Act (42 U.S.C. 1395(e)(13)) is amended by striking “March 27, 2010,” and inserting “March 27, 2017.”

(b) FAYER OF LAST RESORT.—The amendments
made by this section shall apply to items or
services furnished on or after January 1, 2010.

Subtitle L—Maternal and Child Health Services

SEC. 2951. MATERNAL, INFANT, AND EARLY
CHILDHOOD HOME VISITING PROGRAMS.

Title V of the Social Security Act (42 U.S.C. 300 et seq.) is amended by adding at the end the following new section:

“SEC. 511. MATERNAL, INFANT, AND EARLY
CHILDHOOD HOME VISITING PROGRAMS.

(a) PURPOSES.—The purposes of this sec-
tion are—

(1) to strengthen and improve the pro-
grams and activities carried out under this
title;

(2) to improve coordination of services for at-
risk communities; and

(3) to identify and provide comprehensive
services to improve outcomes for families who reside in at risk communities.

(b) REQUIREMENT TO ASSESS STATEWIDE NEEDS AND IDENTIFY AT RISK COMMUNITIES.”
‘‘(1) IN GENERAL.—Not later than 6 months after the date of enactment of this section, each State shall, as a condition of receiving payments from an allotment for the State under section 1902(a) of the Social Security Act for the fiscal year 2011, conduct a statewide needs assessment (which shall be separate from the statewide needs assessment required under section 506(a) that identified—

‘‘(A) communities with concentrations of—

‘‘(i) premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health;

‘‘(ii) poverty;

‘‘(iii) crime;

‘‘(iv) domestic violence;

‘‘(v) high rates of high-school drop-outs;

‘‘(vi) substance abuse;

‘‘(vii) unemployment; or

‘‘(viii) child maltreatment;

‘‘(B) the quality and capacity of existing programs or initiatives for early childhood home visitation in the State including—

‘‘(i) the number and types of individuals and families who are receiving services under such programs or initiatives;

‘‘(ii) rates in which children will participate in early childhood home visitation in the State; and

‘‘(iii) the extent to which such programs or initiatives are meeting the needs of eligible families (including 50% of (A) both the most recently completed assessment and any such assessment in progress), the communitywide strategic planning and needs assessments conducted in accordance with section 610(g)(1)(C) of the Head Start Act, and the inventory of current unmet needs and current community-based and prevention-focused activities to prevent child abuse and neglect, and other family resources services operating in the State required under subparagraph (B) of section 123 of the Child Abuse Prevention and Treatment Act.

‘‘(2) COORDINATION WITH OTHER ASSESSMENTS.—In conducting the statewide needs assessment required under paragraph (1), the State shall coordinate with, and take into account, other appropriate needs assessments conducted by the State, as determined by the Secretary, including the needs assessment conducted under subsection (k) of section 505(a) (both the most recently completed assessment and any such assessment in progress), the communitywide strategic planning and needs assessments conducted in accordance with section 610(g)(1)(C) of the Head Start Act, and the inventory of current unmet needs and current community-based and prevention-focused activities to prevent child abuse and neglect, and other family resources services operating in the State required under subparagraph (B) of section 123 of the Child Abuse Prevention and Treatment Act.

‘‘(3) SUBMISSION TO THE SECRETARY.—Each State shall submit to the Secretary, in such form and manner as the Secretary shall require—

‘‘(A) the results of the statewide needs assessment required under paragraph (1); and

‘‘(B) a description of how the State intends to address needs identified by the assessment, particularly with respect to communities identified under paragraph (1)(A), which may include—

‘‘(i) strategies to improve the capacity of the State to meet the needs of eligible families participating in the program, to result in the participation of the highest priority eligible families identified under such programs or initiatives;

‘‘(ii) the gaps in early childhood home visitation programs, with a grant duration as the Secretary shall require under section 205(3) of the Child Abuse Prevention and Treatment Act, that result in the participation of the highest priority eligible families identified under such programs or initiatives; and

‘‘(iii) the extent to which such programs or initiatives are meeting the needs of eligible families, consistent with State child welfare agency training.

‘‘(4) TECHNICAL ASSISTANCE.—The Secretary shall provide—

‘‘(A) an Early Childhood Home Visitation Program conducted with a grant that receives a grant under paragraph (1) with technical assistance in administering programs or activities conducted in whole or in part with grant funds, that satisfy the requirements of subsection (d).

‘‘(B) D EMONSTRATION OF IMPROVEMENTS IN BENCHMARK AREAS.—

‘‘(i) AUTHORITY TO MAKE GRANTS.—In addition to any other payments made under this title to a State, the Secretary shall make grants to eligible entities to develop and implement an improvement plan under clause (i) if it fails to demonstrate improvement in at least 4 of the areas specified in subparagraph (A).

‘‘(ii) corrective action plan.—If the report submitted to the Secretary under clause (i) fails to demonstrate improvement in at least 4 of the areas specified in subparagraph (A), the entity shall develop and implement an improvement plan in each of the areas specified in subparagraph (A), subject to approval by the Secretary. The plan shall include provisions for the Secretary to monitor the implementation of the plan and conduct continued oversight of the program, including through submission by the entity of regular reports to the Secretary.

‘‘(iii) TECHNICAL ASSISTANCE.—

‘‘(i) IN GENERAL.—The Secretary shall provide an Early Childhood Home Visitation Program conducted with a grant under clause (i) with technical assistance to develop and implement the plan. The Secretary may provide the technical assistance directly or through grants, contracts, or cooperative agreements.

‘‘(ii) ADVISORY PANEL.—The Secretary shall establish an advisory panel for purposes of providing advice and guidance regarding the technical assistance provided to entities in accordance with subclause (i).

‘‘(iii) NO IMPROVEMENT OR FAILURE TO SUBMIT.—If the Secretary determines, after a period of time specified by the Secretary that an eligible entity implementing an improvement plan under clause (i) has failed to demonstrate any improvement in the areas specified in subparagraph (A), or if the Secretary determines that an eligible entity has failed to submit the required report under clause (i), the Secretary shall terminate the entity’s grant and may include any unexpended grant funds in grants made to other well-designed and rigorous programs for the fiscal year 2011, and the requirements of subsection (b)(2)(B).

‘‘(C) FINAL REPORT.—Not later than December 31, 2015, the eligible entity shall submit to the Secretary a report describing improvements (if any) in each of the areas specified in subparagraph (A).
shall use not more than 25 percent of the amount of the grant paid to the entity for a fiscal year for purposes of conducting a program using the service delivery model described in subsection (d)(3)(A).

"(iii) CRITERIA FOR EVIDENCE OF EFFECTIVENESS OF MODELS.—The Secretary shall establish criteria for evidence of effectiveness of the service delivery models and shall ensure that the process for establishing the criteria is transparent and provides the opportunity for public comment.

"(d) ADDITIONAL REQUIREMENTS.—

"(1) The program adheres to a clear, consistent model that satisfies the requirements of paragraph (2) in each of its service delivery models.

"(ii) The program maintains high quality supervision to establish home visitor competency.

"(v) The program establishes appropriate linkages and referral networks to other community resources and supports for eligible families.

"(vi) The program monitors the fidelity of program implementation to ensure that services are delivered pursuant to the specified model.

"(7)独立, expert advisory panel.—The Secretary, in accordance with subsection (d)(1)(A), shall appoint an independent advisory panel consisting of experts in program evaluation, and research, education, and practice. Such requirements, to the greatest extent practicable, be consistent with the requirements applicable to eligible entities that are States and shall require an Indian Tribe (or consortium) and a Tribal Organization, or Urban Indian Organization to—

"(ii) develop an annual report to the Secretary on the results of the evaluation and report required under subsection (j) that are available for expenditure under paragraph (3) of that subsection
to make a grant to an eligible entity that is a nonprofit organization described in subsection (b) only if such an organization to apply for and conduct the program which shall, to the greatest extent practicable, be consistent with the requirements applicable to eligible entities that are States and shall require the organization to—

(i) carry out the program based on the needs assessment conducted by the State under subsection (b); and

(ii) establish quantifiable, measurable 3-year and 5-year benchmarks consistent with subsection (d)(1)(A).

(3) RESEARCH AND OTHER EVALUATION ACTIVITIES.—

(A) IN GENERAL.—The Secretary shall carry out a continuous program of research and evaluation activities in order to increase knowledge about the implementation and effectiveness of home visiting programs, using random assignment designs to the maximum extent feasible. The Secretary may carry out such activities directly, through grants, cooperative agreements, or contracts.

(B) REQUIREMENTS.—The Secretary shall ensure that—

(i) evaluation of a specific program or project is conducted by persons or individuals not directly involved in the operation of such program or project; and

(ii) research and evaluation activities includes consultation with independent researchers, State officials, and developers and providers of home visiting programs on topics including research design and administrative data matching.

(4) REPORT AND RECOMMENDATION.—Not later than December 31, 2015, the Secretary shall submit a report to Congress regarding the programs conducted with grants under this section. The report required under this paragraph shall include—

(A) a statement regarding the extent to which eligible entities receiving grants under this section demonstrated improvements in each of the areas specified in subsection (d)(1)(A); and

(B) information regarding any technical assistance provided under subsection (d)(1)(B)(iii)(I), including the type of assistance provided; and

(C) recommendations for such legislative or administrative action as the Secretary determines appropriate.

(5) APPLICATION OF OTHER PROVISIONS OF TITLE.—

(I) IN GENERAL.—Except as provided in paragraph (2), the other provisions of this title shall not apply to a grant made under this section.

(II) EXCEPTIONS.—The following provisions of this title shall apply to a grant made under this section to the same extent and in the same manner as such provisions apply to allotments made under section 502(c):

(A) Section 505(c)(1)(B) (relating to prohibition on payments to excluded individuals and entities).

(B) Section 508(c)(2) (relating to the use of funds for the purchase of technical assistance).

(C) Section 508(d) (relating to a limitation on administrative expenditures).

(D) Section 509 (relating to reports and audits), but only to the extent determined by the Secretary to be appropriate for grants made under this section.

(E) Section 510 (relating to penalties for false statements).

(F) Section 508 (relating to nondiscrimination).

(G) Section 509(a) (relating to the administration of the grant program).

(II) APPROPRIATIONS.—

(1) IN GENERAL.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated under this Act, and periodically thereafter later than December 31, 2015, the Secretary shall—

(A) $100,000,000 for fiscal year 2010;

(B) $200,000,000 for fiscal year 2011;

(C) $350,000,000 for fiscal year 2012; and

(D) $400,000,000 for fiscal year 2013.

(2) RESERVATIONS.—Of the amount appropriated under this subsection for a fiscal year, the Secretary shall reserve—

(A) 3 percent of such amount for purposes of making grants to eligible entities that are Indian Tribes (or a consortium of Indian Tribes), Tribal Organizations, or Urban Indian Organizations; and

(B) 3 percent of such amount for purposes of carrying out subsections (d)(1)(B)(ii), (g), and (h)(3).

(3) AVAILABILITY.—Funds made available to an eligible entity under this section for a fiscal year shall remain available for expenditure by the eligible entity through the end of the second succeeding fiscal year after award. Any funds that are not expended by the eligible entity during the period in which the funds are available under the preceding sentence may be awarded to a nonprofit organization under subsection (h)(2)(B).

(4) DEFINITIONS.—In this section:

(I) ELIGIBLE ENTITY.—The term ‘eligible entity’ means a State, an Indian Tribe, Tribal Organization, or Urban Indian Organization.

(II) ELIGIBLE FAMILY.—The term ‘eligible family’ means—

(A) a woman who is pregnant, and the father of the child if the father is available; or

(B) a parent or primary caregiver of a child, including grandparents or other relatives of the child, and foster parents who are serving as primary caregivers from birth to kindergarten entry, and including a noncustodial parent who has an ongoing relationship with, and at times provides physical custody of the child.

(III) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms ‘Indian Tribe’ and ‘Tribal Organization’, and ‘Urban Indian Organization’ have the meanings given to such terms in section 4 of the Indian Health Care Improvement Act.”.

SEC. 2952. SUPPORT, EDUCATION, AND RESEARCH FOR POSTPARTUM DEPRESSION.

(a) RESEARCH ON POSTPARTUM CONDITIONS.

(I) EXPANSION AND INTENSIFICATION OF ACTIVITIES.—The Secretary of Health and Human Services (in this subsection and subsection (c) referred to as the “Secretary”) is encouraged to continue activities on postpartum depression or postpartum psychosis (in this subsection and subsection (c) referred to as “postpartum conditions”) and related mental health conditions and their families.

(II) FUNDING.—To the extent practicable and appropriate, the Secretary shall ensure that projects funded under this section provide education and services with respect to the diagnosis and management of postpartum conditions for individuals with or at risk for postpartum conditions and their families.

(b) SENSE OF CONGRESS REGARDING OUTCOGNIZANCE FOR WOMEN OF RESOLVING A PREGNANCY—

(A) SENSE OF CONGRESS.—It is the sense of Congress that the Director of the National Institute of Mental Health may conduct a nationally representative longitudinal study (during the period of fiscal years 2010 through 2019) of the mental health consequences for women of resolving a pregnancy (intended and unintended) in various ways, including carrying the pregnancy to term and placing the child for adoption, miscarriage, and having an abortion. This study may assess the incidence, magnitude, and consequences of the immediate and long-term mental health consequences (positive or negative) of these pregnancy outcomes.

(c) APPROPRIATIONS.—Subject to the completion of the study under subsection (a), beginning not later than 5 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) GRANTS TO PROVIDE SERVICES TO INDIVIDUALS WITH A POSTPARTUM CONDITION AND THEIR FAMILIES.—Title V of the Social Security Act (42 U.S.C. 701 et seq.), as amended by section 251, is amended by adding at the end the following new section:

“SEC. 512. SERVICES TO INDIVIDUALS WITH A POSTPARTUM CONDITION AND THEIR FAMILIES.

“(a) IN GENERAL.—In addition to any other payments made under this title to a State, the Secretary may make grants to eligible entities for projects for the establishment, operation, and coordination of effective and cost-efficient systems for the delivery of services to individuals with or at risk for postpartum conditions and their families.

(b) CERTAIN ACTIVITIES.—To the extent practicable and appropriate, the Secretary shall ensure that projects funded under this section (a) provide education and services with respect to the diagnosis and management of postpartum conditions for individuals with or at risk for postpartum conditions and their families. The Secretary may allow such projects to include the following:

(1) Delivering or enhancing outpatient services to individuals with or at risk for postpartum conditions and their families.

(2) Promoting the well-being of the mother and family and the future development of the infant.

(3) Improving the availability, accessibility, and organization of health care and support services (including transportation services,
attendant care, homemaker services, day or respite care, and providing counseling on financial assistance and insurance).

(4) Providing education about postpartum condition or earlier recognition and treatment. Such education may include—

(A) providing complete information on postpartum conditions, symptoms, methods of coping with the illness, and treatment resources; and

(B) in the case of a grantee that is a State, hospital, or birthing facility—

(i) ensuring that training programs regarding such education are carried out at the health facility;

(ii) the Secretary with other Programs.—To the extent practicable and appropriate, the Secretary may integrate the grant programs carried out by the Secretary, including the program under section 330 of the Public Health Service Act.

(3) THE SECRETARY shall establish requirements for grants made under this section that include a limit on the amount of grants funds that may be used for administration, accounting, reporting, or program oversight functions and a requirement for each eligible entity that receives a grant to submit, for each grant period, a report that describes how grant funds were used during such period.

(c) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to entities seeking a grant under this section in order to assist such entities in complying with the requirements of this section.

(d) APPLICATION OF OTHER PROVISIONS OF THIS TITLE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the provisions of this title shall not apply to a grant made under this section.

(2) EXCEPTIONS.—The following provisions of this title shall apply to a grant made under this section to the same extent and in the manner as such provisions apply to allotments made under section 502(c):

(A) Section 504(b)(6) (relating to prohibition on discrimination to excluded individual entities).

(B) Section 504(c) (relating to the use of funds for the purchase of technical assistance).

(C) Section 504(d) (relating to a limitation on administrative expenditures).

(D) Section 505 (relating to reports and audits)

(E) Section 507 (relating to penalties for false statements).

(F) Section 508 (relating to non-discrimination).

(G) Section 509(a) (relating to the administration of the grant program).

(g) DEFINITIONS.—In this section:

(1) The term ‘eligible entity’—

(A) means a public or nonprofit private entity; and

(B) includes a State or local government, public-private partnership, recipient of a grant under section 330H of the Public Health Service Act (relating to the Healthy Start Initiative), public or nonprofit private hospital, community-based organization, hospital, ambulatory care facility, community health center, migrant health center, public housing primary care center, or homeless health center.

(2) Postpartum condition means postpartum depression or postpartum psychosis.”.

(c) GENERAL PROVISIONS.—

(1) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section and the amendment made by subsection (b), there are authorized to be appropriated:

(A) $3,000,000 for fiscal year 2010; and

(B) such sums as may be necessary for fiscal years 2011 and 2012.

(2) REPORT BY THE SECRETARY.—

(A) STUDY.—The Secretary shall conduct a study on the benefits of screening for postpartum conditions.

(B) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall complete the study required by subparagraph (A) and submit a report to the Congress on the results of such study.

SEC. 2953. PERSONAL RESPONSIBILITY EDUCATION.

Title V of the Social Security Act (42 U.S.C. 1701 et seq.), as amended by sections 2951 and 2952(c), is amended by adding at the end the following:

"SEC. 513. PERSONAL RESPONSIBILITY EDUCATION.

(4) ALLOTMENTS TO STATES.—

(1) AMOUNT.—

(A) IN GENERAL.—For the purpose described in subsection (b), the Secretary shall allot to each State an amount equal to the product of—

(i) the amount appropriated under subsection (f) for the fiscal year and available for allotments to States after the application of subsection (c) and

(ii) the State youth population percentage determined under paragraph (2).

(B) MINIMUM AMOUNT.—

(i) IN GENERAL.—Each State allotment under this paragraph for a fiscal year shall be at least $250,000.

(ii) PRO RATA ADJUSTMENTS.—The Secretary shall adjust on a pro rata basis the amount of the State allotments determined under this paragraph for a fiscal year to the extent necessary to comply with clause (i).

(C) APPLICATION REQUIRED TO ACCESS ALLOTMENTS.—

(i) IN GENERAL.—A State shall not be paid from allotments under this section for a fiscal year unless the Secretary determines that the State has complied with the requirements of this section in preparing and submitting the application and shall include the following, as well as such additional information as the Secretary may require:

(I) Based on data from the Centers for Disease Control and Prevention National Center for Chronic Disease Prevention and Health Promotion, the percentage of women ages 10 and 19 in all such programs for which data are available, the most recent birth rate for each age group.

(II) State-established goals for reducing the proportion of births to unmarried women; and

(III) Programs, initiatives, or activities for which amounts from allotments and grants under this subsection may be expended is less than the amount expended by the State, organization, or entity for such programs or initiatives for fiscal year 2009.

(6) DATA COLLECTION AND REPORTING.—A State or local organization or entity receiving funds under this section shall cooperate with such requirements relating to the collection of data and information and report the outcomes regarding the programs and activities carried out with such funds, as the Secretary shall specify.

(7) PURPOSE.—

(A) IN GENERAL.—The purpose of an allotment under subsection (a)(1) to a State is to enable the State (or, in the case of grants

youth with HIV/AIDS, pregnant youth who are under 21 years of age, mothers who are under 21 years of age, and youth residing in areas with high birth rates for youth.

"(B) DETERMINATION OF NUMBER OF YOUTH.—The number of individuals described in clauses (i) and (ii) of subparagraph (A) in a State shall be determined on the basis of the most recent BHC Data.

(8) AVAILABILITY OF STATE ALLOTMENTS.—Subject to paragraph (4)(A), amounts allotted to a State pursuant to this subsection for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year.

(4) AUTHORITY TO AWARD GRANTS FROM STATE ALLOTMENTS TO LOCAL ORGANIZATIONS AND ENTITIES IN NONPARTICIPATING STATES.—

(A) GRANTS FROM UNEXPENDED ALLOTMENTS.—If a State does not submit an application under this section for fiscal year 2010 or 2011, the State shall no longer be eligible to submit an application to receive funds from the amounts allocated for the fiscal year for each of fiscal years 2010 through 2014 and such amounts shall be used by the Secretary to award grants under this paragraph for each of fiscal years 2012 through 2014. The Secretary also shall use any amounts from the allotments of States that submit applications under this section for a fiscal year that remain unexpended as of the second succeeding fiscal year.

(5) MAINTENANCE OF EFFORT.—No payment shall be made to a State from the allotment for a fiscal year if the State determines for a fiscal year that such State (or, in the case of grants to a local organization or entity awarded a grant under paragraph (4), if the expenditure of non-federal funds by the State or local organization or entity for such programs, or initiatives for which amounts from allotments and grants under this subsection may be expended is less than the amount expended by the State, organization, or entity for such programs or initiatives for fiscal year 2009.

(6) DATA COLLECTION AND REPORTING.—A State or local organization or entity receiving funds under this section shall cooperate with such requirements relating to the collection of data and information and report the outcomes regarding the programs and activities carried out with such funds, as the Secretary shall specify.

(7) PURPOSE.—

(A) IN GENERAL.—The purpose of an allotment under subsection (a)(1) to a State is to enable the State (or, in the case of grants
made under subsection (a)(4)(B), to enable a local organization or entity to carry out personal responsibility education programs consistent with this subsection.

"(2) PERSONAL RESPONSIBILITY EDUCATION PROGRAMS.—

"(A) IN GENERAL.—In this section, the term 'personal responsibility education program' means a program that is designed to educate adolescents on—

"(i) both abstinence and contraception for the prevention of pregnancy and sexually transmitted infections, including HIV/AIDS, consistent with the requirements of subparagraph (B); and

"(ii) at least 3 of the adulthood preparation subjects described in subparagraph (C).

"(B) REQUIREMENTS.—The requirements of this subparagraph are the following:

"(i) The program incorporates evidence-based effective programs or substantially incorporates elements of effective programs that have been proven on the basis of rigorous scientific research to change behavior, which means delaying sexual activity, increasing condom or contraceptive use for sexually active youth, or reducing pregnancy among youth age 15 and younger.

"(ii) The program is medically-accurate and complete.

"(iii) The program includes activities to educate youth who are sexually active regarding responsible sexual behavior with respect to both abstinence and the use of contraception.

"(iv) The program places substantial emphasis on both abstinence and contraception for the prevention of pregnancy among youth and sexually transmitted infections.

"(v) The program provides age-appropriate information and activities.

"(vi) The information and activities carried out under this section shall be conducted in the cultural context that is most appropriate for individuals in the particular population group to which they are directed.

"(C) ADULTHOOD PREPARATION SUBJECTS.—

The adulthood preparation subjects described in this subparagraph are the following:

"(1) Healthy relationships, such as positive self-esteem and relationship dynamics, friendships, dating, romantic involvement, marriage, and family interactions.

"(2) Developmental development, such as the development of healthy attitudes and values about adolescent growth and development, body image, racial and ethnic diversity, and other similar document recognized under State law,'' after ''employment services,''.

"(3) Financial literacy.

"(4) Parent-child communication.

"(5) Educational and career success, such as developing skills for employment preparation, job seeking, independent living, financial self-sufficiency, and workplace productivity.

"(6) Healthy life skills, such as goal-setting, decision making, negotiation, communication and interpersonal skills, and stress management.

"(C) RESERVATIONS OF FUNDS.—

"(1) GRANTS TO IMPLEMENT INNOVATIVE STRATEGIES.—From the amount appropriated under subsection (f) for the fiscal year, the Secretary shall reserve $10,000,000 of such amount for purposes of awarding grants to entities to implement innovative youth pregnancy prevention strategies and target services to high-risk, vulnerable, and culturally under-represented youth populations, including youth in foster care, homeless youth, HIV/AIDS, pregnant women who are under 21 years of age and their partners, mothers who are under 21 years of age and their partners, and youth residing in areas with high birth rates for adolescents, based on developing cognitive, emotional, and behavioral capacity typical for the age or age group.

"(2) MEDICALLY ACCURATE AND COMPLETE.—The term 'medically accurate and complete' means verified or supported by the weight of research conducted in compliance with accepted scientific methods and—

"(A) published in peer-reviewed journals, where applicable;

"(B) comprising information that leading professional organizations and agencies with relevant expertise in the field recognize as accurate, objective, and complete.

"(3) INDIAN TRIBES; TRIBAL ORGANIZATIONS.—The term 'Indian tribe' and 'tribal organization' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1601).

"(4) YOUTH.—The term 'youth' means an individual who has attained age 10 but has not attained age 20.

"(5) APPROPRIATION.—For the purpose of carrying out this section, there is appropriated, out of any money in the Treasury not otherwise appropriated, $75,000,000 for each of fiscal years 2010 through 2014.

SEC. 2554. RESTORATION OF FUNDING FOR ABSTINENCE EDUCATION.

Section 510 of the Social Security Act (42 U.S.C. 710) is amended—

"(1) in subsection (a), by striking "fiscal year 1998 and each subsequent fiscal year" and inserting "each of fiscal years 2010 through 2014"; and

"(2) in subsection (d)—

"(A) in the first sentence, by striking "1996 through 2003" and inserting "2010 through 2014"; and

"(B) in the second sentence, by inserting "(except that such appropriation shall be made under this section to the extent determined by the Secretary to be appropriate for grants to entities to implement innovative youth pregnancy prevention strategies and target services to high-risk, vulnerable, and culturally under-represented youth populations, including youth in foster care, homeless youth, HIV/AIDS, pregnant women who are under 21 years of age and their partners, mothers who are under 21 years of age and their partners, and youth residing in areas with high birth rates for adolescents, based on developing cognitive, emotional, and behavioral capacity typical for the age or age group."
(c) HEALTH OVERSIGHT AND COORDINATION PLAN.—Section 422(b)(15)(A) of such Act (42 U.S.C. 622(b)(15)(A)) is amended—

(1) in clause (v), by striking “and” at the end; and

(2) by adding at the end the following:

“(vii) steps to ensure that the components of the transition plan development process required under section 1850(h)(1) that relate to the health care needs of children aging out of foster care, including the requirements to include options for health insurance, historical data about a health care provider, attorney, health care proxy, or other similar document recognized under State law, and to provide the child with the option to execute such a document, are met; and

(d) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2010.

TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE
Subtitle A—Transforming the Health Care Delivery System
PART I—LINKING PAYMENT TO QUALITY OUTCOMES UNDER THE MEDICARE PROGRAM
SEC. 3001. HOSPITAL VALUE-BASED PURCHASING PROGRAM.

(a) PROGRAM.—

(1) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 4122(a) of the Health Information Technology for Economic and Clinical Health Act (Public Law 111–5), is amended by adding at the end the following new subsection:

“(o) HOSPITAL VALUE-BASED PURCHASING PROGRAM.

“(1) ESTABLISHMENT.—

“(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall establish a hospital value-based purchasing program (in this subsection referred to as the ‘Program’) under which value-based incentive payments are made in a fiscal year to hospitals that meet the performance standards under paragraph (3) for the performance period for such fiscal year (as established under paragraph (4)).

“(B) PROGRAM TO BEGIN IN FISCAL YEAR 2013.—The Program shall apply to payments for discharges occurring on or after October 1, 2012.

“(C) APPLICABILITY OF PROGRAM TO HOSPITALS.—

“(1) IN GENERAL.—For purposes of this subsection, subject to clause (ii), the term ‘hospital’ shall mean a hospital as defined in subsection (d)(1)(B).

“(ii) EXCLUSIONS.—The term ‘hospital’ shall not include, with respect to a fiscal year, hospitals—

“(I) that is subject to the payment reduction under subsection (b)(3)(B)(viii)(I) for such fiscal year;

“(II) for which, during the performance period for such fiscal year, the Secretary has cited deficiencies that pose immediate jeopardy to the health or safety of patients;

“(III) for which there are not a minimum number (as determined by the Secretary) of measures that apply to the hospital for the performance period for such fiscal year;

“(IV) for which there are not a minimum number (as determined by the Secretary) of cases for the measures that apply to the hospital for the performance period for such fiscal year.

“(III) INDEPENDENT ANALYSIS.—For purposes of determining the minimum numbers under subclauses (II) and (IV) of clause (ii), the Secretary may conduct an independent analysis of what numbers are appropriate.

“(iv) EXEMPTION.—In the case of a hospital that is subject to the section 184(h)(1), the Secretary may exempt such hospital from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the goals of promoting patient health outcomes and cost savings established under this subsection.

“(2) MEASURES.—

“(A) IN GENERAL.—The Secretary shall select measures for purposes of the Program. Such measures shall be selected from the measures specified under subsection (b)(3)(B).

“(B) REQUIREMENTS.—

“(i) FOR FISCAL YEAR 2013.—For value-based incentive payments made with respect to discharges occurring during fiscal year 2013, the Secretary shall select the following:

“(I) CONDITIONS OR PROCEDURES.—Measures are selected under subparagraph (A) that cover at least the following 5 specific conditions or procedures:


“(cc) Pneumonia.

“(dd) Surgeries, as measured by the Surgical Care Improvement Project (formerly referred to as ‘Surgical Infection Prevention’ for discharges occurring before July 2006).

“(ee) Healthcare-associated infections, as measured by the prevention metrics and targets established in the HHS Action Plan to Prevent Healthcare-Associated Infections (or any successor plan) of the Department of Health and Human Services.

“(II) HCAHPS.—Measures selected under subparagraph (A) shall be related to the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS).

“(III) FOR FISCAL YEAR 2014.—For value-based incentive payments made with respect to discharges occurring during fiscal year 2014 or a subsequent fiscal year, the Secretary shall ensure that measures selected under subparagraph (A) include efficiency measures, including measures of ‘Medicare spending per beneficiary’. Such measures shall be adjusted for factors such as age, sex, race, severity of illness, and other factors that the Secretary determines appropriate.

“(IV) LIMITATIONS.—

“(a) TIME REQUIREMENT FOR PRIOR REPORTING AND NOTICE.—The Secretary may not select a measure under subparagraph (A) for use under the Program with respect to a performance period (as established under paragraph (3)) unless such measure has been specified under subsection (b)(3)(B)(viii) and included on the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS) Compare Internet website for at least 1 year prior to the beginning of such performance period.

“(b) MEASURE NOT APPLICABLE UNLESS HOSPITAL PERFORMANCE SCORE APPROPRIATE TO THE MEASURE.—A measure selected under subparagraph (A) shall not apply to a hospital if such hospital does not furnish services appropriate to the measure.

“(c) REPLACING MEASURES.—Subclause (VI) of section (b)(3)(B)(viii) shall apply to measures selected under subparagraph (A) in the case where such clause applies to measures selected under such subsection.

“(3) PERFORMANCE STANDARDS.

“(A) ESTABLISHMENT.—The Secretary shall establish performance standards with respect to measures selected under paragraph (2) for a performance period for a fiscal year (as established under paragraph (4)).

“(B) ACHIEVEMENT OF PERFORMANCE GOALS.—The performance standards established under subparagraph (A) shall include levels of achievement and improvement.

“(C) TIMING.—The Secretary shall establish and announce the performance standards under subparagraph (A) not later than 60 days prior to the beginning of the performance period for the fiscal year involved.

“(D) CONSIDERATIONS IN ESTABLISHING PERFORMANCE STANDARDS.—In establishing performance standards with respect to measures under this paragraph, the Secretary shall take into account appropriate factors, such as—

“(i) prior experience with the measures involved, including the proportion of hospitals that achieved the performance threshold; and

“(ii) the opportunity for continued improvement.

“(4) PERFORMANCE PERIOD.—For purposes of the Program, the Secretary shall establish the performance period for a fiscal year. Such performance period shall begin and end prior to the beginning of such fiscal year.

“(5) HOSPITAL PERFORMANCE SCORE.

“(A) IN GENERAL.—Subject to paragraph (2), the Secretary shall develop a methodology for assessing the total performance of each hospital based on performance standards with respect to the measures selected under subparagraph (2), and announce the performance standards during previous performance periods;

“(B) APPLICATION.—

“(i) APPROPRIATE DISTRIBUTION.—The Secretary shall provide for an assessment (in this subsection referred to as the ‘hospital performance score’) for each hospital for each performance period.

“(ii) HIGHER OF ACHIEVEMENT OR IMPROVEMENT.—The methodology developed under subparagraph (A) shall provide that the hospital performance score is determined using the higher of its achievement or improvement score for each measure.

“(iii) WEIGHTS.—The methodology developed under subparagraph (A) shall provide for the assignment of weights for categories of measures as the Secretary determines appropriate.

“(iv) NO MINIMUM PERFORMANCE STANDARD.—The Secretary shall set a minimum performance standard in determining the hospital performance score for any hospital.

“(B) REFLECTION OF MEASURES APPLICABLE TO THE HOSPITAL.—The hospital performance score for a hospital shall reflect the measures that apply to the hospital.

“(C) CALCULATION OF VALUE-BASED INCENTIVE PAYMENTS.—

“(A) IN GENERAL.—In the case of a hospital that the Secretary determines meets (or exceeds) the performance threshold under paragraph (3) for the performance period for a fiscal year (as established under paragraph (4)), the Secretary shall increase the base operating DRG payment amount (as defined in paragraph (7)(D)), as determined after application of paragraph (7)(B)(i), for a hospital for each discharge occurring in such fiscal year for the value-based incentive payment amount.

“(B) VALUE-BASED INCENTIVE PAYMENT AMOUNT.—The value-based incentive payment amount for each hospital in a fiscal year shall be equal to the product of—

“(I) the base operating DRG payment amount (as defined in paragraph (7)(D)) for the discharge for the hospital for such fiscal year; and
“(ii) the value-based incentive payment percentage specified under subparagraph (C) for the hospital for such fiscal year.

(C) VALUE-BASED INCENTIVE PAYMENT PERCENTAGE.—

“(i) IN GENERAL.—The Secretary shall specify a value-based incentive payment percentage for a hospital for a fiscal year.

“(ii) SPECIAL RULES FOR CERTAIN HOSPITALS.—

“(A) SOLICITY OF HOSPITALS WITHIN THE DEPARTMENT.—The Secretary shall determine the value-based incentive payment percentage for each hospital for each fiscal year under clause (i), the Secretary shall ensure that—

“(I) the payment amount that would otherwise be made under subparagraph (d) (determined without regard to subsection (q)) for a discharge if this subsection did not apply; and

“(II) any portion of such payment amount that is attributable to—

“(aa) payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subclause (q); and

“(bb) other payments under subsection (g) is determined appropriate by the Secretary.

“(B) IN GENERAL.—Except as provided in clause (ii), in this subsection, the term ‘base operating DRG payment amount’ means, with respect to a hospital for a fiscal year—

“(I) the payment amount that would otherwise be made under subsection (d),

“(II) any portion of such payment amount that is attributable to—

“(aa) payments under paragraphs (5)(A), (5)(B), (5)(F), and (12) of subsection (d); and

“(bb) other payments under subsection (g) is determined appropriate by the Secretary.

“(C) VALUE-BASED INCENTIVE PAYMENT PERCENTAGE.—

“In the case of a Medicare-dependent, small rural hospital (with respect to discharges occurring during fiscal year 2012 and 2013) or a sole community hospital, in applying subparagraphs (A)(i), the payment amount that would otherwise be made under subsection (d) shall be determined without regard to subparagraphs (I) and (L) of subsection (b)(3) and subparagraphs (D) and (G) of subsection (b)(5).

“(D) HOSPITALS PAID UNDER SECTION 1814.—In the case of a hospital that is paid under section 1814(b)(3), the term ‘base operating DRG payment amount’ means the payment amount under such section.

“(E) ANNOUNCEMENT OF NET RESULT OF ADJUSTMENTS.—Under the Program, the Secretary shall ensure, prior to the fiscal year involved, inform each hospital of the adjustments to payments to the hospital for discharges occurring in such fiscal year under paragraphs (6) and (7)(B)(i).

“(F) NO EFFECT IN SUBSEQUENT FISCAL YEARS.—The value-based incentive payment under paragraph (6) and the payment reduction under paragraph (7)(B)(i) shall each apply only with respect to the fiscal year involved, and the Secretary shall not take into account such value-based incentive payment or payment reduction in making payments to a hospital under this section in a subsequent fiscal year.

“(G) PUBLIC REPORTING.—

“(A) HOSPITAL PERFORMANCE INFORMATION.—

“(i) IN GENERAL.—The Secretary shall make information available to the public regarding the performance of individual hospitals under the Program, including—

“(I) the performance of the hospital with respect to each measure that applies to the hospital;

“(II) the performance of the hospital with respect to each condition or procedure; and

“(III) the hospital performance score assessing the total performance of the hospital.

“(ii) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall ensure that a hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under clause (i) prior to such information being made public.

“(B) AGGREGATE INFORMATION.—The Secretary shall ensure that information shall be posted on the Hospital Compare Internet website in an easily understandable format.

“(C) HOSPITAL PERFORMANCE INFORMATION.—

“(i) Subject to the Hospital Compare Internet website aggregate information on the Program, including—

“(I) the number of hospitals receiving value-based incentive payments under paragraph (6) and the range and total amount of such value-based incentive payments; and

“(II) the number of hospitals receiving less than the maximum value-based incentive payment available to the hospital for the fiscal year involved and the range and amount of such payments.

“(ii) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall ensure that a hospital has the opportunity to review, and submit corrections for, the information to be made public with respect to the hospital under clause (i) prior to such information being made public.

“(D) IMPLEMENTATION.—

“(i) IN GENERAL.—The Secretary shall implement a process for payments beginning with fiscal year 2013, each measure specified by the Secretary under this clause shall be endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is provided for such risk adjustment endorsed or adopted by a consensus organization identified by the Secretary.

“(ii) SPECIAL RULES FOR CERTAIN HOSPITALS.—

“(A) APPEALS.—The Secretary shall establish a process by which hospitals may appeal the calculation of a hospital’s performance score under this clause based on performance standards established under paragraph (3)(A) and the hospital performance score under paragraph (5). The Secretary shall ensure that such process provides for a timely manner.

“(B) LIMITATION ON REVIEW.—Except as provided in subparagraph (A), there shall be no administrative review under section 1889, section 1878, or otherwise of the following:

“(I) the methodology used to determine the amount of value-based incentive payments under paragraph (6) and the determination of such amount.

“(ii) the determination of the amount of funding available for such value-based incentive payments under paragraph (7)(A) and the payment reduction under paragraph (7)(B)(i).

“(iii) the establishment of the performance standards under paragraph (3) and the performance period under paragraph (4).

“(iv) the values, measures, or methodologies under subsection (b)(3)(B)(viii) and the measures selected under paragraph (2).

“(v) the methodology developed under paragraph (5) that is used to calculate hospital performance scores and the calculation of such scores.

“(vi) the definition methodology specified in subparagraph (b)(5).

“(C) CONSULTATION WITH SMALL HOSPITALS.—The Secretary shall consult with small rural and urban hospitals on the application of the Program to such hospitals.

“(D) AMENDMENTS FOR REPORTING OF HOSPITAL QUALITY INFORMATION.—Section 1890(b)(3)(B)(vii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(vii)) is amended—

“(i) in subclause (II), by striking the following sentence: ‘The Secretary may require hospitals to submit data on measures that are not used for the determination of value-based incentive payments under paragraph (6).’; and

“(ii) in subclause (V), by striking ‘beginning with fiscal year 2008’ and inserting ‘for fiscal years 2008 through 2012’;

“(iii) in subclause VII, by inserting ‘such data submitted’ and inserting ‘information regarding measures submitted’; and

“(iv) by adding at the end the following new clause: ‘effective for payments beginning with fiscal year 2013, each measure specified by the Secretary under this clause shall be endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is provided for such risk adjustment endorsed or adopted by a consensus organization identified by the Secretary.’

“(E) TO THE EXTENT PRACTICABLE, THE SECRETARY SHALL—

“(i) adopt measures that are intended to improve the quality of care, take steps to ensure that the measures specified by the Secretary under this clause are coordinated and aligned with quality measures applicable to—

“(aa) physicians under section 1848(k); and

“(bb) other providers of services and suppliers. . . .

“(ii) the Secretary shall establish a process to validate measures specified under this clause as appropriate. Such process shall include the auditing of a number of randomly selected hospitals sufficient to ensure validity of the reporting program under this
clause as a whole and shall provide a hospital with an opportunity to appeal the validation of measures reported by such hospital.

(b) Website Improvements.—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)), as amended by section 102(b) of theHITECH Act (Public Law 111–5), is amended by adding at the end the following new clause:—"(x)(I) The Secretary shall develop standard Internet website reports tailored to reflect the needs of various stakeholders such as hospitals, patients, researchers, and policy-makers. The Secretary shall seek input from such stakeholders on determining the type of information that is useful and the formats that best facilitate the use of the information.

(ii) The Secretary shall modify the Hospital Compare Internet website to make the use and navigation of that website readily available to individuals accessing it.

(g) GAO Study and Report.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study on the performance of the hospital value-based purchasing program established under section 1886(o) of the Social Security Act, as added by paragraph (1). Such study shall include an analysis of the impact of such program on—

(i) the quality of care furnished to Medicare beneficiaries, as defined in paragraph (1) of section 1861(mm) of such Act (42 U.S.C. 1395x(mm)), and

(ii) the performance of hospitals, including any reduced expenditures in terms of race, ethnicity, and socioeconomic status.

(B) REPORT.—The Secretary shall submit to Congress a report on the study conducted under paragraph (A), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(h) Improvements for Critical Access Hospitals.—Section 1886(m) of the Social Security Act (42 U.S.C. 1395ww(m)), as added by section 102(b) of the HITECH Act (Public Law 111–5), is amended by adding at the end the following new clause:


(A) IN GENERAL.—Not later than 2 years after the enactment of this Act, the Secretary shall establish a demonstration program under which the Secretary establishes a value-based purchasing program under the Medicare program under title XVIII of the Social Security Act for critical access hospitals (as defined in paragraph (1) of section 1861(mm) of such Act (42 U.S.C. 1395x(mm))) with respect to inpatient critical access hospital services (as defined in paragraph (2) of such section) in order to test innovative methods of measuring and rewarding quality and efficient health care furnished by such hospitals.

(B) REPORT.—Not later than 18 months after the completion of the demonstration program under this paragraph, the Secretary shall submit to Congress a report on the demonstration program together with—

(i) recommendations on the establishment of a permanent value-based purchasing program under the Medicare program for applicable hospitals with respect to inpatient hospital services; and

(ii) recommendations for such other legislation and administrative action as the Secretary determines appropriate.

(i) Applicable Hospital Defined.—For purposes of this paragraph, the term ‘applicable hospital’ means a hospital as defined in clause (iii) or (iv) of section 1886(o)(1)(C)(i) of the Social Security Act, as added by subsection (a)(1).

(j) Duration.—The demonstration program under this paragraph shall be conducted for a 3-year period.

(k) Studies.—The Secretary shall conduct the demonstration program under this paragraph at an appropriate number (as determined by the Secretary) of applicable hospitals. The Secretary shall ensure that such hospitals are representative of the spectrum of such hospitals that participate in the Medicare program.

(l) Waiver Authority.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration program under this paragraph.

(m) Budget Neutrality Requirement.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the aggregate payments that would have been paid if the demonstration program under this section was not implemented.

(n) Report.—Not later than 18 months after the enactment of this Act, the Secretary shall submit to Congress a report on the demonstration program together with—

(i) recommendations on the establishment of a permanent value-based purchasing program under the Medicare program for applicable hospitals with respect to inpatient hospital services; and

(ii) recommendations for such other legislation and administrative action as the Secretary determines appropriate.

SEC. 3002. IMPROVEMENTS TO THE PHYSICIAN QUALITY REPORTING SYSTEM.

(a) Extension.—Section 1848(b) of the Social Security Act (42 U.S.C. 1395ww(b)(4)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A), in the matter preceding clause (i), by striking ‘‘2010’’ and inserting ‘‘2014’’; and

(B) in subparagraph (B), in clause (i), by striking ‘‘and’’ at the end;

(ii) in clause (ii), by striking the period at the end and inserting a semicolon; and

(iii) by adding at the end the following new clauses:

‘‘(iii) for 2011, 1.0 percent; and

(iv) for 2012, 2013, and 2014, 0.5 percent.’’;

(2) in paragraph (3)—

(A) in subparagraph (A), in the matter preceding clause (i), by inserting ‘‘(or, for purposes of subsection (a)(8), for the quality reporting period for the year’’ after ‘‘reporting period’’; and

(B) in subparagraph (C)(i), by inserting ‘‘or, for purposes of subsection (a)(8), for a quality reporting period for the year’’ after ‘‘year’’ after ‘‘2010, 1.0 percent’’;

(3) in paragraph (5)(E)(iv), by striking ‘‘subsection (a)(5)(A)’’ and inserting ‘‘paragraphs (5)(A) and (8)(A) of subsection (a)’’; and

(4) in paragraph (6)(C)—


(B) in clause (ii)—

(i) by inserting ‘‘(a)(8)’’ after ‘‘(a)(5)’’; and

(ii) by inserting ‘‘(a)(8)’’ after ‘‘(a)(9)’’.
(ii) by striking ‘‘under subparagraph (D)(iii) of such subsection’’ and inserting ‘‘under subsection (a)(5)(D)(iii) or the quality reporting period under subsection (a)(5)(D)(iii) respectively’’.

(b) INCENTIVE PAYMENT ADJUSTMENT FOR QUALITY REPORTING.—Section 1848(a) of the Social Security Act (42 U.S.C. 1395w–4(a)) is amended by adding at the end the following new paragraph:

‘‘(8) INCENTIVES FOR QUALITY REPORTING.—

‘‘(A) ADJUSTMENT.—

‘‘(i) General.—With respect to covered professional services furnished by an eligible professional during 2015 or any subsequent year, if the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year (as determined under subsection (m)(3)(A)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of paragraph (3), (4), and (5), but without regard to this paragraph).

‘‘(ii) APPLICABLE PERCENT.—For purposes of clause (i), the term ‘applicable percent’ means—

‘‘(I) for 2015, 98.5 percent; and

‘‘(II) for 2016 and each subsequent year, 98 percent.

(c) APPLICATION.—

‘‘(1) PHYSICIAN REPORTING SYSTEM RULES.—Paragraphs (5), (6), and (8) of subsection (k) shall apply for purposes of this paragraph in the same manner as they apply for purposes of each subsection.

‘‘(ii) INCENTIVE PAYMENT VALIDATION RULES.—Clauses (ii) and (iii) of subsection (m)(5)(D) shall apply for purposes of this paragraph in a similar manner as they apply for purposes of such subsection.

‘‘(C) DEFINITIONS.—For purposes of this paragraph:

‘‘(i) ELIGIBLE PROFESSIONAL; COVERED PROFESSIONAL SERVICES.—The terms ‘eligible professional’ and ‘covered professional services’ have the meanings given such terms in subsection (k)(3).

‘‘(ii) PHYSICIAN REPORTING SYSTEM.—The term ‘physician reporting system’ means the system established under subsection (k).

‘‘(iii) QUALITY REPORTING PERIOD.—The term ‘quality reporting period’ means, with respect to a year, a period specified by the Secretary.

(c) MAINTENANCE OF CERTIFICATION PROGRAMS.—

(1) IN GENERAL.—Section 1848(k)(4) of the Social Security Act (42 U.S.C. 1395w–4(k)(4)) is amended by adding at the beginning the following new clause:

‘‘(D) By the end of the following year, the Secretary shall publish a report that describes the methodology used to determine performance thresholds for purposes of the quality measurement process under this paragraph, the measures used to determine performance thresholds, the performance thresholds used to determine performance under this paragraph, and any performance rates achieved by such physicians.’’.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply for years after 2015.

(d) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Section 1868(m) of the Social Security Act (42 U.S.C. 1395w–4(m)) is amended by adding at the end the following new paragraph:

‘‘(7) INTEGRATION OF PHYSICIAN QUALITY REPORTING AND EHR REPORTING.—Not later than January 1, 2012, the Secretary shall develop a plan to integrate reporting on quality measures under this subsection with reporting requirements under subsection (o) relating to the electronic use of patient health records. Such integration shall consist of the following:

 ‘‘(A) The selection of measures, the reporting of which would both demonstrate—

 ‘‘(i) meaningful use of an electronic health record for purposes of subsection (o); and

 ‘‘(ii) quality of care furnished to an individual.

 ‘‘(B) Such other activities as specified by the Secretary.

 ‘‘(c) MAINTENANCE OF CERTIFICATION PROGRAMS.—

(1) IN GENERAL.—The Secretary shall, by not later than January 1, 2011, establish and have in place an informal process for eligible professionals to seek a review of the determination that an eligible professional is not satisfactorily submitting data on quality measures under this subsection:

‘‘(i) APPEALS.—Such section is further amended—

‘‘(1) in subparagraph (E), by striking ‘‘There shall’’ and inserting ‘‘Except as provided in subparagraph (I), there shall’’; and

‘‘(2) by adding at the end the following new subparagraph:

‘‘(1) INFORMAL APPEALS PROCESS.—The Secretary shall, by not later than January 1, 2011, establish and have in place an informal process for eligible professionals to seek a review of the determination that an eligible professional is not satisfactorily submitting data on quality measures under this subsection.

‘‘(2) INTEGRATION OF PHYSICIAN QUALITY REPORTING SYSTEM RULES.—The Secretary shall include in the rules established under subsection (k) requirements that specify how the Secretary shall make available to eligible professionals the ability to view, download, and report information on the quality of care furnished to individuals.''

(2) INCENTIVE PAYMENT ADJUSTMENT FOR QUALITY REPORTING.—Section 1848(a) of the Social Security Act (42 U.S.C. 1395w–4(a)) is amended by adding at the end the following new paragraph:

‘‘(9) REPORTS ON UTILIZATION.—

‘‘(A) The Secretary shall, by not later than January 1, 2012, the Secretary shall develop a plan to integrate reporting on quality measures under this subsection with reporting requirements under subsection (o) relating to the electronic use of patient health records. Such integration shall consist of the following:

 ‘‘(i) DEVELOPMENT OF EPISODE GROUPE.—The Secretary shall develop an episode grouper that combines separate but clinically related items and services into an episode of care for an individual, as appropriate.

 ‘‘(ii) TIMELINE FOR DEVELOPMENT.—The episode grouper described in subparagraph (A) shall be developed by not later than January 1, 2012.

‘‘(iii) PUBLIC AVAILABILITY.—The Secretary shall make the details of the episode grouper described in subparagraph (A) available to the public.

‘‘(iv) ENDORSEMENT.—The Secretary shall seek endorsement of the episode grouper developed under subparagraph (A) by the entity with a contract under section 1890(a).

‘‘(B) REPORTS ON UTILIZATION.—Effective beginning with 2012, the Secretary shall provide reports to physicians that compare, as determined appropriate by the Secretary, patterns of resource use of the individual physician to such patterns of other physicians.

‘‘(C) ANALYSIS OF DATA.—The Secretary shall, for purposes of preparing reports under this paragraph, establish methodologies as appropriate, such as to—

 ‘‘(i) attribute episodes of care, in whole or in part, to physicians;

 ‘‘(ii) identify appropriate physicians for purposes of comparison under subparagraph (B); and

 ‘‘(iii) aggregate episodes of care attributed to a physician under clause (i) into a composite measure per individual.

‘‘(D) DATA ADJUSTMENTS.—In preparing reports under this paragraph, the Secretary shall make appropriate adjustments, including adjustments—

‘‘(i) to account for differences in socio-economic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions); and

‘‘(ii) to eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)).

‘‘(E) PUBLIC AVAILABILITY OF METHODOLOGY.—The Secretary shall make available to the public—

 ‘‘(i) the methodologies established under subparagraph (C);

 ‘‘(ii) information regarding any adjustments made to data under subparagraph (D); and

 ‘‘(iii) aggregate reports with respect to physicians.

‘‘(F) DEFINITION OF PHYSICIAN.—In this paragraph:

‘‘(i) IN GENERAL.—The term ‘physician’ has the meaning given such term in section 1861(r)(1).

‘‘(ii) TREATMENT OF GROUPS.—Such term includes, as the Secretary determines appropriate, a group of physicians.

‘‘(G) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the establishment of the methodology under subparagraph (C), including the determination of the episode of care under such methodology.

‘‘(H) COORDINATION WITH OTHER VALUE-BASED PURCHASING REFORMS.—The Secretary shall include in the Program with the value-based payment modifier established under subsection (p) and, as the Secretary determines appropriate, other similar provisions of this title.

‘‘(b) CONFORMING AMENDMENT.—Section 1890(b) of the Social Security Act (42 U.S.C. 1395aa(b)) is amended by adding at the end the following new paragraph:

‘‘(6) REVIEW AND ENDORSEMENT OF EPISODE GROUPE DEVELOPED UNDER THE PHYSICIAN FEEDBACK PROGRAM.—The entity shall provide for the review and, as appropriate, the endorsement of the episode grouper developed by the Secretary under section 1890(b)(9)(A). Such review shall be conducted on an expedited basis.’’
SEC. 3004. QUALITY REPORTING FOR LONG-TERM CARE HOSPITALS, INPATIENT REHABILITATION HOSPITALS, AND HOSPICE PROGRAMS.

(a) LONG-TERM CARE HOSPITALS.—Section 1886(m) of the Social Security Act (42 U.S.C. 1395ww(m)), as amended by section 3401(c), is amended by adding at the end the following new subpart:

"(5) QUALITY REPORTING.—

"(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT.—

"(i) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, in the case of a hospice program that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a fiscal year, after determining the increase or decrease described in paragraph (3), the Secretary shall reduce such increase or decrease by 2 percentage points.

"(ii) SPECIAL RULE.—The application of this subparagraph shall be subject to the following:

"(I) IN GENERAL.—For purposes of this subparagraph, any hospice program shall be subject to the following:

"(II) SPECIAL RULE.—The application of this subparagraph shall be subject to the following:

"(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved and may result in payment rates for the fiscal year being less than such payment rates for the preceding fiscal year.

"(B) QUALITY MEASURES.—

"(i) IN GENERAL.—Subject to clause (ii), any measure specified by the Secretary under this subparagraph shall be made public. The Secretary shall make public the 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 identified by the Secretary.

"(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary in accordance with paragraph (3), the Secretary shall not take into account such reduction in computing the payment amount for the fiscal year with respect to such measure.

"(C) QUALITY REPORTING BY CANCER HOSPITALS.—

"(i) IN GENERAL.—Subject to clause (ii), any hospice program that does not submit data to the Secretary in accordance with subparagraph (C) with respect to such a fiscal year, after determining the increase or decrease described in paragraph (3), the Secretary shall reduce such increase or decrease by 2 percentage points.

"(ii) SPECIAL RULE.—The application of this subparagraph shall be subject to the following:

"(I) IN GENERAL.—For purposes of this subparagraph, any hospice program shall be subject to the following:

"(II) SPECIAL RULE.—The application of this subparagraph shall be subject to the following:

"(B) NONCUMULATIVE APPLICATION.—Any reduction under subparagraph (A) shall apply only with respect to the fiscal year involved and may result in payment rates for the fiscal year being less than such payment rates for the preceding fiscal year.

"(B) QUALITY Report for PPS-EXEMPT CANCER HOSPITALS.—

"(i) IN GENERAL.—For purposes of fiscal year 2014 and each subsequent fiscal year, each hospice program shall submit to the Secretary on quality measures specified by the Secretary for purposes of this subparagraph.

"(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for purposes of this subparagraph, the Secretary shall not take into account such reduction in computing the payment amount for the fiscal year with respect to such measure.
each hospital described in such section shall submit to the Secretary on quality measures specified under paragraph (3). Such data shall be submitted in a form and manner, and at the frequency, that the Secretary may specify by regulation. 

(3) QUALITY MEASURES.—

(A) IN GENERAL.—Subject to subparagraph (B), any quality measure specified under this paragraph must have been endorsed by the entity with a contract under section 1890(a).

(B) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), 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 identified by the Secretary.

(C) TIME FRAME.—Not later than October 1, 2012, the Secretary shall publish the measures selected under this paragraph that will be applicable with respect to fiscal year 2014.

(4) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under paragraph (4) available to the public. Such procedures shall ensure that a hospital described in section 1886(d)(1)(B)(v) has the opportunity to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients' prospective on care, efficiency, and costs of care that relate to services furnished in such hospitals on the Internet website of the Centers for Medicare & Medicaid Services.''

SEC. 3006. PLANS FOR A VALUE-BASED PURCHASING PROGRAM FOR SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES.

(a) SKILLED NURSING FACILITIES.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall develop a plan to implement a value-based purchasing program for payments under the Medicare program under title XVIII of the Social Security Act for home health agencies (as defined in section 1861(o) of such Act (42 U.S.C. 1395x(o))).

(2) DETAILS.—In developing the plan under paragraph (1), the Secretary shall consider the following:

(A) The ongoing development, selection, and modification process for measures (including under section 1890 of the Social Security Act (42 U.S.C. 1395f) and section 1890A such Act, as added by section 3014), to the extent feasible and practicable, of all dimensions of quality and efficiency in home health agencies.

(B) The reporting, collection, and validation of quality data.

(C) The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based bonus payments.

(D) Methods for the public disclosure of information on the performance of home health agencies.

(E) Any other issues determined appropriate by the Secretary.

(3) COSTS.—For purposes of paragraph (1), the Secretary shall take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions) and other factors determined appropriate by the Secretary.

(4) IMPLEMENTATION.—

(A) IMPLEMENTATION.—

(1) IN GENERAL.—The Secretary shall establish appropriate measures of the quality of care furnished by a physician or group of physicians to individuals enrolled under this part, such as measures that reflect patient outcomes. Such measures shall be determined as appropriate by the Secretary.

(B) MEASURES.—

(i) The Secretary shall establish appropriate measures of the quality of care furnished by a physician or group of physicians to individuals enrolled under this part, such as measures that reflect patient outcomes. Such measures shall be determined as appropriate by the Secretary.

(ii) The Secretary shall seek endorsement of the measures described in this subsection by the entity with a contract under section 1890(a).

(C) BUDGET NEUTRALITY.—The payment modifier established under this subsection for items and services furnished by a physician or group of physicians to individuals enrolled under this part, such as measures that reflect patient outcomes, shall not result in an increase in the total payment to physicians (as determined under subsection (B)).

(iii) The Secretary shall establish a payment modifier that provides for payments under the Medicare program under part B of title XVIII of the Social Security Act (42 U.S.C. 1395dr) to the extent feasible and practicable, based on a composite of measures of the quality of care furnished by a group of physicians to individuals enrolled under this part, such as measures that reflect patient outcomes.

(5) REPORT TO CONGRESS.—Not later than October 1, 2011, the Secretary shall submit to Congress a report containing the plan developed under paragraph (1).

(6) IMPLEMENTATION, PERFORMANCE PERIOD.—Not later than January 1, 2015, the Secretary shall submit to Congress a report containing the plan developed under paragraph (1).

SEC. 3007. VALUE-BASED PAYMENT MODIFIER UNDER THE PHYSICIAN FEE SCHEDULE.

Section 1848 of the Social Security Act (42 U.S.C. 1395gg) shall be amended by inserting "(1) in subsection (b)(1), by inserting "subject to subsection (p)," after "1998," and (2) by adding at the end the following new subsection:

(p) ESTABLISHMENT OF VALUE-BASED PAYMENT MODIFIER.—

(1) IN GENERAL.—The Secretary shall establish a payment modifier that provides for differential payment to a physician or a group of physicians under the fee schedule established under subsection (b) based upon the quality of care furnished compared to cost (as determined under paragraphs (2) and (3), respectively) during a performance period. Such payment modifier shall be separate from the value-based payment adjustment factors established under subsection (e).

(2) QUALITY.—

"(A) IN GENERAL.—For purposes of paragraph (1), quality of care shall be evaluated, to the extent practicable, based on a composite of measures of the quality of care furnished by a specified area or medical topic determined appropriate by the Secretary (such as the composite measure under the methodology established under subsection (a)(9)(C)(iii)) that eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)) and take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions) and other factors determined appropriate by the Secretary.

(B) DETERMINATION.—The payment modifier shall be determined by the Secretary under this subsection for items and services furnished by a physician to individuals enrolled under this part, such as measures that reflect patient outcomes. Such measures shall be determined as appropriate by the Secretary.

(C) TIME FRAME.—Not later than October 1, 2011, the Secretary shall submit to Congress a report containing the plan described in this subsection for items and services furnished by a specified area or medical topic determined appropriate by the Secretary (such as the composite measure under the methodology established under subsection (a)(9)(C)(iii)) that eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)) and take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions) and other factors determined appropriate by the Secretary.

(D) METHODS FOR THE PUBLIC DISCLOSURE OF INFORMATION.—

(i) The Secretary shall establish appropriate measures of the quality of care furnished by a group of physicians to individuals enrolled under this part, such as measures that reflect patient outcomes. Such measures shall be determined as appropriate by the Secretary.

(ii) The Secretary shall seek endorsement of the measures described in this subsection by the entity with a contract under section 1890(a).

(E) COSTS.—For purposes of paragraph (1), the payment modifier shall be, to the extent practicable, based on a composite of appropriate measures of costs established by the Secretary (such as the composite measure under the methodology established under subsection (a)(9)(C)(iii)) that eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)) and take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions) and other factors determined appropriate by the Secretary.

(F) IMPLEMENTATION.—

(A) IN GENERAL.—The Secretary shall establish appropriate measures of the quality of care furnished by a group of physicians to individuals enrolled under this part, such as measures that reflect patient outcomes. Such measures shall be determined as appropriate by the Secretary.

(B) DETERMINATION.—The payment modifier shall be determined by the Secretary under this subsection for items and services furnished by a physician to individuals enrolled under this part, such as measures that reflect patient outcomes. Such measures shall be determined as appropriate by the Secretary.

(C) TIME FRAME.—Not later than October 1, 2011, the Secretary shall submit to Congress a report containing the plan described in this subsection for items and services furnished by a specified area or medical topic determined appropriate by the Secretary (such as the composite measure under the methodology established under subsection (a)(9)(C)(iii)) that eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)) and take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions) and other factors determined appropriate by the Secretary.

(D) METHODS FOR THE PUBLIC DISCLOSURE OF INFORMATION.—

(i) The Secretary shall establish appropriate measures of the quality of care furnished by a group of physicians to individuals enrolled under this part, such as measures that reflect patient outcomes. Such measures shall be determined as appropriate by the Secretary.

(ii) The Secretary shall seek endorsement of the measures described in this subsection by the entity with a contract under section 1890(a).

(E) COSTS.—For purposes of paragraph (1), the payment modifier shall be, to the extent practicable, based on a composite of appropriate measures of costs established by the Secretary (such as the composite measure under the methodology established under subsection (a)(9)(C)(iii)) that eliminate the effect of geographic adjustments in payment rates (as described in subsection (e)) and take into account risk factors (such as socioeconomic and demographic characteristics, ethnicity, and health status of individuals (such as to recognize that less healthy individuals may require more intensive interventions) and other factors determined appropriate by the Secretary.)
“(5) SYSTEMS-BASED CARE.—The Secretary shall, as appropriate, apply the payment modifier established under this subsection in a manner that promotes systems-based care.

“(6) OF SPECIFIC, SPECIAL CIRCUMSTANCES OF CERTAIN PROVIDERS.—In applying the payment modifier under this subsection, the Secretary shall, as appropriate, take into account the special circumstances of physicians or groups of physicians in rural areas and other underserved communities.

“(7) APPLICATION.—For purposes of the initial application of the payment modifier established under this subsection during the period beginning on January 1, 2015, and ending on December 31, 2016, the term ‘physician’ includes individuals as defined in section 1861(r). On or after January 1, 2017, the Secretary may apply this subsection to eligible professionals (as defined in subsection (k)(3)(B)) as the Secretary determines appropriate.

“(8) DEFINITIONS.—For purposes of this subsection:

“(A) Costs.—The term ‘costs’ means expenditures per individual as determined appropriate by the Secretary. In making the determination under the preceding sentence, the Secretary may take into account the amount of growth in expenditures per individual for a physician compared to the amount of such growth for other physicians.

“(B) Performance period.—The term ‘performance period’ means a period specified by the Secretary.

“(9) COORDINATION WITH OTHER VALUE-BASED PURCHASING REFORMS.—The Secretary shall coordinate the value-based payment modifier established under this subsection with the Physician Feedback Program under subsection (k) and the applicable period, as determined by the Secretary.

“(10) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of—

“(A) the establishment of the value-based payment modifier under this subsection;

“(B) the establishment of appropriate measures of the quality of care under paragraph (2);

“(C) the dates for implementation of the value-based payment modifier under paragraph (7); and

“(D) the determination of costs under paragraph (8)(A).

SEC. 2008. PAYMENT ADJUSTMENT FOR CONDITIONS ACQUIRED IN HOSPITALS.

(a) In General.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by section 3001, is amended by adding at the end the following:

“(o) and (q) and section 1814(j)(4) but without regard to this subsection).

“(2) APPLICABLE HOSPITALS.—

“(A) IN GENERAL.—For purposes of this subsection, the term ‘applicable hospital’ means—

“(I) a hospital (as defined in section 1861(r)) that is a subsection (d) hospital that meets the criteria described in subparagraph (B).

“(II) CRITERIA DESCRIBED.—

“(i) In general.—The criteria described in this subparagraph, with respect to a subsection (d) hospital, is that the subsection (d) hospital is in the top quartile of all subsection (d) hospitals, relative to the national average, of hospital acquired conditions during the applicable period, as determined by the Secretary.

“(ii) Risk adjustment.—In carrying out clause (i), the Secretary shall establish and apply an appropriate risk adjustment methodology.

“(C) EXEMPTION.—In the case of a hospital that is paid under section 1814(b)(3), the Secretary may exempt such hospital from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for participating hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection.

“(D) Hospital acquired conditions.—For purposes of this subsection, the term ‘hospital acquired condition’ means a condition identified for subsection (d)(4)(D)(iv) and any other condition determined appropriate by the Secretary that an individual acquires during a stay in an applicable hospital, as determined by the Secretary.

“(E) APPLICABLE PERIOD.—In this subsection, the term ‘applicable period’ means, with respect to each fiscal year, a period specified by the Secretary.

“(F) REPORTING HOSPITAL SPECIFIC INFORMATION.—

“(A) IN GENERAL.—The Secretary shall make information available to the public regarding hospital acquired conditions of each applicable hospital.

“(B) OPPORTUNITY TO REVIEW AND SUBMIT CORRECTIONS.—The Secretary shall ensure that an applicable hospital has the opportunity to review and submit corrections for the information to be made public with respect to the hospital under subparagraph (A) prior to such information being made public.

“(C) WEBSITE.—Such information shall be posted on the Hospital Compare Internet website in an easily understandable format.

“(D) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the following:

“(A) The criteria described in paragraph (2)(A).

“(B) The specification of hospital acquired conditions under paragraph (3).

“(C) The specification of the applicable period under paragraph (4).

“(D) The provision of reports to applicable hospitals under paragraph (6) and the information made available to the public under paragraph (6).

“(E) STUDY AND REPORT ON EXPANSION OF HEALTH DISPARITY POPULATIONS CONDITION TO OTHER PROVIDERS.—

“(A) STUDY.—The Secretary of Health and Human Services shall conduct a study on expanding the conditions policy under subsection (d)(4)(D) of section 1866 of the Social Security Act (42 U.S.C. 1395ww) to payments made to other facilities under the Medicare program under title XVIII of the Social Security Act, including such payments made to inpatient rehabilitation facilities and other hospitals excluded from the inpatient prospective payment system under such section, hospital outpatient departments, and other hospitals excluded from the inpatient prospective payment system under such section, skilled nursing facilities, ambulatory surgical centers, and health clinics. Such study shall include an analysis of how such policies could impact quality of patient care, patient safety, and spending under the Medicare program.

“(B) REPORT.—Not later than January 1, 2017, the Secretary shall submit a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

PART II—NATIONAL STRATEGY TO IMPROVE HEALTH CARE QUALITY

SEC. 3011. NATIONAL STRATEGY.

Title III of the Public Health Service Act (42 U.S.C. 241 et seq.) is amended by adding at the end the following:

“PART II—NATIONAL STRATEGY TO IMPROVE HEALTH CARE QUALITY.

“Subpart 1—National Strategy for Quality Improvement in Health Care.


“(a) ESTABLISHMENT OF NATIONAL STRATEGY AND PRIORITIES.—

“(1) NATIONAL STRATEGY.—The Secretary, through a transparent collaborative process, shall establish a national strategy to improve the delivery of health care services, patient health outcomes, and population health.

“(2) IDENTIFICATION OF PRIORITIES.—

“(A) IN GENERAL.—The Secretary shall identify national priorities for improvement in developing the strategy under paragraph (1).

“(B) REQUIREMENTS.—The Secretary shall ensure that priorities identified under subparagraph (A) will—

“(i) have the greatest potential for improving health outcomes and patient-centeredness of health care for all populations, including children and vulnerable populations;

“(ii) address gaps in health care services that have the potential for rapid improvement in the quality and efficiency of patient care;

“(iii) address gaps in quality, efficiency, comparative effectiveness information, and health outcomes measures and data aggregation techniques;

“(iv) improve Federal payment policy to emphasize quality and efficiency;

“(v) enhance the use of health care data to improve quality, efficiency, transparency, and access;

“(vi) address the health care provided to patients with high-cost chronic diseases;

“(vii) improve research and dissemination of strategies and best practices to improve patient safety and reduce medical errors, preventable admissions and readmissions, and health care-associated infections;

“(viii) reduce disparities across health disparity populations (as defined in section 485E) and geographic areas; and

“(ix) address other areas as determined appropriate by the Secretary.

“(C) CONSIDERATIONS.—In identifying priorities under subparagraph (A), the Secretary shall take into consideration the recommendations submitted by the Secretary with a contract under section 1890(a) of the Social Security Act and other stakeholders.
"(D) COORDINATION WITH STATE AGENCIES.—The Secretary shall collaborate, coordinate, and consult with State agencies responsible for administering the Medicaid program under title XIX of the Social Security Act and the Children’s Health Insurance Program under title XXI of such Act with respect to developing and disseminating strategies, goals, and timetables that are consistent with the national priorities identified under subparagraph (A).

"(E) HEALTH CARE QUALITY INTERNET WEBSITE.—Not later than January 1, 2011, the Secretary shall create an Internet website to make public information regarding—

"(i) the national priorities for health care quality improvement established under subsection (a)(2);

"(ii) the agency-specific strategic plans for health care quality described in subsection (b)(2)(B) and

"(iii) other information, as the Secretary determines to be appropriate.

"(F) IN GENERAL.—The President shall convene the Working Group, known as the Interagency Working Group on Health Care Quality (referred to in this section as the ‘‘Working Group’’), to carry out this section.

"(G) GOALS.—The goals of the Working Group shall be to achieve the following:

"(1) Collaboration, cooperation, and consultation between Federal departments and agencies with respect to developing and disseminating strategies, goals, models, and timetables consistent with the national priorities identified under title XIX of the Social Security Act (as added by section 10111).

"(2) Avoidance of inefficient duplication of quality improvement efforts and resources, where practicable, and a streamlined process for quality reporting and compliance requirements.

"(3) Assess alignment of quality efforts in the public sector with private sector initiatives.

"(H) COMPOSITION.—

"(i) IN GENERAL.—The Working Group shall be composed of—

"(A) the Department of Health and Human Services;

"(B) the Centers for Medicare & Medicaid Services;

"(C) the National Institutes of Health;

"(D) the Centers for Disease Control and Prevention;

"(E) the Food and Drug Administration;

"(F) the Health Resources and Services Administration;

"(G) the Agency for Healthcare Research and Quality;

"(H) the Office of the National Coordinator for Health Information Technology;

"(I) the Substance Abuse and Mental Health Services Administration;

"(J) the Administration for Children and Families;

"(K) the Department of Commerce;

"(L) the Office of Management and Budget;

"(M) the United States Coast Guard;

"(N) the Federal Bureau of Prisons;

"(O) the National Highway Traffic Safety Administration;

"(P) the Federal Trade Commission;

"(Q) the Social Security Administration;

"(R) the Department of Labor;

"(S) the United States Office of Personnel Management;

"(T) the Department of Defense;

"(U) the Department of Education;

"(V) the Department of Veterans Affairs;

"(W) the Veterans Health Administration; and

"(X) any other Federal agencies and departments with activities relating to improving health care quality and safety, as determined by the President.

"(2) CHAIR AND VICE-CHAIR.—

"(A) CHAIR.—The Working Group shall be chaired by the Secretary of Health and Human Services.

"(B) VICE-CHAIR.—The Vice-Chair shall be selected by the Secretary of Health and Human Services.

"(C) GRANTS OR CONTRACTS FOR QUALITY IMPROVEMENT.—In making grants or contracts for quality improvement established under section 1139A of the Social Security Act, and (C) quality measures identified through the Medicaid Quality Measurement Program under section 1139B of the Social Security Act.

"(2) PRIORITIZATION IN THE DEVELOPMENT OF QUALITY MEASURES.—In awarding grants, contracts, or agreements under this subsection, the Secretary shall give priority to the development of quality measures that allow the assessment of—

"(A) health outcomes and functional status of patients;

"(B) the management and coordination of health care across episodes of care and care transitions for patients across the continuum of providers, health care settings, and health plans;

"(C) the experience, quality, and use of information provided to and used by patients, caregivers, and authorized representatives to

"SEC. 3012. INTERAGENCY WORKING GROUP ON HEALTH CARE QUALITY.

"(a) IN GENERAL.—The President shall convene the Working Group, known as the Interagency Working Group on Health Care Quality (referred to in this section as the ‘‘Working Group’’).

"(b) GOALS.—The goals of the Working Group shall be to achieve the following:

"(1) Collaboration, cooperation, and consultation between Federal departments and agencies with respect to developing and disseminating strategies, goals, models, and timetables consistent with the national priorities identified under title XIX of the Social Security Act.

"(2) Avoidance of inefficient duplication of quality improvement efforts and resources, where practicable, and a streamlined process for quality reporting and compliance requirements.

"(3) Assess alignment of quality efforts in the public sector with private sector initiatives.

"(4) In general—

"(i) the national priorities for health care quality improvement established under subsection (a)(2);

"(ii) the agency-specific strategic plans for health care quality described in subsection (b)(2)(B) and

"(iii) other information, as the Secretary determines to be appropriate.

"(c) PERIODIC UPDATE OF NATIONAL STRATEGY.—The Secretary shall update the national strategy not less than annually. Any such update shall include a review of short- and long-term goals.

"(d) SUBMISSION AND AVAILABILITY OF NATIONAL STRATEGY AND UPDATE.—

"(1) DEADLINE FOR INITIAL SUBMISSION OF STRATEGY.—Not later than January 1, 2011, the Secretary shall submit to the relevant committees of Congress the national strategy described in subsection (a).

"(2) SUBSEQUENT UPDATES.—

"(A) IN GENERAL.—The Secretary shall submit to the relevant committees of Congress an annual update to the strategy described in paragraph (1).

"(B) INFORMATION SUBMITTED.—Each update submitted under subparagraph (A) shall include—

"(i) a review of the short- and long-term goals of the national strategy and any gaps in such strategy;

"(ii) an analysis of the progress, or lack of progress, in achieving such goals and any barriers to such progress;

"(iii) the information reported under section 1139A of the Social Security Act, consistent with the reporting requirements of such section; and

"(iv) in the case of an update required to be submitted on or after January 1, 2011, the information reported under section 1139B(b)(4) of the Social Security Act, consistent with the reporting requirements of such section.

"(2) PRIORITIZATION OF OTHER REPORTING REQUIREMENTS.—Compliance with the requirements of clauses (iii) and (iv) of subparagraph (B) shall satisfy the reporting requirements of the preceding section 1139A(b)(6) and 1139B(b)(4), respectively, of the Social Security Act.
inform decisionmaking about treatment options, including the use of shared decision-making tools and preference-sensitive care (as defined in section 506);

(2) the meaningful use of health information technology;

(3) the safety, effectiveness, patient-centeredness, appropriateness, and timeliness of care;

(4) the efficiency of care;

(5) the equity of health services and health disparities across health disparity populations (as defined in section 485E) and geographic areas;

(6) patient experience and satisfaction;

(7) the use of innovative strategies and methodologies identified under section 953; and

(8) other areas determined appropriate by the Secretary.

(3) ELIGIBLE ENTITIES.—To be eligible for a grant or contract under this subsection, an entity shall—

(A) demonstrate expertise and capacity in the development and evaluation of quality measures;

(B) have adopted procedures to include in the quality measure development process—

(i) the views of other parties who also will use the quality measures (such as patients, consumers, and health care purchasers);

(ii) collaboration with the entity with a contract under section 1890(a) of the Social Security Act and other stakeholders, as practicable, and the Secretary so that quality measures developed by the eligible entity will meet the requirements to be considered for endorsement by the entity with a contract under such section 1890(a);

(iii) have transparent policies regarding governance and conflicts of interest; and

(E) submit an application to the Secretary at such time and in such manner, as the Secretary may require.

(4) USE OF FUNDS.—An entity that receives a grant, contract, or agreement under this subsection shall use such award to develop quality measures that meet the following requirements:

(A) Such measures support requirements—

(i) for use pursuant to section 1890(b)(1)(B), section 1890(c)(6), section 1890(c)(7), section 1848(k)(2)(C), section 1866(k)(2)(A)(ii), 1866(k)(3)(ii), 1866(k)(4)(B)(viii), 1886(m)(4)(A)(ii), 1886(m)(5)(D), 1886(n)(2), and 1890(b)(3)(B)(v); and

(ii) for use pursuant to sections 1395 et seq.) is amended by inserting after chapter 1886(o)(2), and 1895(b)(3)(B)(v); and

(B) Such measures support requirements—

(i) for use pursuant to section 1890(b)(7), the entity shall convene multi-stakeholder groups to provide input to the Secretary on the selection of quality measures described in paragraph (B) of this subsection;

(ii) for use pursuant to section 1890(c)(6), section 1890(c)(7), section 1848(k)(2)(C), section 1866(k)(2)(A)(ii), 1866(k)(3)(ii), 1866(k)(4)(B)(viii), 1886(m)(4)(A)(ii), 1886(m)(5)(D), 1886(n)(2), and 1890(b)(3)(B)(v); and

(C) To the extent practicable, data on such quality measures is able to be collected using health information technologies.

(D) Such quality measures are free of charge to users of such measure.

(E) Each quality measure is publicly available on an Internet website.

(F) Each quality measure is free of charge to users of such measure.

(G) The Secretary may use amounts available under this section to update and maintain the Secretary’s demonstration of meaningful use of health information technology.

(H) Each quality measure is publicly available to the Secretary for the collection or reporting of quality measures; and

(I) such quality measures are developed under section 1393(a)(2)(A) of the Social Security Act, and where targeted research may address such gaps; and

(J) areas in which evidence is insufficient to support endorsement of quality measures in priority areas identified by the Secretary under the national strategy established under section 399HH of the Public Health Service Act, and where quality measures are not available or inadequate to identify or address such gaps;

(V) the matters described in clauses (I) and (ii) of paragraph (7)(A).

(5) RATIONALE FOR USE OF QUALITY MEASURES.—(A) In general.—The entity shall convene multi-stakeholder groups to provide input on—

(i) the selection of quality measures described in subparagraph (B), from among—

(I) such measures that have been endorsed by the entity; and

(II) such measures that have not been considered for endorsement by such entity, but are used or proposed to be used by the Secretary for the collection or reporting of quality measures; and

(ii) national priorities (as identified under section 399HH of the Public Health Service Act) for improvement in population health and in the delivery of health care services for consideration under the national strategy established under section 399HH of the Public Health Service Act.

(B) Quality measures.—(i) In general.—Subject to clause (ii), the quality measures described in this subparagraph are quality measures—

(I) for use pursuant to sections 1813(b)(7), 1848(k)(2)(C), 1866(k)(3)(ii), 1866(k)(4)(B)(viii), 1886(m)(5)(D), 1886(n)(2), and 1890(b)(3)(B)(v); and

(ii) for use pursuant to sections 1395 et seq.) is amended by inserting after chapter 1886(o)(2), and 1895(b)(3)(B)(v); and

(6) REQUIREMENT FOR TRANSPARENCY IN PROCESS.—(i) In general.—In convening multi-stakeholder groups under subparagraph (A) with respect to the selection of quality measures, the entity shall provide for an open and transparent process for the activities conducted pursuant to such convening.

(ii) Transparency in multi-stakeholder groups.—The process described in clause (i) shall ensure that the selection of representatives from multi-stakeholder groups provides for public nominations for, and the opportunity for public comment on, such selection.

(7) Transmission of multi-stakeholder group input.—Not later than each year (beginning with 2012), the entity shall transmit to the Secretary the input of multi-stakeholder groups described in paragraph (1).

(8) Rationale for use of quality measurements.—The Secretary shall publish in the Federal Register the rationale for the use of quality measurements described in section 1890(b)(7)(B) that have not been endorsed by the entity with a contract under section 1890.
“(6) ASSESSMENT OF IMPACT.—Not later than March 1, 2012, and at least once every three years thereafter, the Secretary shall—

(A) conduct an assessment of the quality improvement practices and measures endorsed under subsection (b) and determine whether any such measures should be eliminated, revised, reprioritized, expanded, or otherwise modified; and

(B) make such assessment available to the public.

(7) MEASURES FOR DISSEMINATION OF MEASURES USED BY THE SECRETARY.—

(1) IN GENERAL.—The Secretary shall establish a process for disseminating quality measures used by the Secretary. Such process shall include the following:

(A) The incorporation of such measures, where applicable, in workforce programs, training, and other dissemination determined appropriate by the Secretary.

(B) The dissemination of such quality measures through the national strategy developed under section 399HH of the Public Health Service Act.

(8) EXISTING METHODS.—To the extent practicable, the Secretary shall utilize and expand existing dissemination methods in disseminating quality measures under the provisions of the sunset law described in paragraph (1).

(9) REVIEW OF QUALITY MEASURES USED BY THE SECRETARY.—

(1) IN GENERAL.—The Secretary shall—

(A) in no case less often than once every 3 years, review quality measures described in section 1809(b)(7)(B); and

(B) and with respect to each such measure, determine whether to—

(i) maintain the use of such measure; or

(ii) phase out such measure.

(2) IN GENERAL.—In conducting the review under paragraph (1), the Secretary shall take steps to—

(A) seek to avoid duplication of measures used;

(B) take into consideration current innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices for such quality improvement and measures endorsed by the entity with a contract under section 1890 since the previous review by the Secretary;

(3) RULE OF CONSTRUCTION.—Nothing in this section shall preclude a State from using any measures identified under sections 1139A and 1139B.

(10) FUNDING.—For purposes of carrying out the amendments made by this section, the Secretary may use amounts transferred from the Federal Hospital Insurance Trust Fund under section 1317 of the Social Security Act (42 U.S.C. 1395c) and the Federal Inpatient Hospital Services Trust Fund under section 1841 of such Act (42 U.S.C. 1395w), in such proportion as the Secretary determines appropriate, of $20,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2010 through 2014. Amounts transferred under the preceding sentence shall be available, but not obligated, until expended.

(11) DATA COLLECTION; PUBLIC REPORTING.—

Title III of the Public Health Service Act (42 U.S.C. 200 et seq.), as amended by section 3011, is further amended by adding the following:

SEC. 3011. COLLECTION AND ANALYSIS OF DATA FOR QUALITY AND RESOURCE USE MEASURES.

(a) IN GENERAL.—The Secretary shall collect and maintain data on quality and resource use measures from information systems used to support health care delivery to implement the public reporting of performance improvement models, as described in section 399JJ, and may award grants or contracts for this purpose. The Secretary shall ensure that such collection, aggregation, and analysis systems span an increasingly broad range of patient populations, providers, and geographic areas over time.

(b) CONTRACTS OR GRANTS FOR DATA COLLECTION.—

(1) IN GENERAL.—The Secretary may award grants or contracts to eligible entities to support new, or improve existing, efforts to collect and aggregate quality and resource use measures described under subsection (c).

(2) ELIGIBLE ENTITIES.—To be eligible for a grant or contract under this subsection, an entity shall—

(A) be—

(i) a multi-stakeholder entity that coordinates the development of methods and implementation plans for the consistent reporting of summary quality and cost information; and

(ii) an entity capable of submitting such summary data for a particular population and providers, such as a disease registry, regional collaboration, health plan collaboration, or other population-wide source; or

(iii) a Federal Indian Health Service program or a health program operated by an Indian tribe that is included in the Indian Health Care Improvement Act);

(B) make available through the Internet websites, performance information that is useful to stakeholders and other clinicians, patients, and other consumers, and appropriate, to the extent practicable, of $20,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for each of fiscal years 2010 through 2014. Such models, the Secretary shall give priority to models that the CMI is carrying out the duties described in this section. The purpose of the CMI is to promote the use of the systems that the Secretary determines appropriate, of $20,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for each fiscal year and the Secretary may award grants or contracts under this subsection only to entities that enable summary data that can be integrated and compared across multiple sources. The Secretary shall provide standards for the protection of the security and privacy of patient data.

(2) MATCHING FUNDS.—The Secretary may award grants or contracts under this section only to entities that enable summary data that can be integrated and compared across multiple sources. The Secretary shall provide standards for the protection of the security and privacy of patient data.

(3) CONSULTATION.—In carrying out the duties described in this section, the Secretary shall—

(A) periodically (but in no case less often than once every 3 years) review quality measures described in section 1809(b)(7)(B); and

(B) and make such review results available to the public.

(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated such sums as may be necessary for fiscal years 2010 through 2014.

(d) GRANTS OR CONTRACTS FOR DATA COLLECTION.—In general, Title XI of the Social Security Act is amended by adding the following:—

SEC. 1115A. (a) CENTER FOR MEDICARE AND MEDICAID INNOVATION.

(1) ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID INNOVATION—

SEC. 3021. ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID INNOVATION WITHIN CMS.

(a) IN GENERAL.—Title XI of the Social Security Act is amended by adding the following:

SEC. 3021. ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID INNOVATION WITHIN CMS.

(a) IN GENERAL.—There is created within the Centers for Medicare & Medicaid Services a center for Medicare and Medicaid Innovation, which in this section is referred to as the ‘‘CMI’’ to carry out the duties described in this section. The purpose of the CMI is to test innovative payment and service delivery models, and to reduce Medicare and Medicaid expenditures under the applicable titles while preserving or enhancing the quality of care furnished to individuals under such titles. In selecting such models, the Secretary shall give preference to models that also improve the coordination, quality, and efficiency of health care services furnished to applicable individuals as defined in paragraph (4)(A).

(b) DEADLINE.—Not later than January 1, 2011, the Secretary shall ensure that the CMI is carrying out the duties described in this section.

(c) CONSULTATION.—In carrying out the duties under this section, the CMI shall consult with representatives of other Federal agencies, and clinical and analytical experts with expertise in medicine and health care management. The CMI shall use open door forums or other mechanisms to seek input from interested parties.

(d) DEFINITIONS.—In this section:

(1) APPLICABLE INDIVIDUAL.—The term ‘‘applicable individual’’ means—

(A) an individual who is entitled to, or enrolled for, benefits under part A of title XVIII or enrolled for benefits under part B of title XIX, under a State plan or waiver; or

(B) an individual who is eligible for medical assistance under title XIX, under a State plan or waiver; or

(C) a participant in a health care delivery system that is subject to the provisions of title XVIII or title XIX; and

(D) any other individual (including any family member) to whom the Secretary determines it appropriate to apply the provisions of this section.

(2) AUTHORIZATION.—In carrying out this section, the Secretary shall consult with the entities described in section 1890(a) of the Social Security Act, and other entities, as appropriate, to determine the type of information that is useful to stakeholders and the format that best facilitates use of the reports and of performance reporting Internet websites.

(3) PUBLIC REPORTING.—In carrying out this section, the Secretary shall consult with the entities described in section 1890(a) of the Social Security Act, and other entities, as appropriate, to determine the type of information that is useful to stakeholders and the format that best facilitates use of the reports and of performance reporting Internet websites.
"(iii) Whether an individual meets the criteria of both clauses (i) and (ii).

"(B) APPLICABLE TITLE.—The term ‘applicable title’ means title XVII, title XIX, or both.

"(b) 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 (b)(1)(B)) on program expenditures and of both clauses (i) and (ii).

"(2) SELECTION OF MODELS TO BE TESTED.—

"(A) IN GENERAL.—The Secretary shall select models to be tested from models where the Secretary determines that there is evidence and identified under section 936(c)(2)(A) of the Public Health Service Act, that improve care and by practicing already addressing those for which there are deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. The models selected under the preceding sentence may include the models described in subparagraph (B).

"(B) OPPORTUNITIES.—The models described in this subparagraph are the following models:

"(i) Promoting broad payment and practice reform through the development and testing of patient-centered medical homes for high-need applicable individuals, medical homes that address women’s unique health care needs, and models of transition planning and care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment.

"(ii) Linking directly with groups of providers of services and suppliers to promote innovative care delivery models, such as through risk-based comprehensive payment models or capitation.

"(iii) Utilizing geriatric assessments and comprehensive care plans to coordinate the care (including through interdisciplinary teams) of applicable individuals with multiple chronic conditions and at least one of the following:

"(I) Inability to perform 2 or more activities of daily living.

"(II) Cognitive impairment, including dementia.

"(IV) Promote care coordination between providers of services and suppliers that transition health care providers away from fee-for-service based reimbursement and toward salary-based or capitation.

"(v) Supporting care coordination for chronically-ill applicable individuals at high risk of hospitalization through a health information technology-enabled provider network that includes care coordinators, a chronic disease registry, and home telehealth technology.

"(vi) Contracting payment to physicians who order advanced diagnostic imaging services (as defined in section 1833(e)(1)(B) according to the physician’s adherence to appropriate- ness guidelines established pursuant to such services, as determined in consultation with physician specialty groups and other relevant stakeholders.

"(vii) Utilizing medication therapy management services, such as those described in section 935 of the Public Health Service Act.

"(viii) Establishing community-based health teams to support small-practice medical homes by assisting the primary care practitioner in chronic care management, including patient self-management, activities.

"(ix) Offering consultation in making informed health care choices by paying providers of services and suppliers for using patient decision-support tools, including tools that address the needs and preferences of applicable individuals.

"(x) Allowing States to test and evaluate full payment for the medical care of residents of the State, including dual eligible individuals.

"(xii) Providing and testing evidence-based guidelines of cancer care with proven care methods within such institution that is responsible for—

"(I) Developing, documenting, and disseminating best practices and proven care methods;

"(ii) Implementing such best practices and proven care methods within such institution to demonstrate further improvements in quality and efficiency;

"(III) Providing assistance to other health care institutions on how best to employ such best practices and proven care methods to improve health care quality and lower costs.

"(xv) Facilitating inpatient care, including intensive care, of hospitalized applicable individuals at their local hospital through the use of electronic monitoring by specialists, including intensivists and critical care specialists, based at integrated health systems.

"(xvi) Providing inpatient and outpatient services and timely access to outpatient services (such as outpatient physical therapy services) through models that do not require a physician or other practitioner to refer the patient for the service or be involved in establishing the plan of care for the service, when such service is furnished by a health professional who has the authority to furnish the service under existing State law.

"(xvii) Establishing comprehensive payment models to Healthcare Innovation Zones, consisting of groups of providers that include a teaching hospital, physicians, and other clinical entities, that, through their structure, operations, and joint-activity deliver a full array of comprehensive health services to applicable individuals while also incorporating innovative methods for the clinical training of future health care professionals.

"(C) ADDITIONAL FACTORS FOR CONSIDERATION.—In selecting models for testing under subparagraph (A), the CMI may consider the following additional factors:

"(i) Whether the model includes a regular process for monitoring and updating patient care plans in a manner that is consistent with the needs and preferences of applicable individuals.

"(ii) Whether the model places the applicable individual, including family members and caregivers, at the center of the care of the applicable individual.

"(iii) Whether the model provides for in-person contact with applicable individuals.

"(iv) Whether the model utilizes technology, such as electronic health records and real-time remote monitoring systems, to coordinate care over time and across settings.

"(v) Whether the model provides for the maintainance of a close relationship between care coordinators, primary care practitioners, specialist physicians, community-based organizations, and other providers of services and suppliers on a real time basis.

"(vi) Whether the model relies on a team-based approach to interventions, such as comprehensive care assessments, care planning, self-management training, and collaborative teams.

"(vii) Whether, under the model, providers of services and suppliers are able to share information with patients, caregivers, and other providers of services and suppliers on a real time basis.

"(C) 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 expenditure under the applicable title.

"(B) TERMINATION OR MODIFICATION.—The Secretary shall terminate or modify the design and implementation of a model unless the Secretary certifies that the Secretary determines is necessary to monitor and evaluate such model.

"(4) EVALUATION.—

"(A) IN GENERAL.—The Secretary shall conduct an evaluation of each model tested under this subsection. Such evaluation shall include an analysis of—

"(i) the quality of care furnished under the applicable title, including the measurement of patient-level outcomes and patient-centeredness criteria determined appropriate by the Secretary; and

"(ii) the changes in spending under the applicable titles by reason of the model.

"(B) INFORMATION.—The Secretary shall make the results of each evaluation under this paragraph available to the public in a timely fashion and may establish require-
‘(2) The Chief Actuary of the Centers for Medicare & Medicaid Services certifies that such expansion would reduce program spending under applicable titles.

‘(d) Determination and Approval.—

‘(1) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and of section 1115A of title XVIII of the Social Security Act (42 U.S.C. 1396o) where the Secretary determines that such waiver would not be administratively feasible or appropriate to the health care delivery system of the State.

‘(2) DEMONSTRATION PROGRAM.—Subsections (b) and (c) of section 1115A of title XVIII of the Social Security Act (42 U.S.C. 1396o) are amended by inserting ‘designated by the Secretary’ after ‘selected by the Secretary’.

‘(e) USE OF CERTAIN FUNDS.—Out of amounts appropriated for activities initiated under this section:

‘(B) $10,000,000,000 for the activities initiated in fiscal years 2012 and 2013.

‘(f) FUNDING.—

‘(1) WAIVER AUTHORITY .—The Secretary may carry out activities under this section:

‘(A) with respect to title XXI in the same manner as such title is carried out with respect to the program under the applicable titles.

‘(2) USE OF CERTAIN FUNDS.—Out of amounts appropriated for the activities initiated under this section:

‘(B) for the activities initiated in fiscal years 2012 and 2013.

‘(g) REPORT TO CONGRESS.—Beginning in 2012, and not less than once every other year thereafter, the Secretary shall submit to Congress a report on activities under this section.

‘(h) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the testing and evaluation of models or expansion of such models under this section.

‘(i) APPLICATION TO CHIP.—The Center for Medicaid & CHIP Services shall carry out activities under this section in the same manner as such title is carried out with respect to the program under the applicable titles.

‘(j) FUNDING.—

‘(1) IN GENERAL.—There are appropriated, from amounts in the Treasury not otherwise appropriated—

‘(A) $5,000,000,000 for the design, implementation, and evaluation of models under subsection (b) for fiscal year 2010;

‘(B) $10,000,000,000 for the activities initiated under this section for fiscal years 2011 through 2013.

‘(2) REQUIREMENTS.—An ACO shall meet quality performance standards established by the Secretary that it meets patient-centeredness, include care transitions across health care settings, including hospital discharge planning and post-hospital follow-up by ACO professionals, as the Secretary determines appropriate.

‘(k) QUALITY PERFORMANCE STANDARDS.—The Secretary shall establish quality performance standards to assess the quality of care furnished by ACOs, such as measures of—

‘(i) clinical processes and outcomes;

‘(ii) patient and, where practicable, caregiver experience of care; and

‘(iii) utilization (such as rates of hospital admissions for ambulatory care sensitive conditions).
under this title, or any other program or demonstration project that involves such shared savings.

"(B) The independence at home medical practice demonstration project under section 1862K.

"(c) ASSIGNMENT OF MEDICARE FEE-FOR-SERVICE BENEFICIARIES TO ACOs.—The Secretary shall determine an appropriate method for assigning Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provided under this title by an ACO professional described in subsection (b)(1)(A).

"(d) PAYMENTS AND TREATMENT OF SAVINGS.—

"(1) PAYMENTS.—

"(A) IN GENERAL.—Under the program, subject to paragraph (3), payments shall continue to be made to providers of services and suppliers participating in an ACO under the original Medicare fee-for-service program under parts A and B in the same manner as they would otherwise be made except that a participating ACO is eligible to receive payment for shared savings under paragraph (2) if—

"(i) the ACO meets quality performance standards established by the Secretary under subsection (b)(3); and

"(ii) the ACO meets the requirement under subparagraph (B)(i).

"(B) SAVINGS REQUIREMENT AND BENCHMARK.—

"(i) DETERMINING SAVINGS.—In each year of the agreement period, an ACO shall be eligible to receive payment for shared savings under paragraph (2) only if the estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for parts A and B services, adjusted for beneficiary characteristics, is at least the percent specified by the Secretary below the applicable benchmark under clause (ii). The Secretary shall determine the appropriate percent described in the preceding sentence to account for normal variation in expenditures under this title, based upon the number of Medicare fee-for-service beneficiaries assigned to an ACO.

"(ii) ESTABLISH AND UPDATE BENCHMARK.—The Secretary shall estimate a benchmark for each agreement period for each ACO using nationally available data and an estimate of per-beneficiary expenditures for parts A and B services for Medicare fee-for-service beneficiaries assigned to the ACO. Such benchmark shall be adjusted for beneficiary characteristics and such other factors as the Secretary determines appropriate and updated by the projected absolute amount of growth in national per capita Medicare expenditures for parts A and B services under the original Medicare fee-for-service program, as estimated by the Secretary. Such benchmark shall be reset at the start of each agreement period.

"(2) PAYMENTS FOR SHARED SAVINGS.—Subject to performance with respect to the quality performance standards established by the Secretary under subsection (b)(3), if an ACO meets the requirements under paragraph (1), a percent (as determined appropriate by the Secretary) of the difference between such estimated average per capita Medicare expenditures in a year, adjusted for beneficiary characteristics, under the ACO and such benchmark for the ACO may be paid to the ACO and such savings. The remainder of such difference shall be retained by the program under this title. The Secretary shall establish limits on the total amount of shared savings that may be paid to an ACO under this paragraph.

"(3) MONITORING AVOIDANCE OF AT-RISK PATIENTS.—If the Secretary determines that an ACO has taken steps to avoid patients at high risk in order to reduce the likelihood of increasing costs to the ACO the Secretary may impose an appropriate sanction on the ACO, including termination from the program.

"(4) TERMINATION.—The Secretary may terminate an agreement with an ACO if it does not meet the quality performance standards established by the Secretary under subsection (b)(3).

"(e) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to the program.

"(f) WAIVER AUTHORITY.—The Secretary may waives such requirements of sections 1128A and 1128B and title XVIII of this Act as may be necessary to carry out the provisions of this section.

"(g) LIMITATIONS ON REVIEW.—There shall be no administrative or judicial review under section 1869, section 1876, or otherwise of—

"(1) the determination of criteria under subsection (a)(1)(B);

"(2) the assessment of the quality of care furnished by an ACO and the establishment of performance standards under subsection (b)(3);

"(3) the assignment of Medicare fee-for-service beneficiaries to an ACO under subsection (c);

"(4) the determination of whether an ACO is eligible for shared savings under subsection (d)(2) and the amount of such shared savings; and

"(5) the percent of shared savings specified by the Secretary under subsection (d)(2) and any limit on the total amount of shared savings established by the Secretary under such subsection; and

"(5) the determination of an ACO under subsection (d)(4).

"(h) DEFINITIONS.—In this section:

"(1) ACO PROFESSIONAL.—The term 'ACO professional' means—

"(A) a physician (as defined in section 1861(v)(1)); and

"(B) a practitioner described in section 1861(b)(18)(C)(i).

"(2) HOSPITAL.—The term 'hospital' means a subsection (d) hospital (as defined in section 1886(q)(1)).

"(3) FEE-FOR-SERVICE BENEFICIARY.—The term 'Medicare fee-for-service beneficiary' means an individual who is enrolled in the original Medicare fee-for-service program and is not enrolled in an MA plan under part C, an eligible organization under section 1876, or a MBSI program under section 1894.

"SEC. 3023. NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING.

Title XVIII of the Social Security Act, as amended by section 3022, is amended by inserting after section 1886C the following new section:

"NATIONAL PILOT PROGRAM ON PAYMENT BUNDLING

"SEC. 1866D. (a) IMPLEMENTATION.—

"(1) IN GENERAL.—The Secretary shall establish a pilot program for integrated care during an episode of care provided to an applicable beneficiary under the program in order to improve the coordination, quality, and efficiency of health care services under this title.

"(2) DEFINITIONS.—In this section:

"(A) APPLICABLE BENEFICIARY.—The term 'applicable beneficiary' means an individual who—

"(i) is entitled to, or enrolled for, benefits under part B and enrolled for benefits under part A; or

"(ii) is admitted to a hospital for an applicable condition.

"(B) APPLICABLE CONDITION.—The term 'applicable condition' means 1 or more of 8 conditions selected by the Secretary. In selecting conditions under the preceding sentence, the Secretary shall take into consideration the following factors:

"(i) Whether the conditions selected include a mix of chronic and acute conditions.

"(ii) Whether the condition is one for which the evidence of opportunity for opportunity for providers of services and suppliers to improve the quality of care furnished while reducing total expenditures under this title.

"(iii) Whether a condition has significant variation in—

"(1) the number of readmissions; and

"(2) the amount of expenditures for post-acute care spending under this title.

"(iv) Whether a condition is high-volume and high post-acute care expenditures under this title.

"(v) Which conditions the Secretary determines are most amenable to bundling across the spectrum of care given practice patterns under this title.

"(C) APPLICABLE SERVICES.—The term 'applicable services' means the following:

"(i) Acute care inpatient services.

"(ii) Physicians' services delivered in and outside of an acute care hospital.

"(iii) Outpatient hospital services, including emergency department services.

"(iv) Post-acute care services, including home health services, skilled nursing services, inpatient rehabilitation services, and inpatient hospital services furnished by a long-term care hospital.

"(v) Other services the Secretary determines appropriate.

"(D) EPISODE OF CARE.—

"(i) IN GENERAL.—Subject to clause (ii), the term 'episode of care' means an applicable beneficiary, the period that includes—

"(I) the 3 days prior to the admission of the applicable beneficiary to a hospital for the applicable condition;

"(II) the length of stay of the applicable beneficiary in such hospital; and

"(III) the 30 days following the discharge of the applicable beneficiary from such hospital.

"(ii) ESTABLISHMENT OF PERIOD BY THE SECRETARY.—The Secretary, as appropriate, may establish a period (other than the period described in clause (i)) for an episode of care under the pilot program.

"(E) PHYSICIANS SERVICES.—The term 'physicians services' has the meaning given such term in section 1861(q).

"(F) PILOT PROGRAM.—The term 'pilot program' means the pilot program under this section.

"(G) PROVIDER OF SERVICES.—The term 'provider of services' has the meaning given such term in section 1861(u).

"(H) READMISSION.—The term 'readmission' has the meaning given such term in section 1861(s)(5).

"(I) SUPPLIER.—The term 'supplier' has the meaning given such term in section 1861(s).

"(J) DEADLINE FOR IMPLEMENTATION.—The Secretary shall establish the pilot program not later than January 1, 2013.

"(K) DEVELOPMENTAL PHASE.—

"(1) DETERMINATION OF PATIENT ASSESSMENT INSTRUMENT.—The Secretary shall determine which patient assessment instrument (such as the Continuity Assessment Record and Evaluation (CARE) tool) shall be used under the pilot program to evaluate the condition for purposes of determining the most clinically appropriate site for the provision
of post-acute care to the applicable benefici-

1. Development of quality measures for an episode of care and for post-acute care.

(a) In general.—The Secretary, in con-

(b) Site-neutral post-acute care quality me-

(c) Coordination with quality measure de-

(d) Site-neutral post-acute care qual-

(e) Participating providers of services and sup-

(f) Requirements.—The Secretary shall de-

(g) Methodology.—

(h) Requirements.—

(i) Establishment of payment meth-

(j) Requirements for entities partici-

(k) No additional program expendi-

(l) Waiver.—The Secretary may waive

(m) Independent evaluation and re-

(n) Independent evaluation.

(o) Independent evaluation of

(p) Independent evaluation of

(q) Final report.—Not later than 3 years

(r) Consultation.—The Secretary shall

SEC. 3024. INDEPENDENCE AT HOME DE-

in independent evaluation conducted un-

1. Development of quality measures for an

2. Development of quality measures for an

3. Development of quality measures for an

4. Development of quality measures for an
appropriate who have experience providing home-based primary care to applicable beneficiaries, make in-home visits, and are available 24 hours per day, 7 days per week to caregivers. Such practices described in subparagraph (A)(i), (iii) has documented experience in providing home-based primary care services to high-risk chronically ill beneficiaries, as determined appropriate by the Secretary; (iv) furnishes services to at least 200 applicable beneficiaries (as defined in subsection (d)) during each year of the demonstration program; (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.

The entity shall report on quality measures (in such form, manner, and frequency as specified by the Secretary, which may be for the group, for the plan, or for any provider, enrollee, or covered beneficiary) and such data as the Secretary determines appropriate to monitor and evaluate the demonstration program.

(B) PHYSICIAN.—The term ‘physician’ includes, except as the Secretary may otherwise provide, any individual who furnishes services for which payment may be made as physicians’ services and has the medical training and experience to fulfill the physician’s role described in subparagraph (A)(i).

(2) PARTICIPATION OF NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS.—Nothing in this section shall be construed to prevent a nurse practitioner or physician assistant from participating in, or leading, a home-based primary care team 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 may be, is acting consistent with State law; and (C) the nurse practitioner or physician assistant has the medical training or experience to fulfill the physician’s role described in paragraph (1)(A)(i).

(3) INCLUSION OF PROVIDERS AND PRACTITIONERS.—Nothing in this section shall be construed as preventing an independence at home medical practice from including a provider of services or a participating practitioner described in section 1842(b)(18)(C) that is affiliated with the practice under an arrangement structured so that such provider of services or participating practitioner participates in the demonstration program and shares in any savings under the demonstration program.

(4) QUALITY AND PERFORMANCE STANDARDS.—The Secretary shall develop quality performance standards for independence at home medical practices participating in the demonstration program.

(c) PAYMENT METHODOLOGY.—

(1) ESTABLISHMENT OF TARGET SPENDING LEVEL.—The Secretary shall establish an estimated annual spending target, for the amount the Secretary estimates would have been spent if such independence at home medical practice, for the second of 2 consecutive years under the demonstration program.

Such spending targets shall be determined on a per capita basis. Such spending targets shall include a risk corridor that takes into account normal variation in expenditures for items and services covered under parts A and B furnished to such beneficiaries with the purpose of encouraging such independence at home medical practice under the demonstration program.

(2) INCENTIVE PAYMENTS.—Subject to performance on quality measures, a qualifying independence at home medical practice is eligible to receive an incentive payment under this section if actual expenditures for a year for the applicable beneficiaries it enrolls are less than the estimated spending target established under paragraph (1) for such year. An incentive payment for such year shall be equal to a portion of the amount of the incentive payments under this section that is determined appropriate.

(3) NO BENEFICIARY DUPLICATION IN DEMONSTRATION PARTICIPATION.—The Secretary may participate in the demonstration program on coordination of care, expenditures under this title, applicable beneficiary access to services, and the quality of health care services provided to applicable beneficiaries.

(4) FUNDING.—For purposes of administering and carrying out the demonstration program, other than for payments for items and services furnished under this title and incentive payments under subsection (c), in addition to funds otherwise appropriated, there shall be transferred to the Secretary for the Center for Medicare & Medicaid Services Program Management Account from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1811 (in proportion to funds otherwise appropriated by the Secretary) $5,000,000 for each of fiscal years 2010 through 2015. Amounts transferred under this subsection for a fiscal year shall be available until expended.

(ii) FUNDING.—For purposes of administering and carrying out the demonstration program, other than for payments for items and services furnished under this title and incentive payments under subsection (c), in addition to funds otherwise appropriated, there shall be transferred to the Secretary for the Center for Medicare & Medicaid Services Program Management Account from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1811 (in proportion to funds otherwise appropriated by the Secretary) $5,000,000 for each of fiscal years 2010 through 2015. Amounts transferred under this subsection for a fiscal year shall be available until expended.

(i) TERMINATION.—

(1) MANDATORY TERMINATION.—The Secretary may terminate an independence at home medical practice if—

(A) the Secretary estimates or determines that such practice will not receive an incentive payment for the second of 2 consecutive years under the demonstration program; or (B) such practice fails to meet quality standards during any year of the demonstration program.

(2) PERMISSIVE TERMINATION.—The Secretary may terminate an agreement with an independence at home medical practice if—

(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) use electronic medical records, health information technology, and individualized plans of care.

(3) LIMITATION ON NUMBER OF PRACTICES.—In selecting qualified independence at home medical practices to participate under the demonstration program, the Secretary shall limit the number of such practices so that the number of applicable beneficiaries that may participate in the demonstration program does not exceed 10,000.

(6) 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.

(7) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to this section.

(8) EVALUATION AND MONITORING.—

(1) IN GENERAL.—The Secretary shall evaluate each independence at home medical practice under the demonstration program to assess whether the practice achieved the results described in subsection (a).

(2) MONITORING APPLICABLE BENEFICIARIES.—The Secretary may monitor data on expenditures and quality of services under this title after an applicable beneficiary discloses receiving services under this title through a qualifying independence at home medical practice.

(3) REPORTS TO CONGRESS.—The Secretary shall conduct an independent evaluation of the demonstration program and submit to Congress a final report, including best practices under the demonstration program.

Such report shall include an analysis of the demonstration program on coordination of care, expenditures under this title, applicable beneficiary access to services, and the quality of health care services provided to applicable beneficiaries.

(iii) MONITORING APPLICABLE BENEFICIARIES.—The Secretary may monitor data on expenditures and quality of services under this title after a beneficiary discloses receiving services under this title through a qualifying independence at home medical practice.

(7) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to this section.

(8) EVALUATION AND MONITORING.—

(1) IN GENERAL.—The Secretary shall evaluate each independence at home medical practice under the demonstration program to assess whether the practice achieved the results described in subsection (a).

(2) MONITORING APPLICABLE BENEFICIARIES.—The Secretary may monitor data on expenditures and quality of services under this title after an applicable beneficiary discloses receiving services under this title through a qualifying independence at home medical practice.

(3) REPORTS TO CONGRESS.—The Secretary shall conduct an independent evaluation of the demonstration program and submit to Congress a final report, including best practices under the demonstration program.

Such report shall include an analysis of the demonstration program on coordination of care, expenditures under this title, applicable beneficiary access to services, and the quality of health care services provided to applicable beneficiaries.

(iii) MONITORING APPLICABLE BENEFICIARIES.—The Secretary may monitor data on expenditures and quality of services under this title after an applicable beneficiary discloses receiving services under this title through a qualifying independence at home medical practice.

(7) ADMINISTRATION.—Chapter 35 of title 44, United States Code, shall not apply to this section.

(8) EVALUATION AND MONITORING.—

(1) IN GENERAL.—The Secretary shall evaluate each independence at home medical practice under the demonstration program to assess whether the practice achieved the results described in subsection (a).

(2) MONITORING APPLICABLE BENEFICIARIES.—The Secretary may monitor data on expenditures and quality of services under this title after an applicable beneficiary discloses receiving services under this title through a qualifying independence at home medical practice.

(3) REPORTS TO CONGRESS.—The Secretary shall conduct an independent evaluation of the demonstration program and submit to Congress a final report, including best practices under the demonstration program.

Such report shall include an analysis of the demonstration program on coordination of care, expenditures under this title, applicable beneficiary access to services, and the quality of health care services provided to applicable beneficiaries.

(iii) MONITORING APPLICABLE BENEFICIARIES.—The Secretary may monitor data on expenditures and quality of services under this title after an applicable beneficiary discloses receiving services under this title through a qualifying independence at home medical practice.
...
(B) POSTING OF HOSPITAL SPECIFIC PATIENT READMISSION RATES.—The Secretary shall make information on all patient readmission rates calculated under subparagraph (A) available on the CMS Hospital Compare website in a form and manner determined appropriate by the Secretary. The Secretary may also make other information determined appropriate by the Secretary available on such website.

(C) HOSPITAL SUBMISSION OF ALL PATIENT DATA.

(1) Except as provided for in clause (ii), each specified hospital (as defined in subparagraph (D)(ii)) shall submit to the Secretary, in such form and time specified by the Secretary, data and information determined necessary by the Secretary for the Secretary to calculate the all patient readmission rates described in subparagraph (A).

(ii) Instead of a specified hospital submitting to the Secretary the data and information described in clause (i), such data and information may be submitted to the Secretary, on behalf of such a specified hospital, by a state or an entity determined appropriate by the Secretary.

Def. Definitions.—For purposes of this paragraph:

(i) The term ‘all patients’ means patients who are treated on an inpatient basis and discharged from a specified hospital (as defined in clause (ii)).

(ii) The term ‘specified hospital’ means a hospital that the Secretary determines has a high rate of risk adjusted readmissions.

(iii) The term ‘high-rate hospital’ means a hospital that—

(A) represents appropriate by the Secretary. The Secretary, based on a diagnosis of multiple chronic conditions or other risk factors associated with a hospital readmission or standard transition into post-hospitalization care, which may include 1 or more of the following:

(a) Cognitive impairment.

(b) Depression.

(c) A history of multiple readmissions.

(d) Any other chronic disease or risk factor as determined by the Secretary.

(iv) The term ‘Medicare beneficiary’ means an individual who is entitled to benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and enrolled under part B of such title, but not enrolled under part C of such title.

(v) The term ‘program’ means the program conducted under this section.

(vi) The term ‘readmission’ has the meaning given such term in section 1886(q)(8)(A) of the Social Security Act, as added by section 3025.

(b) QUALITY IMPROVEMENT.—Part S of title III of the Public Health Service Act, as amended by section 3025, is further amended by adding at the end the following:

SEC. 399K. QUALITY IMPROVEMENT PROGRAM FOR MEDICARE-BENEFICIARY-FACILITY-ADJUSTED READMISSION RATE.

(a) EMBRACE — In general.—Not later than 2 years after the date of enactment of this section, the Secretary shall make available a program for eligible hospitals to improve their readmission rates through the use of patient safety organizations (as defined in section 291(4)).

(ii) ELIGIBLE HOSPITAL—In this subsection, the term ‘eligible hospital’ means a hospital that the Secretary determines has a high rate of risk adjusted re-admissions. Risk adjusted re-admissions described in section 1886(q)(8)(A) of the Social Security Act and not taken appropriate steps to reduce such readmissions and improve patient safety as evidenced through historically high rates of readmissions, as determined by the Secretary.

(iii) RISK ADJUSTMENT.—The Secretary shall establish appropriate risk adjustment measures to determine eligible hospitals.

(b) REPORT TO THE SECRETARY.—As determined appropriate by the Secretary, eligible hospitals and patient safety organizations working with those hospitals shall report to the Secretary on the processes employed by the hospitals to reduce readmissions and the impact of such processes on readmission rates.

SEC. 3026. COMMUNITY-BASED CARE TRANSITION PROGRAM.

(a) In general.—The Secretary shall establish a Community-Based Care Transitions Program under which the Secretary provides funding to eligible entities that furnish improved care transition services to high-risk Medicare beneficiaries.

(b) Definitions.—For purposes of this section:

(1) ELIGIBLE ENTITY.—The term ‘eligible entity’ means the following:

(A) A subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) identified by the Secretary as having a high readmission rate, and the Secretary determines is appropriate by the Secretary, eligible hospital.

(B) An appropriate community-based organization that provides care transition services under this section across a continuum of care through arrangements with subsection (d) hospitals (as so defined) to furnish the services described in subsection (c)(2)(B)(i) and which support government initiatives to improve representation of multiple health care stakeholders (including consumers).

(ii) Community-Based Care Transition Program.—The term ‘community-based care transition program’ means a Medicare beneficiary who has attained a minimum hierarchical condition category score, as determined by the Secretary, based on a diagnosis of multiple chronic conditions or other risk factors associated with a hospital readmission or standard transition into post-hospitalization care, which may include 1 or more of the following:

(A) Cognitive impairment.

(B) Depression.

(C) A history of multiple readmissions.

(D) Any other chronic disease or risk factor as determined by the Secretary.

(iii) Medicare beneficiary.—The term ‘Medicare beneficiary’ means an individual who is entitled to benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and enrolled under part B of such title, but not enrolled under part C of such title.

(iv) Program.—The term ‘program’ means the program conducted under this section.

(v) Readmission.—The term ‘readmission’ has the meaning given such term in section 1886(q)(8)(A) of the Social Security Act, as added by section 3025.

(vi) Secretary.—The term ‘Secretary’ means the Secretary of Health and Human Services.

(vii) Requirements.—

(1) DURATION.—

(A) In general.—The program shall be conducted for a 5-year period, beginning January 1, 2011.

(B) Expansion.—The Secretary may expand the duration and scope of the program, to the extent determined appropriate by the Secretary, if the Secretary determines (and the Chief Actuary of the Centers for Medicare and Medicaid Services (with respect to spending under this title, certifies)) that such expansion would reduce spending under this title without reducing quality.

(2) APPLICATION.—

(A) In general.—

(i) Application.—An eligible entity seeking to participate in the program shall submit an application at such time, in such manner, and containing such information as the Secretary may require.

(ii) Partnership.—If an eligible entity is a hospital, the hospital shall enter into a partnership with a community-based organization to participate in the program.

(iii) Intervention Proposal.—Subject to subparagraph (A), an application submitted under subparagraph (A)(1) shall include a detailed proposal for at least 1 care transition intervention, which may include the following:

(a) Initiating care transition services for a high-risk Medicare beneficiary not later than 24 hours prior to the discharge of the beneficiary.

(b) Arranging timely post-discharge follow-up services to the high-risk Medicare beneficiary to provide the beneficiary and, as appropriate, the primary caregiver of the beneficiary with assistance to ensure productive and timely interactions between patients and post-acute and outpatient providers.

(c) Assessing and actively engaging with a high-risk Medicare beneficiary (and, as appropriate, the primary caregiver of the beneficiary) with assistance to ensure productive and timely interactions between patients and post-acute and outpatient providers.

(d) Conducting comprehensive medication reviews and management services (including appropriate, counseling and self-management support).

(e) Limitation.—A care transition intervention proposed under subparagraph (B) may not include payment for services required under the discharge planning process described in section 1861(ee) of the Social Security Act (42 U.S.C. 1395l(ee)).

(3) Selection.—In selecting eligible entities to participate in the program, the Secretary shall give priority to eligible entities that—

(A) participate in a program administered by the Administration on Aging to provide concurrent care transitions interventions with multiple hospital partners; or

(B) provide services to medically underserved populations, small communities, and rural areas.

(4) Implementation.—Notwithstanding any other provision of law, the Secretary may implement the provisions of this section by program instruction or otherwise.

(5) Waiver Authority.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out this section.

(f) Funding.—For purposes of carrying out this section, the Secretary of Health and Human Services shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395f) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395b), in such proportion as the Secretary determines, of $500,000,000, to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2011 through 2015. Amounts transferred under the preceding sentence shall remain available until expended.

SEC. 3027. EXTENSION OF GAINSHARING DEMONSTRATION.

(a) In general.—Subsection (d)(3) of section 5007 of the Deficit Reduction Act of 2005 (Public Law 109–171) is amended by inserting “and for fiscal years 2010, 2011, in the case of a demonstration project in operation as of October 1, 2008” after “December 31, 2009”.

(b) Funding.—

(1) In general.—Subsection (f)(1) of such section is amended by inserting “and for fiscal years 2010, 2011, in the case of a demonstration project in operation as of October 1, 2008” after “December 31, 2009”.

(2) Availability.—Subsection (f)(2) of such section is amended by striking “2010” and inserting “2014 or until expended”.

(c) Reports.—

(1) QUALITY IMPROVEMENT AND SAVINGS.—Subsection (e)(3) of such section is amended by striking “December 1, 2008” and inserting “March 31, 2011”.

(2) FINAL REPORT.—Subsection (e)(4) of such section is amended by striking “May 1, 2010” and inserting “March 31, 2013”.

S11688

CONGRESSIONAL RECORD — SENATE

November 19, 2009
SUBTITLE B—IMPROVING MEDICARE FOR PATIENTS AND PROVIDERS

PART I—ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES

SEC. 3101. INCREASE IN THE PHYSICIAN PAYMENT UPDATE.

Section 1904(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) is amended by striking 2010 and inserting 2011.

SEC. 3102. EXTENSION OF THE WORK GEOGRAPHIC INDEX FLOOR AND REVISIONS TO THE PRACTICE EXPENSE GEOGRAPHIC ADJUSTMENT UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

(a) Extension of Work GPCI Floor.—Section 1848(e) of the Social Security Act (42 U.S.C. 1395w–4(e)) is amended by striking “2010” and inserting “2011”.

(b) Practice Expense Geographic Adjustment for 2010 and Subsequent Years.—Section 1848(e)(1) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)) is amended—

(1) in the matter preceding clause (i)—

(II) the office expense portion of the practice expense geographic index described in subparagraph (A)(i), including the extent to which types of office expenses are determined in local markets instead of national markets.

(2) in each of clauses (i) and (ii), by inserting “2011”.

(c) Practice Expense Geographic Adjustment for 2011 and Subsequent Years.—(A) IN GENERAL.—Subject to paragraphs (2) and (3), for services furnished during 2011, the practice expense adjustment described in subparagraph (A)(i) shall be reduced below the practice expense geographic adjustment described in subparagraph (A)(i) by 1 percent.

(B) EFFECT OF COMPUTATION OF CONVERSION FACTOR FOR 2011 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2011 and subsequent years as if subparagraph (A) had never applied.

SEC. 3103. EXTENSION OF PAYMENT PROVISIONS FOR MEDICARE THERAPY CAPS.

Section 1833(g)(5) of the Social Security Act (42 U.S.C. 1395h–4(g)(5)) is amended by striking “2009” and inserting “2010, and on or after January 1, 2011”.

SEC. 3104. EXTENSION OF PAYMENT FOR THERAPY SERVICES FURNISHED DURING 2011.

Section 1833(g)(5) of the Social Security Act (42 U.S.C. 1395h–4(g)(5)) is amended by striking “2010” and inserting “2011”.

SEC. 3105. EXTENSION OF AMBULANCE ADD-ONS.

(a) Ground Ambulance.—Section 1833(l)(13)(A) of the Social Security Act (42 U.S.C. 1395m(l)(13)(A)) is amended—

(1) in the matter preceding clause (i)—

(II) the Secretary may apply to such area the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275) is amended by striking “December 31, 2010”.

(b) Air Ambulance.—Section 1842(b)(1) of the Social Security Act (42 U.S.C. 1395f(a)(2)) is amended by striking “December 31, 2009” and inserting “December 31, 2010”.

(c) Super Rural Ambulance.—Section 1844(a)(12)(A) of the Social Security Act (42 U.S.C. 1395m(l)(12)(A)) is amended by striking “2010” and inserting “2011”.

SEC. 3106. EXTENSION OF CERTAIN PAYMENT RULES FOR LONG-TERM CARE HOSPITALS, BONE MARROW TRANSPLANT FACILITIES, AND HOSPITALS ON THE ESTABLISHMENT OF CERTAIN HOSPITALS AND FACILITIES.

(a) Extension of Certain Payment Rules.—Section 114(c) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395ww note), as amended by section 4302(a) of the American Recovery and Reinvestment Act (Public Law 111–5), is further amended by striking “3-year period” each place it appears and inserting “4-year period”.

(b) Extension of Moratorium.—Section 114(d)(1) of such Act (42 U.S.C. 1395ww note), in the matter preceding subparagraph (A), is amended by striking “3-year period” and inserting “4-year period”.

SEC. 3107. EXTENSION OF PHYSICIAN FEE SCHEDULE UMBRELLAL MENTAL HEALTH ADD-ON.

Section 1384(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. 3108. PERMITTING PHYSICIAN ASSISTANTS TO ORDER POST-HOSPITAL EXTENDED CARE SERVICES.

(a) Ordering Post-Hospital Extended Care Services.—

(1) IN GENERAL.—Section 1844(a)(2) of the Social Security Act (42 U.S.C. 1395m(l)(2)), in the matter preceding subparagraph (A), is amended by striking “clinical nurse specialist” and inserting “clinical nurse specialist and physician assistant”.

(2) Certificate of Need.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2011.

SEC. 3109. EXEMPTION OF CERTAIN PHARMACIES FROM ACCREDITATION REQUIREMENTS.

(a) In General.—Section 3404(a)(30) of the Social Security Act (42 U.S.C. 1395n(a)(30)), as added by section 154(b)(1)(A) of the Medicare Improvements for Patients and Providers Act of 2008 (Public Law 110–275), is amended—

(1) in subparagraph (F)(i)—

(A) by inserting “and” and subparagraph (G) after clause (ii); and

(B) by inserting “; except that the Secretary shall not require a pharmacy to have submitted to the Secretary such evidence of accreditation under this section before January 1, 2011” before the semicolon at the end; and

(2) by adding at the end the following new subparagraph:

“(G) application of accreditation requirements to certain pharmacies.

“(i) IN GENERAL.—With respect to items and services furnished on or after January 1, 2011, in implementing quality standards under this paragraph—

“(I) subject to clause (ii), in applying such standards and the accreditation requirements of subparagraph (B), with respect to pharmacies described in clause (ii) furnishing such items and services, such standards and accreditation requirements shall not apply to such pharmacies; and

“(II) the Secretary may apply to such pharmacies an alternative accreditation requirement established by the Secretary if the alternative accreditation requirement is more appropriate for such pharmacies.

“(ii) PHARMACIES DESCRIBED.—A pharmacy described in clause (i) is a pharmacy that meets each of the following criteria:

“(I) the total billings by the pharmacy for the previous 3 calendar
years, 3 fiscal years, or other yearly period specified by the Secretary.

(II) The pharmacy has been enrolled under section 1866(b) as a supplier of durable medical equipment, prosthetics, orthotics, supplies, and home health services, has been issued (which may include the renewal of) a provider number for at least 5 years, and for which a final adverse action (as defined in section 1841 of the Social Security Act (42 U.S.C. 1395t); and

(III) The pharmacy submits to the Secretary an attestation, in a form and manner, and at a time, specified by the Secretary, that the pharmacy meets the criteria described in subparagraphs (I) and (II). Such attestation shall be made to section 1001 of title 18, United States Code.

(IV) The pharmacy agrees to submit materials as requested by the Secretary, or during the course of an audit conducted on a random sample of pharmacies selected annually, to verify that the pharmacy meets the criteria described in subparagraphs (I) and (II).

Materials submitted under the preceding sentence shall include a certification by an accountant on behalf of the pharmacy or the submission of tax returns filed by the pharmacy for the relevant fiscal years, as requested by the Secretary.

(b) Administration.—Notwithstanding any other provision of law, the Secretary may implement the amendments made by subsection (a) by program instruction or otherwise.

(c) Rule of construction.—Nothing in the provisions of or amendments made by this section shall be construed as affecting the application of an accreditation requirement for pharmacies to qualify for bidding in a competitive acquisition area under section 1847 of the Social Security Act (42 U.S.C. 1395w–3).

SEC. 3110. PART B SPECIAL ENROLLMENT PERIOD FOR DISABLED TRICARE BENEFICIARIES.

(a) In general.—

(1) Section 1837 of the Social Security Act (42 U.S.C. 1395p) is amended by adding at the end the following new subsection:

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Supplemental Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t), to the Centers for Medicare & Medicaid Services Program Management Account for any amounts transferred under the preceding sentence shall remain available until expended.

SEC. 3114. IMPROVED ACCESS FOR CERTIFIED HOME HEALTH CARE SERVICES

Section 1833(a)(1)(K) of the Social Security Act (42 U.S.C. 1395l(a)(1)(K)) is amended by inserting “(or 100 percent for services furnished on or after January 1, 2011)” after “1992, 65 percent”.

PART II—RURAL PROTECTIONS

SEC. 3121. EXTENSION OF OUTPATIENT HOSPITAL HARMLESS PROVISION.

(a) IN GENERAL.—Section 1833(t)(7)(D)(i) of the Social Security Act (42 U.S.C. 1395t(c)(7)(D)(i)) is amended—

(1) in subclause (II)—

(A) in the first sentence, by striking “2010” and inserting “2011”; and

(B) in the second sentence, by striking “or 2009” and inserting “or 2010”; and

(2) in subclause (III), by striking “January 1, 2010” and inserting “January 1, 2011”.

(b) PERMITTING ALL SOLE COMMUNITY HOSPITALS TO BE ELIGIBLE FOR HARMLESS.—Section 1833(t)(7)(D)(iii)(I) of the Social Security Act (42 U.S.C. 1395t(c)(7)(D)(iii)(I)) is amended by adding at the end the following new sentence: “In the case of covered OPD services furnished on or after January 1, 2011, and before January 1, 2012, the preceding sentence shall be applied without regard to the 100-bed limitation.”.

SEC. 3122. EXTENSION OF MEDICARE REASONABLE ANDcustomATORY COSTS PAYMENTS FOR CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED TO HOSPITALIZED PATIENTS IN CERTAIN RURAL AREAS.

Section 416(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395i–4) is amended by section 105 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395l note) and section 107(b) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (42 U.S.C. 1395l note), is amended by inserting “or during the 1-year period beginning on July 1, 2010” at the end.

SEC. 3123. EXTENSION OF THE RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

(a) ONE-YEAR EXTENSION.—Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2272) is amended by adding at the end the following new subsection:

“(g) ONE-YEAR EXTENSION OF DEMONSTRATION PROGRAM.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall conduct the demonstration program under this section for an additional 1-year period with respect to each of the States with low population densities determined by the Secretary under such subsection to 20. In determining which States to include in such expansion, the Secretary shall use the same criteria and data that the Secretary used to determine the States under such subsection for purposes of the initial 1-year period.

(2) EXPANSION OF DEMONSTRATION STATES.—Notwithstanding subsection (a)(2), during the 1-year extension period, the Secretary shall expand the number of States with low population densities determined by the Secretary under such subsection to 20. In determining which States to include in such expansion, the Secretary shall use the same criteria and data that the Secretary used to determine the States under such subsection for purposes of the initial 1-year period.

(3) IN GENERAL.—Subsection (a)(1)(A) of section 1886 of the Social Security Act (42 U.S.C. 1395ww(d)(1)(A)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (B), by striking “(or, with respect to fiscal years 2011 and 2012, 15 road miles)” after “25 road miles”;

(ii) in subparagraph (C), by striking “and after paragraph (3),” and inserting “and after subparagraph (3),”;

(iii) in subparagraph (D), by striking “or, with respect to further participation under part A or after paragraph (3)” and inserting “or, with respect to benefits under part A and after paragraph (3)”;

(iv) in subparagraph (E), by striking “(or, with respect to fiscal years 2011 and 2012, 1,500 discharges of individuals entitled to, or enrolled for, benefits under part A)” after “800 discharges”; and

(b) IN SUBSECTION (c)—

(1) in paragraph (2), by striking subparagraph (A) and inserting the following:

“(A) by inserting “(or, with respect to fiscal years 2011 and 2012, 15 road miles)” after “25 road miles”;

(b) REMOVAL OF REFERENCES TO RURAL HEALTH CLINIC SERVICES AND INCLUSION OF PHYSICIAN SERVICES IN SCOPE OF DEMONSTRATION PROJECT.—Such section 123 is amended—

(1) in subsection (d)(4)(B)(3), by striking subparagraph (III); and

(2) in subsection (c)(1)–

(A) in paragraph (6), by striking subparagraph (B) and inserting the following:

“(B) Physicians’ services (as defined in section 1902(b) of the Social Security Act (42 U.S.C. 1395x(q))”,

(B) by striking paragraph (9); and

(C) by redesignating paragraph (10) as paragraph (9).

SEC. 3127. MEDIPCA STUDY ON ADEQUACY OF MEDICARE PAYMENTS FOR HEALTH PROFESSIONAL SERVICES SERVING IN RURAL AREAS.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the adequacy of payment to providers of services and items and services furnished by providers of services and suppliers in rural areas under the Medicare program for services and items furnished by providers of services and suppliers in rural areas under the Medicare program and for services and items furnished by providers of services and suppliers in rural areas under the Medicare program and for services and items furnished by providers of services and suppliers in rural areas under the Medicare program and for services and items furnished by providers of services and suppliers in rural areas under the Medicare program.

(b) REPORT.—Not later than January 1, 2011, the Medicare Payment Advisory Commission shall submit to Congress a report containing the results of the study conducted under subsection (a). Such report shall include recommendations on appropriate modifications to any adjustments in payments to providers of services and suppliers that furnish items and services in rural areas, together with recommendations for such legislation and administrative actions as may be necessary to implement such recommendations.
Act (42 U.S.C. 1395m) are each amended by inserting "101 percent of" before "the reasonable costs".

(b) **Effective Date.**—The amendments made by the section (a) shall take effect as if included in the enactment of section 405(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173; 117 Stat. 1289).

**SEC. 3129. EXTENSION OF AND REVISIONS TO MEDI CARE RURAL HOSPITAL FLEXIBILITY PROGRAM.**

(a) **Authorization.**—Section 1820(j) of the Social Security Act (42 U.S.C. 1395j-4(j)) is amended—

(1) by striking "2010, and for" and inserting "2010, for"; and

(2) by inserting "and for making grants to all States under subsection (g), such sums as may be necessary in each of fiscal years 2011 and 2012, to remain available until expended before the period at the end.

(b) **Use of Funds.**—Section 1820(c)(3) of the Social Security Act (42 U.S.C. 1395j-4(g)(5)) is amended—

(1) in subparagraph (A), by inserting "and to assist such hospitals in participating in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations, and other delivery system reform programs determined appropriate by the Secretary" before the period at the end; and

(2) in subparagraph (E)—

(A) by striking "(i), and" and inserting ", and"; and

(B) by inserting "and to participate in delivery system reforms under the provisions of and amendments made by the Patient Protection and Affordable Care Act, such as value-based purchasing programs, accountable care organizations under section 1899, the National pilot program on payment bundling under section 1866D, and other delivery system reform programs determined appropriate by the Secretary" before the period at the end.

(c) **Effective Date.**—The amendments made by this section shall apply to grants made on or after January 1, 2010.

**PART III—IMPROVING PAYMENT ACCURACY**

**SEC. 3131. PAYMENT ADJUSTMENTS FOR HOME HEALTH CARE.**

(a) **Requiring Home Health Prospective Payment Amount.**—(1) Section 1838(b)(3)(A) of the Social Security Act (42 U.S.C. 1395f(b)(3)(A)) is amended—

(A) in clause (i)(III), by striking "For peri-

ods" and inserting "Subject to clause (iii), for periods"; and

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

"(iii) **Adjustment for 2013 and Subsequent Years.—**

"(I) **In General.**—Subject to subsection (II), for 2013 and subsequent years, the amount (or amounts) that would otherwise be appli-

able under clause (i)(III) shall be adjusted by a percentage determined appropriate by the Secretary to reflect such factors as changes in the number of visits in an episode, the level of intensity of services in an episode, the average cost of providing care per episode, and other factors that the Secretary considers to be relevant. In conducting the analysis under the preceding sentence, the Secretary may consider differences between hospital and nonhospital-based agencies, and

between the costs of urban and rural agencies. Such adjustment shall be made before the update under subparagraph (B) is applied for the year.

"(II) **Transition.**—The Secretary shall pro-

vide for a phase-in (in equal incre-

ments) of the adjustment under clause (I), with such adjustment being fully imple-

mented for 2016. During each year of such adjustment period, the amount of any adjustment under clause (I) for the year may not ex-

ceed 3.5 percent of the amount (or amounts) applicable under clause (i)(III) as of the date of enactment of the Patient Protection and Affordable Care Act."

"(2) **MiniPAC Study and Report.**—(A) **MiniPAC Study.**—The Medicare Payment Advi-

sory Commission shall conduct a study on the implementation of the amendments made by paragraph (1). Such study shall in-

clude an analysis of the impact of such amendments on—

"(i) access to care;";

"(ii) quality outcomes;";

"(iii) the number of home health agencies; and";

"(iv) rural agencies, urban agencies, for-

profit agencies, and nonprofit agencies.

(B) **Report.**—Not later than January 1, 2015, the Medicare Payment Advisory Com-

mission shall submit a report on the study conducted under subparagraph (A), to-gether with recommendations for such leg-

islation and administrative action as the Commission determines appropriate.

(B) **Program-Specific Outlier Cap.**—Sec-

tion 1820(c)(3) of the Social Security Act (42 U.S.C. 1395f(b)(5)) is amended—

(1) in paragraph (3)(C), by striking "the ag-

gregate" and all that follows through the pe-

riod at the end; and

(2) in paragraph (5)—

(A) by striking "OUTLIER. The Sec-

retary..." and inserting the following:

"OUTLIER.**—The Secretary** shall conduct a study under the Medicare and Medicaid programs; and access to care, such as—

"(i) population density and relative patient access to care;";

"(ii) variations in service costs for providing care to individuals who are dually eligible under the Medicare and Medicaid programs;";

"(iii) the presence of severe or chronic dis-

eases, as evidenced by multiple, discontin-

uous home health episodes;";

"(iv) poverty status, as evidenced by the receipt of Supplemental Security Income under title XVI of the Social Security Act;";

"(E) the absence of caregivers;";

"(F) language barriers;";

"(G) atypical transportation costs;";

"(H) security costs; and";

"(I) other factors determined appropriate by the Secretary.

(3) **Report.**—Not later than March 1, 2011, the Secretary shall submit to Congress a re-

port on the study conducted under paragraph (2), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(4) **Consultations.**—In conducting the study under paragraph (1) and preparing the report under paragraph (3), the Secretary shall consult with—

**ORDER TO ENSURE ACCESS TO CARE AND QUALITY SERVICES.**

(1) **In General.**—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall conduct a study to evaluate the costs and quality of care among efficient home health agencies relative to other such agencies in providing on-

going access to care and in treating Medicare beneficiaries with varying severity levels of illness. Such study shall include an analysis of the following:

(A) Methods to revise the home health pro-

spective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395f(b)) to more accurately reflect the costs related to patient severity of illness or to improving beneficiary access to care, includ-

ing—

"(i) payment adjustments for services that may be under- or over-valued;";

"(ii) necessary changes to reflect the re-

source use relative to providing home health services to low-income Medicare bene-

ficiaries or Medicare beneficiaries living in medically underserved areas;";

"(iii) ways the outlier payment may be im-

proved to more accurately reflect the cost of treating Medicare beneficiaries with high severity levels of illness;";

"(iv) the role of quality of care incentives and incentives in delivering provider and patient behavior;";

"(v) improvements in the application of a wage index; and";

"(vi) other factors determined appropriate by the Secretary.

(B) **The Validity and Reliability of Re-

sponses on the OASIS Instrument.**—With par-

icular emphasis on questions that relate to higher payment under the home health prospective payment system and higher out-

come scores under Home Care Compare.

(C) **Additional Research or Payment Revi-

sions.**—With the home health prospective pay-

ment system that may be necessary to set the payment rates for home health services based on costs of high-quality and efficient home health agencies or to improve Medi-

care beneficiary access to care.

(D) **A timetable for implementation of any a-

propriate changes based on the analysis of the matters described in subparagraphs (A), (B), and (C)."

(E) **Other areas determined appropriate by the Secretary.**

(2) **Considerations.**—In conducting the study under paragraphs (1) and (2), the Secretary shall consider whether certain factors should be used to measure patient severity of illness and access to care, such as—

"(i) population density and relative patient access to care;";

"(ii) variations in service costs for providing care to individuals who are dually eligible under the Medicare and Medicaid programs;";

"(iii) the presence of severe or chronic dis-

eases, as evidenced by multiple, discontin-

uous home health episodes;";

"(iv) poverty status, as evidenced by the receipt of Supplemental Security Income under title XVI of the Social Security Act;";

"(E) the absence of caregivers;";

"(F) language barriers;";

"(G) atypical transportation costs;";

"(H) security costs; and";

"(I) other factors determined appropriate by the Secretary.

(3) **Report.**—Not later than March 1, 2011, the Secretary shall submit to Congress a re-

port on the study conducted under paragraph (1) and preparing the report under paragraph (3), the Secretary shall consult with—
(A) stakeholders representing home health agencies;
(B) groups representing Medicare beneficiaries;
(C) the Medicare Payment Advisory Commission;
(D) the Inspector General of the Department of Health and Human Services; and
(E) the Comptroller General of the United States.

SEC. 3132. HOSPICE REFORM.

(a) HOSPICE CARE PAYMENT REFORMS.—

(1) IN GENERAL.—Subsection (d) of the Social Security Act (42 U.S.C. 1395f) is amended, as amended by section 300(c), is amended—

(A) by redesignating paragraph (6) as paragraph (7); and

(B) by inserting after paragraph (5) the following new paragraph:

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SEC. 3133. IMPROVEMENT TO MEDICARE DISPROPORTIONATE SHARE HOSPITAL PAYMENTS.

(a) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww), as amended by sections 3001, 3008, and 3025, is amended—

(1) in subparagraph (A)(i) of section 1886(f)(1), by striking “For” and inserting “Subject to subsection (r),” for; and

(2) by adding at the end the following new subsection:

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"(i) IDENTIFICATION OF POTENTIALLY MISVALUED CODES.—For purposes of identifying potentially misvalued services pursuant to clause (i)(1), the Secretary shall examine (assuming determined to be appropriate) codes (and families of codes as appropriate) for which there has been the fastest growth; codes (and families of codes as appropriate) with low relative values; particular those that are often billed multiple times for a single treatment; codes which have not been subject to review since the implementation of IPPS (the "Harvard-valued codes"); and such other codes determined to be appropriate by the Secretary.

"(ii) REVIEW AND ADJUSTMENTS.—

(1) The Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services described in clause (i)(II).

(2) The Secretary may conduct surveys, other data collection activities, studies, or other methods determined by the Secretary to be appropriate to facilitate the review and appropriate adjustment described in clause (i)(II).

(III) The Secretary may use analytic contractors to identify and analyze services identified under clause (i)(I), conduct surveys or collect data, and make recommendations on the review and appropriate adjustment of services described in clause (i)(II).

(IV) The Secretary may coordinate the review and adjustment described in clause (i)(II) with the periodic review described in subparagraph (B).

(V) As part of the review and adjustment described in clause (i)(II), including with respect to codes with low relative values described in clause (ii), the Secretary may make appropriate coding revisions (including using existing processes for consideration of coding changes) which may include consolidation of individual services into bundled codes for payment under the fee schedule under subsection (a).

(VI) The provisions of subparagraph (B)(i)(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)(i)(II).

(L) VALIDATING RELATIVE VALUE UNITS.—

(1) In general.—The Secretary shall establish a process to validate relative value units under the fee schedule under subsection (a).

(II) COMPONENTS AND ELEMENTS OF WORK.—

The process described in clause (i) may include validation of work elements with low relative values, particularly those that are often billed multiple times for a single treatment; codes which have not been subject to review since the implementation of IPPS (the "Harvard-valued codes"); and such other codes determined to be appropriate by the Secretary.

(III) REVIEW AND ADJUSTMENTS.—

(1) The Secretary may use existing processes to receive recommendations on the review and appropriate adjustment of potentially misvalued services described in clause (i)(II).

(II) The Secretary may conduct surveys, other data collection activities, studies, or other methods determined by the Secretary to be appropriate to facilitate the review and appropriate adjustment described in clause (i)(II).

(III) The Secretary may use analytic contractors to identify and analyze services identified under clause (i)(I), conduct surveys or collect data, and make recommendations on the review and appropriate adjustment of services described in clause (i)(II).

(IV) The Secretary may coordinate the review and adjustment described in clause (i)(II) with the periodic review described in subparagraph (B).

(V) As part of the review and adjustment described in clause (i)(II), including with respect to codes with low relative values described in clause (ii), the Secretary may make appropriate coding revisions (including using existing processes for consideration of coding changes) which may include consolidation of individual services into bundled codes for payment under the fee schedule under subsection (a).

(VI) The provisions of subparagraph (B)(i)(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)(i)(II).

(VII) EFFECTIVE DATE.—

(1) In general.—Subject to paragraph (2), the amendments made by subsection (a) shall apply to services furnished on or after July 1, 2010, and shall apply to power-driven wheelchairs furnished on or after such date.
entered into under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) prior to January 1, 2011, pursuant to the implementation of subsection (a)(1)(B)(i)(I) of such section 1847.

SEC. 3117. HOSPITAL WAGE INDEX IMPROVEMENT.

(a) EXTENSION OF SECTION 508 HOSPITAL RECLASSIFICATION.—


(b) USE OF PARTICULAR WAGE INDEX IN FISCAL YEAR 2010.—For purposes of implementation of the amendment made by this subsection during fiscal year 2010, the Secretary shall use the hospital wage index that was promulgated by the Secretary in the Federal Register on August 27, 2009 (74 Fed. Reg. 43754), and any subsequent corrections.

(c) REFORMING THE MEDICARE HOSPITAL WAGE INDEX SYSTEM.—

(1) IN GENERAL.—Not later than December 31, 2011, the Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall submit to Congress a report that includes a plan to reform the hospital wage index system under section 1886 of the Social Security Act.

(2) DETAILS.—In developing the plan under paragraph (1), the Secretary shall take into account the goals for reforming such system set forth in the Medicare Payment Advisory Commission June 2007 report entitled “Report to Congress: Promoting Greater Efficiency in Medicare”, including establishing a new hospital compensation index system that—

(A) uses Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages for each geographic area involved;

(B) minimizes wage index adjustments between and within metropolitan statistical areas and statewide rural areas;

(C) includes methods to minimize the volatility of wage index adjustments that result from implementation of policy, while maintaining budget neutrality in applying such adjustments;

(D) takes into account the effect that implementation of the system would have on health care providers and on each region of the country;

(E) addresses issues related to occupational mix, such as staffing practices and ratios, and any evidence on the effect on quality of care or patient safety as a result of the implementation of the system; and

(F) provides for a transition.

(3) EFFECTIVE DATE.—In developing the plan under paragraph (1), the Secretary shall consult with relevant affected parties.

SEC. 3118. TREATMENT OF CERTAIN CANCER HOSPITALS.

(a) ESTABLISHMENT.—Section 1833(t) of the Social Security Act (42 U.S.C. 1395i(t)) 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 under 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.

(B) AUTHORIZATION OF ADJUSTMENT.—Insofar as the Secretary determines under subparagraph (A) that costs incurred by other hospitals furnishing services under this subsection, the Secretary shall take into consideration the cost of drugs and biologicals incurred by such hospitals.

SEC. 3119. PAYMENT FOR BIOSIMILAR BIOLOGICAL PRODUCTS.

(a) IN GENERAL.—Section 1847A of the Social Security Act (42 U.S.C. 1395w–9a) is amended—

(1) in subsection—

(A) in paragraph (1)—

(i) in subparagraph (A)—

(I) REFERENCE BIOLOGICAL PRODUCT.—The term ‘reference biological product’ means a biological product approved under an abbreviated application for license of a biological product that is licensed under section 351 of the Public Health Service Act.

(II) Licensure.—The term ‘license’ means a license of a biological product licensed under section 351 of the Public Health Service Act.

(III) Application.—The term ‘application’ means an application for license of a biological product under section 351 of the Public Health Service Act.

(II) PRODUCTION OF A SIMILAR BIOLOGICAL PRODUCT.—The term ‘production of a similar biological product’ means the manufacturing of a similar biological product, including any additional payments or adjustments under such section (including those payments or adjustments described in paragraph (10)).

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payments for similar biological products beginning with the first day of the second calendar quarter after enactment of legislation providing for a biosimilar pathway (as determined by the Secretary).

SEC. 3140. MEDICARE HOSPICE CONCURRENT CARE DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall establish a Medicare Hospice Concurrent Care demonstration program at participating hospice programs under which Medicare beneficiaries enrolled, during such hospice care and any other items or services covered under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) from funds otherwise paid under such title to such hospice programs.

(2) DURATION.—The demonstration program under this section shall be conducted for a 3-year period.

(b) INDEPENDENT EVALUATION AND REPORTS.—

(1) INDEPENDENT EVALUATION.—The Secretary shall provide for an independent evaluation of the demonstration program under subsection (a) by an independent entity. The independent evaluation shall determine whether the demonstration program has improved patient care, quality of life, and cost-effectiveness for Medicare beneficiaries participating in the demonstration program.

(2) REPORTS.—The Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with such recommendations as the Secretary determines appropriate.

(c) BUDGET NEUTRALITY.—With respect to the 3-year period of the demonstration program under this section, the Secretary shall ensure that the aggregate expenditures under title XVIII for such period shall not exceed the aggregate expenditures that would have been expended under such title if the demonstration program under this section had not been in effect. Such hospice programs shall be located in urban and rural areas.

SEC. 3141. APPLICATION OF BUDGET NEUTRALITY ON A NATIONAL BASIS IN THE CALCULATION OF THE MEDICARE HOSPICE WAGE INDEX.

In the case of discharges occurring on or after October 1, 2010, for purposes of applying section 4410 of the Balanced Budget Act of 1997 (42 U.S.C. 1395ww note) and paragraph (b) of section 1881 of the Federal Regulations, the Secretary of Health and Human Services shall administer subsection (b) of such section 4410 and paragraph (c) of such section 1124 in the same manner as the Secretary administered such subsection (b) and paragraph (c) for discharges occurring during fiscal year 2008 (through a uniform, national adjustment to the area wage index).

SEC. 3142. IIDH STUDY ON URBAN MEDICARE-DEPENDENT HOSPITALS.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall conduct a study on the need for an additional payment for urban Medicare-dependent hospitals for inpatient hospital services under section 1886 of the Social Security Act (42 U.S.C. 1395ww). Such study shall include an analysis of—

(A) the Medicare inpatient margins of urban Medicare-dependent hospitals, as determined by the Secretary, and (B) whether payments to Medicare-dependent, small rural hospitals under subsection

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SEC. 3201. MEDICARE ADVANTAGE PAYMENT.

(a) MA Benchmark Based on Plan’s Competitive Benchmark Amount.

(1) In general.—Section 1853(j) of the Social Security Act (42 U.S.C. 1395w–27(f)) is amended—

(A) by striking ''AMOUNTS.—For purposes'' and inserting ''AMOUNTS.—'';

(B) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and indenting the subparagraphs appropriately;

(C) in subparagraph (A), as redesignated by subparagraph (B), by—

(i) striking the reference to ''amount'' in clause (i);

(ii) in clause (iii), as redesignated by clause (i), by striking paragraph (A) and inserting ''amount'';

(iii) in clause (ii), as redesignated by clause (i), by striking paragraph (A) and inserting ''amount'';

(2) Urban Medicare-Dependent Hospitals.

(A) In general.—Except for purposes of computing the MA competitive benchmark amount for an area for a year, the MA competitive benchmark amount for an area for a year shall be equal to the weighted average of the unadjusted MA statutory non-drug monthly bid amount (as so defined) for each MA plan in the area, for each month for which the Secretary shall compute the percentage specified in subparagraph (A) and other relevant percentages under this part.

(B) Weighting rules.—

(i) Single plan rule.—In the case of an MA plan area in which only a single MA plan is being offered, the weight under subparagraph (A) shall be equal to—

(I) for years before 2007, 1⁄2 of the annual MA capitation rate under section 1853(j)(1)(B) for each MA plan in the area, for each month for which the Secretary shall compute the percentage specified in subparagraph (A) and other relevant percentages under this part;

(ii) use of simple average among multiple plans if no plans offered in previous year.—In the case of an MA payment area in which no MA plan was offered in the previous year and more than 1 MA plan is offered in the current year, the Secretary shall use a simple average of the unadjusted MA statutory non-drug monthly bid amount (as so defined) for purposes of computing the MA competitive benchmark amount under subparagraph (A).

(C) Multiple Plans If No Plans Offered in Previous Year.—In the case where the Secretary determines that in any month for which the Secretary determines that in any year (beginning with 2012) for each MA payment area the Secretary shall compute an MA competitive benchmark amount equal to the weighted average of the unadjusted MA statutory non-drug monthly bid amount (as so defined) for each MA plan in the area, for each month for which the Secretary shall compute the percentage specified in subparagraph (A) and other relevant percentages under this part.

(D) Weighting rules.—

(i) single plan rule.—In the case of a MA payment area in which only a single MA plan is being offered, the weight under subparagraph (A) shall be equal to—

(I) for years before 2007, 1⁄2 of the annual MA capitation rate under section 1853(j)(1)(B) for each MA plan in the area, for each month for which the Secretary shall compute the percentage specified in subparagraph (A) and other relevant percentages under this part;

(ii) use of simple average among multiple plans if no plans offered in previous year.—In the case of an MA payment area in which no MA plan was offered in the previous year and more than 1 MA plan is offered in the current year, the Secretary shall use a simple average of the unadjusted MA statutory non-drug monthly bid amount (as so defined) for purposes of computing the MA competitive benchmark amount under subparagraph (A).

(E) In subparagraph (A), as redesignated by subparagraph (B), by—

(i) striking paragraph (A) and inserting ''amount'';

(ii) in clause (ii), as redesignated by clause (i), by striking an amount equal to'' and inserting ''an amount equal to'';

(iii) in clause (iii), as redesignated by clause (i), by striking ''amount equal to'' and inserting ''an amount equal to'';

(iv) by adding at the end the following new subparagraphs:

(A) the applicable amount determined under subsection (k)(1) for the area for the year, adjusted as appropriate for the purpose of risk adjustment;

(B) for which more than 60 percent of its inpatient days or discharges during 2 of the 3 most recently audited cost reporting periods for which the Secretary has a settled cost report were attributable to inpatients for which the Secretary has a settled cost report;

(C) Section 1858(f) of the Social Security Act (42 U.S.C. 1395w–29(d)(1)(A)) is amended by striking ''for a year after 2002'' and inserting ''for a year after 2010'';

(D) the MA competitive benchmark amount (as so defined) for the area for the month; and

(E) the applicable amount determined under subparagraph (k)(1) for the area for the year, adjusted as appropriate for the purpose of risk adjustment;

(ii) by adding at the end the following new subparagraphs:

(A) the applicable amount determined under subsection (k)(1) for the area for the year, adjusted as appropriate for the purpose of risk adjustment;

(B) for which more than 60 percent of its inpatient days or discharges during 2 of the 3 most recently audited cost reporting periods for which the Secretary has a settled cost report were attributable to inpatients for which the Secretary has a settled cost report;

(C) Section 1858(f) of the Social Security Act (42 U.S.C. 1395w–29(d)(1)(A)) is amended by striking ''for a year after 2002'' and inserting ''for a year after 2010'';

(D) the MA competitive benchmark amount (as so defined) for the area for the month; and

(E) the applicable amount determined under subparagraph (k)(1) for the area for the year, adjusted as appropriate for the purpose of risk adjustment.

(3) MA Plan Competitive Benchmark Amount.—In no case shall the MA competitive benchmark amount for an area for a month in a year be greater than the applicable actuarial determination for purposes of this section, the MA competitive benchmark amount established under subsection (k)(1) for the area for the year, adjusted as appropriate for the purpose of risk adjustment.

(B) by adding at the end the following new clauses:

(v) for 2015 and each subsequent year, 1.75 percent.

(2) Urban Medicare-Dependent Hospitals.—In the case of urban Medicare-dependent hospitals (as so defined) for purposes of computing the MA competitive benchmark amount, the MA competitive benchmark amount shall be determined under subsection (k)(1) for the area for the year, adjusted as appropriate for the purpose of risk adjustment.

(3) Effectiveness Date.—The amendments made by this subsection shall apply to bid
(e) MA LOCAL PLAN SERVICE AREAS.—

(1) IN GENERAL.—Section 1833(d) of the Social Security Act (42 U.S.C. 1395w–23(d)) is amended—

(A) in the subsection heading, by striking “MA REGION” and inserting “MA REGION; MA LOCAL PLAN SERVICE AREA”;

(B) in paragraph (1), by striking subparagraph (A) and inserting the following:

“(A) with respect to an MA local plan—

(i) for years before 2012, an MA local area that is an entire urban or rural area, as applicable (as described in paragraph (5)); and

(ii) for 2012 and succeeding years, a service area that is an entire urban or rural area, as applicable (as described in paragraph (5)); and

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

“(5) MA LOCAL PLAN SERVICE AREA.—For 2012 and succeeding years, the service area for an MA local plan shall be an entire urban or rural area in each State as follows:

(A) URBAN AREAS.—

(i) In general.—Subject to clause (ii) and subparagraphs (B) and (D), the service area for an MA local plan in an urban area shall be the Core Based Statistical Area (in this paragraph referred to as a ‘CBSA’) or, if applicable, any other similar classification, as defined by the Director of the Office of Management and Budget.

(ii) CBSA covering more than one state or region.—Subject to subparagraph (A), the service area for an MA local plan in a rural area shall be a county that does not qualify for inclusion in a CBSA (or alternative classification), as defined by the Director of the Office of Management and Budget.

(B) RURAL AREAS.—Subject to subparagraph (A), if the service area for an MA local plan in a rural area shall be a county that does not qualify for inclusion in a CBSA (or alternative classification) that covers more than one State, the Secretary shall divide the CBSA (or alternative classification) into separate service areas for each State covered by the CBSA (or alternative classification).

(C) RENEWALS TO SERVICE AREAS.—For 2015 and succeeding years, in order to reflect actual patterns of health care service utilization and capacity, the Secretary may, in addition to any other adjustments under subparagraph (C), make limited exceptions to service area requirements otherwise applicable under this paragraph. The Secretary shall make such renewals in a manner that, in the aggregate, maintains the systems and programs described in this paragraph.

(D) ADDITIONAL AUTHORITY TO MAKE LIMITED EXCEPTIONS TO SERVICE AREA REQUIREMENTS FOR MA LOCAL PLANS.—The Secretary may, in addition to any adjustments under subparagraph (C), make limited exceptions to service area requirements otherwise applicable under this paragraph. The Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to—

(i) 0.5 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year; and

(ii) the total number of programs described in clause (ii) of subparagraph (C) that the Secretary determines the plan is conducting for the year under such subparagraph.

(E) REPORTING OF DATA.—Each Medicare Advantage organization shall provide to the Secretary the information needed to determine whether they are eligible for a bonus payment, which may be paid at a time and in a manner specified by the Secretary.

(F) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of programs described in subparagraph (C) for which an MA plan receives a care coordination and management performance bonus under this paragraph.

The Secretary shall monitor auditing activities conducted under this subparagraph.

(G) QUALITY PERFORMANCE BONUSES.—

(A) IN GENERAL.—For years beginning with 2014, subject to subparagraph (B), in the case of an MA plan that conducts 1 or more programs described in subparagraph (C) with respect to an MA local plan that is an improved quality plan, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to—

(i) in the case of a plan that achieves a 3 star rating (or comparable rating) on a rating system described in subparagraph (C) in a manner appropriate for an urban or rural area, as applicable.

(B) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395w–23) is amended by adding at the end the following new section:

“(i) IN GENERAL.—The rating of an MA plan—

(A) that achieves a 3 star rating (or comparable rating) on such systematic coordination of care by primary care physicians across the full spectrum of specialties and sites of care, such as medical homes, capitation arrangements, or pay-for-performance programs.

(B) Programs that address, identify, and ameliorate health disparities among principal at-risk populations.

(C) Therapy management programs that are more extensive than is required under section 1860D–4(c) (as determined by the Secretary).

(D) Health information technology programs, including clinical decision support tools to detect and ensure patient-centered, appropriate care.

(E) Such other care management and coordination programs as the Secretary determines appropriate.

(F) CONDUCT OF PROGRAM IN URBAN AND RURAL AREAS.—An MA plan may conduct a program described in subparagraph (C) in a manner appropriate for an urban or rural area, as applicable.

(G) REPORTING OF DATA.—Each Medicare Advantage organization shall provide to the Secretary the information needed to determine whether they are eligible for a bonus payment, which may be paid at a time and in a manner specified by the Secretary.

(H) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of programs described in subparagraph (C) for which an MA plan receives a care coordination and management performance bonus under this paragraph.

(I) QUALITY PERFORMANCE BONUSES.—

(A) QUALITY BONUS.—For years beginning with 2014, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to an MA plan that achieves at least a 3 star rating (or comparable rating) on a rating system described in subparagraph (C) in an amount equal to—

(i) in the case of a plan that achieves a 3 star rating (or comparable rating) on such systematic coordination of care by primary care physicians across the full spectrum of specialties and sites of care, such as medical homes, capitation arrangements, or pay-for-performance programs.

(ii) 4 or 5 star rating (or comparable rating on such systematic coordination of care by primary care physicians across the full spectrum of specialties and sites of care, such as medical homes, capitation arrangements, or pay-for-performance programs.

(B) IMPROVED QUALITY BONUS.—For years beginning with 2014, in the case of an MA plan that does not receive a quality bonus under subparagraph (A), and is an improved quality plan with respect to the year (as identified by the Secretary), the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to 1 percent of such national monthly per capita cost for the year.

(C) USE OF RATING SYSTEM.—For purposes of subparagraph (A), a rating system described in this paragraph is—

(i) a rating system that uses up to 5 stars to rate clinical quality and enrollee satisfaction and performance at the Medicare Advantage contract or MA plan level; or

(ii) such other system established by the Secretary that provides for the determination of a comparable quality performance rating to the rating system described in clause (i).

(D) DATA USED IN DETERMINING SCORE.—

(i) IN GENERAL.—The rating of an MA plan under the rating system described in subparagraph (A) (with respect to coverage of an individual under this part, to the MA plan in an amount equal to based on on based on the most recent data available.
“(ii) Plans that fail to report data.—An MA plan which does not report data that enables the Secretary to rate the plan for purposes of subparagraph (A) or identify the plan for purposes of subparagraph (B) shall not be counted, for purposes of such rating or identification, as having the lowest plan performance rating and the lowest percentage improvement rate.

“(3) Quality bonus for new and low enrollment MA plans.—

“(A) New MA plans.—For years beginning with the first year of operation of an MA plan that first submits a bid under section 1854(a)(1)(A) for 2012 or a subsequent year, only receives rebates calculated under part (D) of paragraph (2) for the year, and in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to 2 percent of national monthly per capita cost for expenditures for individuals enrolled under the original Medicare fee-for-service program for the year, or, if lower, such plan may be subrogated, the MA plan shall be paid in the same manner as other MA plans with comparable enrolment.

“(B) Low enrollment plans.—For years beginning with the first year of operation of an MA plan that has low enrollment (as defined by the Secretary) and would not otherwise be able to receive a bonus under subparagraph (A) or (B) of paragraph (2) for the year, the Secretary shall identify MA local areas in which, with respect to 2009, average bids submitted by an MA organization under section 1854(a) for MA local plans in the area are not greater than 75 percent of the adjusted average per capita cost for the year, and determined under section 1876(a)(4), for the area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1840(a)(1), 1866(h), and 1886(h).

“(2) Election to provide rebates to grandfathered enrollees.—

“(A) In general.—For years beginning with 2012, each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) may elect to provide rebates to grandfathered enrollees under section 1854(b)(1)(C). In the case where an MA organization makes such an election, the monthly per capita dollar amount of such rebates shall not exceed the applicable amount for the year (as defined in subparagraph (B)).

“(B) Application.—For purposes of this subsection, the term ‘applicable amount’ means—

“(i) for 2012, the monthly per capita dollar amount of such rebates provided to enrollees under the MA local plan with respect to 2011; and

“(ii) for a subsequent year, 95 percent of the amount determined under this subparagraph for the preceding year.

“(3) Special rules for plans in identified areas.—Notwithstanding any other provision of this part, the following shall apply with respect to each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) that makes an election described in paragraph (2):

“(A) Payments.—The amount of the monthly payment under this section to the Medicare Advantage organization with respect to coverage of a grandfathered enrollee under this part in the area for a month, shall be equal to—

“(i) for 2012 and 2013, the sum of—

“(I) the bid amount under section 1854(a) for the MA local plan; and

“(II) the applicable amount (as defined in paragraph (2)(B)) for the MA local plan for the year.

“(ii) for 2014 and subsequent years, the sum of—

“(I) the MA competitive benchmark amount under subsection (j)(1)(A)(i) for the area for the month, adjusted, only to the extent the Secretary determines necessary, to reflect the difference in the amount of rebates provided to grandfathered enrollees (except that such adjustment shall not exceed 0.5 percent of such MA competitive benchmark amount); and

“(II) the applicable amount (as so defined) for the MA local plan for the year.

“(B) Requirement to submit bids under competitive bidding.—The Medicare Advantage organization shall submit a single bid amount under section 1854(a) for the MA local plan in an area that would not be entitled for any bonus payment under subsection (n) or any rebate under this subsection (other than as provided under this subsection) with respect to grandfathered enrollees.

“(C) Nonapplication of payment amounts to grandfathered enrollees.—Section 1854(c) shall not apply with respect to the MA local plan.

“(D) Nonapplication of uniform bid and payment amounts to grandfathered enrollees.—Section 1854(c) shall not apply with respect to the MA local plan. The Secretary shall provide the payment under section 1854(b)(1)(C) to grandfathered enrollees in the same manner as the Secretary risk adjusts beneficiary rebates under section 1854(b)(1)(C).

“(4) Definition of grandfathered enrollee.—In this subsection, the term ‘grandfathered enrollee’ means an individual who is enrolled effective as of the date of enactment of this section in an MA local plan in an area that is identified by the Secretary under paragraph (1).

“(F) Risk adjustment.—The Secretary shall risk adjust rebates to grandfathered enrollees in the same manner as the Secretary risk adjusts beneficiary rebates described in section 1854(b)(1)(C).

“(P) Transitional extra benefits.—

“(1) In general.—For years beginning with 2012, the Secretary shall provide extra benefits to grandfathered enrollees under section 1854(b)(1)(C) for the provision of extra benefits (as specified by the Secretary) to enrollees described in paragraph (2).

“(2) Enrollees described.—An enrollee described in this paragraph is an individual who—

“(A) enrolls in an MA local plan in an applicable area; and

“(B) experiences a significant reduction in extra benefits described in clause (i) of section 1854(b)(1)(C); or

“(C) experiences a significant reduction in the amount of such extra benefits.
the year involved, determined under section 1876(a)(4), for the county for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to services under sections 1861(c)(18)(A), 1866(n), and 1886(h).

"(C) If the Secretary determines appropriate, a county contiguous to an area or counties described in subparagraph (A) or (B), respectively.

"(4) REVIEW OF PLAN HIDS.—In the case of a bid submitted by an MA organization under section 1854(a) for an MA local plan in an applicable area, the Secretary shall review such bid in order to ensure that extra benefits (as specified by the Secretary) are provided as described in paragraph (3)."

"(5) FUNDING.—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 established under section 1817, in such proportion as the Secretary determines appropriate, of an amount not to exceed $5,000,000,000 for the period of fiscal years 2012 through 2019 for the purpose of providing transitional rebates under section 1854(b)(1)(A) for the provision of extra benefits under this subsection.

(1) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS AND CLARIFICATION OF MA PAYMENT AREA FOR PACE PROGRAMS.—

(1) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS FOR PACE PROGRAMS.—Section 1894 of the Social Security Act (42 U.S.C. 1395w–24) is amended—

(A) by redesignating subsections (h) and (i) as subsections (i) and (j), respectively;

(B) by inserting after subsection (g) the following new subsection:

"(h) NONAPPLICATION OF COMPETITIVE BIDDING AND RELATED PROVISIONS UNDER PART C.—With respect to a PACE program under this subpart (and regulations relating to such provisions) shall not apply:

(1) Section 1853(y)(1)(A)(i), relating to MA area-specific non-drug monthly benchmark amount being based on competitive bids.

(2) Section 1853(d)(5), relating to the establishment of MA local plan service areas.

(3) Section 1853(l), relating to the payment of performance bonuses.

(4) Section 1853(e), relating to grandfathering supplemental benefits for current enrollees after implementation of competitive bidding;

(5) Section 1853(p), relating to transitional extra benefits.

(2) SPECIAL RULE FOR MA PAYMENT AREA FOR PACE PROGRAMS.—Section 1853(d) of the Social Security Act (42 U.S.C. 1395w–24(d)) is amended as added by subsection (e), is amended by adding at the end the following new paragraph:

"(6) SPECIAL RULE FOR MA PAYMENT AREA FOR PACE PROGRAMS.—For years beginning with October 1, 2012, and ending on December 31 of the year, a PACE program approved under section 1894, the MA payment area shall be the MA local area as defined in paragraph (2)."

SEC. 2002. BENEFIT PROTECTION AND SIMPLIFICATION.

(a) LIMITATION ON VARIATION OF COST SHARING FOR CERTAIN BENEFITS.—

(1) IN GENERAL.—Section 1852(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)(B)) is amended—

(A) in clause (1), by inserting "subject to clause (ii), after "and B";

(B) by adding at the end the following new clauses:

(iii) LIMITATION ON VARIATION OF COST SHARING FOR CERTAIN BENEFITS.—Subject to the requirements described in clause (iv), cost-sharing for services described in clause (iv) shall not exceed the cost-sharing required for those services under parts A and B.

(iv) SERVICES DESCRIBED.—The following services are described in this clause:

(I) Chemotherapy administration services.

(II) Renal dialysis services (as defined in section 1851(b)(14)(B)).

(III) Skilled nursing care.

(IV) Such other services that the Secretary determines appropriate (including services that the Secretary determines reduce Medicare spending and improve beneficiary outcomes).

(v) EXCEPTION.—In the case of services described in clause (iv) for which there is no cost-sharing required under parts A and B, cost-sharing may be required for those services in accordance with clause (i).

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning on or after January 1, 2011.

(b) APPLICATION OF REBATES, PERFORMANCE BONUSES, AND FORM OF REBATE FOR PLAN YEAR 2012 AND SUBSEQUENT PLAN YEARS.—

(1) APPLICATION OF REBATES.—Section 1854(b)(1)(C) of the Social Security Act (42 U.S.C. 1395w–24(b)(1)(C)) is amended—

(A) in clause (i)(I), by inserting "REBATE.—A rebate and" and inserting "REBATE FOR PLAN YEARS BEFORE 2012.—For plan years before 2012, a rebate may not be used for the purpose described in clause (ii)(I). The Secretary shall provide through the application of the amount of the rebate in the following priority order:

(I) First, to use the most significant share to meaningfully reduce cost-sharing otherwise applicable for benefits under the original medicare fee-for-service program under parts A and B and for qualified prescription drug coverage under part D, including the reduction of any deductibles, copayments, and maximum limitations on out-of-pocket expenses otherwise applicable. Any reduction of maximum limitations on out-of-pocket expenses otherwise applicable for benefits under the original medicare fee-for-service program option. The Secretary may provide guidance on meaningfully reducing cost-sharing under this subclause, except that such guidance may not require a particular amount of cost-sharing or reduction in cost-sharing.

(II) Second, to use the next most significant share to meaningfully provide coverage of other health care benefits (as defined by the Secretary) which are not benefits under the original medicare fee-for-service program, such as eye examinations and dental care, and are not benefits described in subclause (II).

(III) Third, to use the remaining share to meaningfully provide other health care benefits which are not benefits under the original medicare fee-for-service program, such as smoking cessation, a free flu shot, and an annual physical examination.

(B) by redesigning clauses (iii) and (iv) as clauses (iv) and (v); and

(C) by inserting after clause (ii) the following new clause:

"(III) FORM OF REBATE FOR PLAN YEAR 2012 AND SUBSEQUENT PLAN YEARS.—For plan years beginning on or after January 1, 2012, a rebate required under this subparagraph may not be used for the purpose described in clause (ii)(I). The Secretary shall provide through the application of the amount of the rebate in the following priority order:

(I) First, to use the most significant share to meaningfully reduce cost-sharing otherwise applicable for benefits under the original medicare fee-for-service program under parts A and B and for qualified prescription drug coverage under part D, including the reduction of any deductibles, copayments, and maximum limitations on out-of-pocket expenses otherwise applicable. Any reduction of maximum limitations on out-of-pocket expenses otherwise applicable for benefits under the original medicare fee-for-service program option. The Secretary may provide guidance on meaningfully reducing cost-sharing under this subclause, except that such guidance may not require a particular amount of cost-sharing or reduction in cost-sharing.

(II) Second, to use the next most significant share to meaningfully provide coverage of other health care benefits (as defined by the Secretary) which are not benefits under the original medicare fee-for-service program, such as eye examinations and dental care, and are not benefits described in subclause (II).

(III) Third, to use the remaining share to meaningfully provide coverage of other health care benefits which are not benefits under the original medicare fee-for-service program, such as smoking cessation, a free flu shot, and an annual physical examination.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect with respect to 2011 and succeeding years.

(3) APPLICATION OF MA MONTHLY SUPPLEMENTARY BENEFICIARY PREMIUM.—Section 1854(b)(2)(C) of the Social Security Act (42 U.S.C. 1395w–24(b)(2)(C)) is amended—

(A) by striking "PREMIUM. The term" and inserting "PREMIUM.——"

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

"(IV) APPLICATION OF MA MONTHLY SUPPLEMENTARY BENEFICIARY PREMIUM.—For plan years beginning on or after January 1, 2012, any MA monthly supplementary beneficiary premium charged to an individual enrolled in an MA plan shall be used for the purposes, and in the priority order, described in subsection (A) through (III) of paragraph (1)(C)(III)."

SEC. 2203. APPLICATION OF CODING INTENSITY ADJUSTMENT FOR DURING MA PAYMENT TRANSITION.

Section 1833(a)(1)(C) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(C)) is amended by adding at the end the following new clause:

"(III) APPLICATION OF CODING INTENSITY ADJUSTMENT FOR 2011 AND SUBSEQUENT YEARS.—

(A) REQUIREMENT TO APPLY IN 2011 THROUGH 2013.—In order to ensure payment accuracy, the Secretary shall conduct an analysis of the differences described in clause (ii)(I). The Secretary shall apply the results of such analysis to the risk scores for 2011, 2012, and 2013.

(B) AUTHORITY TO APPLY IN 2014 AND SUBSEQUENT YEARS.—The Secretary may, as appropriate, incorporate the results of such analysis into the risk scores for 2014 and subsequent years.

SEC. 2204. SIMPLIFICATION OF ANNUAL BENEFICIARY ELECTION PERIODS.

(a) ANNUAL 45-DAY PERIOD FOR ENROLLMENT FROM MA PLANS TO ELECT TO RECEIVE BENEFITS UNDER THE ORIGINAL MEDICARE Fee-FOR-SERVICE PROGRAM.—

(1) IN GENERAL.—Section 1851(i)(2)(C) of the Social Security Act (42 U.S.C. 1395w–1(e)(2)(C)) is amended to read as follows:

"(C) ANNUAL 45-DAY PERIOD FOR ENROLLMENT FROM MA PLANS TO ELECT TO RECEIVE BENEFITS UNDER THE ORIGINAL MEDICARE Fee-FOR-SERVICE PROGRAM.—Subject to subparagraph (D), at any time during the first 45 days of a year beginning in 2011, an individual who is enrolled in an MA Advantage plan may change the election under subsection (a)(1), but only with respect to coverage under the original medicare fee-for-service program, including parts A and B, and may elect qualified prescription drug coverage in accordance with section 1906O–1.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to 2011 and succeeding years.

(b) TIMING OF THE ANNUAL, COORDINATED ELECTION PERIOD UNDER PARTS C AND D.— Section 1833(a)(3)(B) of the Social Security Act (42 U.S.C. 1395w–1(e)(3)(B)) is amended—

(1) in clause (ii), by striking "and" at the end;

(2) in clause (iv)—

(A) by striking "and succeeding years" and inserting "2006, 2009, and 2010"; and

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

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

"(v) with respect to 2012 and succeeding years, the period beginning on or after January 15 and ending on December 7 of the year before such year.

SEC. 2205. EXTENSION FOR SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.

(a) EXTENSION OF SNP AUTHORITY.—Section 1851(i)(2)(C) of the Social Security Act (42 U.S.C. 1395w–28(f)(1)), as amended by section 164(a) of the Medicare Improvements for Patients
(b) Authority To Apply Frailty Adjustment Under Capitated Payment Rules.—Section 1853(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–28(a)(1)(B)) is amended by adding at the end of the following new clause: “(c) IN GENERAL.—Notwithstanding the preceding provisions of this paragraph, for plan year 2011 and subsequent plan years, in the case of a plan described in subparagraph (II), the Secretary shall apply the payment rules under section 1894(n) (other than paragraph (3) of such section) rather than the payment rules that would otherwise apply under this part, but only to the extent necessary to reflect the costs of treating high concentrations of frail individuals."

(II) PLAN DESCRIBED.—A plan described in this subclause is a specialized MA plan for special needs individuals described in section 1859(b)(6)(B)(ii) that is fully integrated with capitated contracts with States for Medicaid benefits and benefits under programs that have similar average levels of frailty (as determined by the Secretary) as the PACE program.

(c) Transition and Exception Regarding Restriction on Enrollment.—Section 1859(f) of the Social Security Act (42 U.S.C. 1395w–28(f)) is amended by adding at the end of the following new paragraph:

"(6) TRANSITION AND EXCEPTION REGARDING RESTRICTION ON ENROLLMENT.—(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall establish procedures for the transition of applicable individuals to—

"(i) a Medicare Advantage plan that is not a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); or

"(ii) the original medicare fee-for-service program under parts A and B."

"(B) APPLICABLE INDIVIDUALS.—For purposes of clause (i), the term ‘applicable individual’ means an individual who—

"(I) is enrolled under a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); and

"(II) is not within the 1 or more of the classes of special needs individuals to which enrollment in a non-specialized MA plan is restricted by subsection (b)(6) for 2011 or subsequent years, the Secretary shall require—

"(a) evaluation of the costs of treating high concentrations of frail individuals.

"(b) EFFECTIVE DATE.—The amendment made by this section shall take effect on January 1, 2011, and shall be applied to plan years beginning on or after such date.

SEC. 3209. AUTHORITY TO REQUIRE DUAL MA OR MA FEE-FOR-SERVICE PLANS.

(a) IN GENERAL.—Section 1854(a)(5) of the Social Security Act (42 U.S.C. 1395w–24(a)(5)) is amended by adding at the end of the following new paragraph:

"(i) IN GENERAL.—Nothing in this section shall be construed as requiring the Secretary to deny bids submitted by an MA organization under this subsection.

"(ii) AUTHORITY TO DENY BIDS THAT PROPOSE SIGNIFICANT INCREASES IN COST SHARING OR DECREASES IN BENEFITS.—The Secretary may deny a bid submitted by an MA organization for an MA plan if it proposes significant increases in cost sharing or decreases in benefits offered under such plan.

"(c) EFFECTIVE DATE.—The amendment made by this section shall take effect on January 1, 2011.
SEC. 3301. MEDICARE COVERAGE GAP DISCOUNT PROGRAM.

(a) CONSIDERATION FOR COVERAGE OF DRUGS UNDER PART D.—Part D of Title XVIII of the Social Security Act (42 U.S.C. 1395w–101 et seq.), is amended by adding at the end the following new subsection:

"(b) MEDICARE COVERAGE GAP DISCOUNT PROGRAM.—Part D of title XVIII of the Social Security Act (42 U.S.C. 1395w–101) is amended by inserting after section 1860D–14 the following:

"SEC. 1860D–14A. (a) ESTABLISHMENT.—The Secretary shall establish a Medicare coverage gap discount program (in this section referred to as the "program") not later than July 1, 2010. Under the program, the Secretary shall enter into agreements described in subsection (b) with manufacturers as the Secretary determines, and allow for comment on such model agreement.

"(b) TERMS OF AGREEMENT.—

"(1) IN GENERAL.—(A) Agreement.—An agreement under this section shall require the manufacturer to provide applicable beneficiaries access to discounted prices for applicable drugs of the manufacturer.

"(B) PROVISION OF DISCOUNTED PRICES AT THE POINT-OF-SALE.—Except as provided in clause (ii), the discounted prices shall be provided to the applicable beneficiary at the pharmacy or by the mail order service at the point-of-sale of an applicable drug.

"(C) TIMING OF AGREEMENT.—

"(i) SPECIAL RULE FOR 2010 AND 2011.—In order for an agreement with a manufacturer to be in effect under this section with respect to the period beginning on January 1, 2010, and ending on December 31, 2011, the manufacturer shall enter into such agreement not later than January 30 of the preceding year.

"(ii) 2012 AND SUBSEQUENT YEARS.—In order for an agreement with a manufacturer to be in effect under this section with respect to plan year 2012 or a subsequent plan year, the manufacturer shall enter into such agreement (or such agreement shall be renewed under paragraph (4)(A)) not later than January 30 of the preceding year.

"(ii) PROVIDE APPROPRIATE DATA.—Each manufacturer with an agreement in effect under this section shall collect and have available appropriate data, as determined by the Secretary, to ensure that it can demonstrate to the Secretary compliance with the requirements of this section.

"(iii) COMPLIANCE WITH REQUIREMENTS FOR ADMINISTRATION OF PROGRAM.—Each manufacturer with an agreement in effect under this section shall be responsible for ensuring that the requirements imposed by the Secretary or a third party under a contract with a manufacturer under subsection (d)(3), as applicable, for purposes of administering the program, including any determinations under clause (i) of subsection (c)(1)(A) or procedures established under such subsection (c)(1)(A), are in effect.

"(4) LENGTH OF AGREEMENT.—

"(A) IN GENERAL.—An agreement under this section shall be effective for an initial period of not less than 18 months and shall be automatically renewed for a period of not less than 1 year unless terminated under subparagraph (B).

"(B) TERMINATION.—

"(i) BY MANUFACTURER.—The Secretary may provide for termination of an agreement under this section for a knowing and willful violation of the requirements of the agreement.

"(ii) BY SECRETARY.—The Secretary may provide for termination of an agreement under this section for a knowing and willful violation of the requirements of the agreement.

"(ii) EFFECTIVE DATE.—Subsection (a) shall apply to agreements described in this subsection on or after January 1, 2010.

"(c) AUTHORIZING COVERAGE FOR DRUGS NOT COVERED UNDER AGREEMENTS.—Subsection (a) shall not apply to the dispensing of a covered part D drug if—

"(1) the Secretary has made a determination that the availability of the drug is essential to the health of beneficiaries under this part; or

"(2) the Secretary determines that in the period beginning on July 1, 2010, and ending on December 31, 2010, there were extenuating circumstances.

"(d) DEFINITION OF MANUFACTURER.—In this section, the term `manufacturer' has the meaning given such term in section 1860D–14A(g)(5)."

(b) MEDICARE COVERAGE GAP DISCOUNT PROGRAM.—Part D of title XVIII of the Social Security Act (42 U.S.C. 1395w–101) is amended by inserting after section 1860D–14 the following:

"SEC. 1860D–14A. (a) ESTABLISHMENT.—The Secretary shall establish a Medicare coverage gap discount program (in this section referred to as the "program") not later than July 1, 2010. Under the program, the Secretary shall enter into agreements described in subsection (b) with manufacturers as the Secretary determines, and allow for comment on such model agreement.

"(b) TERMS OF AGREEMENT.—

"(1) IN GENERAL.—(A) Agreement.—An agreement under this section shall require the manufacturer to provide applicable beneficiaries access to discounted prices for applicable drugs of the manufacturer.

"(B) PROVISION OF DISCOUNTED PRICES AT THE POINT-OF-SALE.—Except as provided in clause (ii), the discounted prices shall be provided to the applicable beneficiary at the pharmacy or by the mail order service at the point-of-sale of an applicable drug.

"(C) TIMING OF AGREEMENT.—

"(i) SPECIAL RULE FOR 2010 AND 2011.—In order for an agreement with a manufacturer to be in effect under this section with respect to the period beginning on January 1, 2010, and ending on December 31, 2011, the manufacturer shall enter into such agreement (or such agreement shall be renewed under paragraph (4)(A)) not later than January 30 of the preceding year.

"(ii) 2012 AND SUBSEQUENT YEARS.—In order for an agreement with a manufacturer to be in effect under this section with respect to plan year 2012 or a subsequent plan year, the manufacturer shall enter into such agreement (or such agreement shall be renewed under paragraph (4)(A)) not later than January 30 of the preceding year.

"(ii) PROVIDE APPROPRIATE DATA.—Each manufacturer with an agreement in effect under this section shall collect and have available appropriate data, as determined by the Secretary, to ensure that it can demonstrate to the Secretary compliance with the requirements of this section.

"(iii) COMPLIANCE WITH REQUIREMENTS FOR ADMINISTRATION OF PROGRAM.—Each manufacturer with an agreement in effect under this section shall be responsible for ensuring that the requirements imposed by the Secretary or a third party under a contract with a manufacturer under subsection (d)(3), as applicable, for purposes of administering the program, including any determinations under clause (i) of subsection (c)(1)(A) or procedures established under such subsection (c)(1)(A), are in effect.

"(4) LENGTH OF AGREEMENT.—

"(A) IN GENERAL.—An agreement under this section shall be effective for an initial period of not less than 18 months and shall be automatically renewed for a period of not less than 1 year unless terminated under subparagraph (B).

"(B) TERMINATION.—

"(i) BY MANUFACTURER.—The Secretary may provide for termination of an agreement under this section for a knowing and willful violation of the requirements of the agreement.

"(ii) BY SECRETARY.—The Secretary may provide for termination of an agreement under this section for a knowing and willful violation of the requirements of the agreement.

"(ii) EFFECTIVE DATE.—Subsection (a) shall apply to agreements described in this subsection on or after January 1, 2010.

"(c) AUTHORIZING COVERAGE FOR DRUGS NOT COVERED UNDER AGREEMENTS.—Subsection (a) shall not apply to the dispensing of a covered part D drug if—

"(1) the Secretary has made a determination that the availability of the drug is essential to the health of beneficiaries under this part; or

"(2) the Secretary determines that in the period beginning on July 1, 2010, and ending on December 31, 2010, there were extenuating circumstances.

"(d) DEFINITION OF MANUFACTURER.—In this section, the term `manufacturer' has the meaning given such term in section 1860D–14A(g)(5)."
(C) Collection of data from prescription drug plans and MA-PD plans.—The Secretary may collect appropriate data from prescription drug plans and MA-PD plans in a timely manner for each subsequent plan year, in the case where an applicable beneficiary has supplemental benefits with respect to applicable drugs under the prescription drug plan or MA-PD plan that the applicable beneficiary is enrolled in, the applicable beneficiary shall not be provided a discounted price for an applicable drug under this section until after such supplemental benefits have been applied with respect to the applicable drug.

(3) Special rule for supplemental benefits.—

(A) In general.—The Secretary shall impose a civil money penalty on a manufacturer that fails to provide applicable beneficiary discounts for applicable drugs of the manufacturer under this section for each failure for which the Secretary determines is commensurate with the sum of—

(1) the amount that the manufacturer would have paid with respect to such discounts under the agreement, with which the manufacturer would have been required to provide; and

(2) 25 percent of such amount.

(B) Application.—The provisions of section 1128A(f)(4)(B) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

(C) Clarification regarding availability of other covered part D drugs.—Nothing in this section shall prevent an applicable beneficiary from purchasing a covered part D drug that is not an applicable drug (including a generic drug or a drug that is not on the formulary of the prescription drug plan or MA-PD plan that the applicable beneficiary is enrolled in).

(4) Definitions.—In this section:

(A) In general.—The term 'applicable beneficiary' means an individual who, on the date of dispensing an applicable drug:

(1) is enrolled in a prescription drug plan or an MA-PD plan;

(2) is not enrolled in a qualified retiree prescription drug plan;

(3) is not entitled to an income-related subsidy under section 1860D–14(a);

(4) is not subject to a reduction in premium subsidy under section 1839(i); and

(5) is not on the formulary of the prescription drug plan or MA–PD plan that the applicable beneficiary is enrolled in.

(B) PDP sponsor.—The term 'qualified retiree prescription drug plan' has the meaning given such term under section 1860D–14A.

(C) MA–PD plan.—The term 'qualified retiree prescription drug plan' has the meaning given such term in section 1860D–22.

(d) Documentation of such failure.—

(1) In general.—Subject to paragraph (2), the Secretary shall provide for the implementation of this section, including the performance of the duties described in subsection (c)(1).

(2) Limitation.—

(A) In general.—Subject to subparagraph (B), in providing for such implementation, the Secretary shall not receive or distribute any funds of a manufacturer under the program described in subsection (c). (B) Exception.—The limitation under subparagraph (A) shall not apply to the Secretary with respect to drugs dispensed during the period beginning on July 1, 2010, and ending on December 31, 2010, but only if the Secretary determines that the exception to such limitation under this subparagraph is necessary in order for the Secretary to begin implementation of this section and provide applicable beneficiaries timely access to discounted prices during such period.

(e) Third parties.—

(1) In general.—The Secretary shall enter into a contract with 1 or more third parties to administer the requirements established by the Secretary in order to carry out this section. At a minimum, the contract with a third party under the preceding sentence shall require that the third party—

(A) receive and transmit information between the Secretary, manufacturers, and other individuals or entities the Secretary determines appropriate;

(B) receive, distribute, or facilitate the distribution of funds of manufacturers to appropriate individuals or entities in order to meet the obligations of manufacturers under agreements under this section;

(C) provide adequate and timely information to manufacturers, consistent with the agreement with the manufacturer under this section, as necessary for the manufacturer to fulfill its obligations under this section; and

(D) permit manufacturers to conduct periodic audits, directly or through contracts, of the data and information used by the third party to determine discounts for applicable drugs of the manufacturer under the program described in this section.

(2) Performance requirements.—The Secretary shall establish performance requirements for a third party with a contract under paragraph (1) and safeguards to protect the independence and integrity of the activities carried out by the third party under the program under this section.

(f) Civil money penalty.—

(1) In general.—The Secretary shall impose a civil money penalty on a manufacturer that fails to provide applicable beneficiary discounts for applicable drugs of the manufacturer under this section for each failure for which the Secretary determines is commensurate with the sum of—

(A) the amount that the manufacturer would have paid with respect to such discounts under the agreement, with which the manufacturer would have been required to provide; and

(B) 25 percent of such amount.

(g) Definitions.—In this section:

(A) In general.—In applying section 1860D–14(a);

(B) PDP sponsor.—In applying subparagraph (E), in applying such section 351); and

(C) MA–PD plan.—In applying subparagraph (H) added by section 1860D–14A, regardless of whether part of such costs were paid by a manufacturer under such program.
(ii) by moving such subparagraph 2 ems to the left; and
(iii) by striking the period at the end and inserting ‘‘; and’’; and
(D) adding at the end the following new subparagraph:

‘‘(J) a discount in the price of an applicable drug (as defined in paragraph (2) of section 1860D–14A) is determined without regard to any reduction in such premium as a result of any beneficiary rebate under section 1855(b)(1)(C) or bonus payment under section 1863m(e)(2) that is provided after the date on which the determination or redetermination would have been made under this subparagraph, such effective period shall be extended through the date that is 1 year after the date of such determination or redetermination (but for the application of this clause) otherwise cease to be effective.’’.

(E) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2011.

SEC. 3304. IMPROVEMENT IN DETERMINATION OF MEDICARE PART D LOW-INCOME BENEFICIARY PREMIUM.

(a) IN GENERAL.—Section 1860D–1(a)(2)(B)(ii)(I) of the Social Security Act (42 U.S.C. 1395w–114(a)(2)(B)(ii)(I)) is amended by inserting ‘‘, or any discounts provided by manufacturers under the Medicare coverage gap discount program under section 1860D–1A’’ before the period at the end.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to premiums for months beginning on or after January 1, 2011.

SEC. 3305. IMPROVED INFORMATION FOR SUBSIDY ELIGIBLE INDIVIDUALS REASSIGNED TO PRESCRIPTION DRUG PLANS AND MA–PD PLANS.

Section 1860D–4(f)(42 U.S.C. 1395w–114) is amended—

(1) by redesignating subsection (d) as subsection (e); and
(2) by inserting after subsection (c) the following new subsection:

‘‘(d) FAÇILITATION OF REASSIGNMENTS.—Beginning not later than January 1, 2011, the Secretary shall, in the case of a subsidy eligible individual who is enrolled in one prescription drug plan and is subsequently reassigned to the Secretary to a new prescription drug plan, provide the individual, within 30 days of such reassignment, with—

(1) information on formulary differences between the individual’s former plan and the plan to which the individual is reassigned with respect to the individual’s drug regimen; and

(2) a description of the individual’s right to request a coverage determination, exception, or reconsideration under section 1860D–4(g), bring an appeal under section 1860D–4(h), or resolve a grievance under section 1860D–4(i).’’.

SEC. 3306. FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS.

(a) ADDITIONAL FUNDING FOR STATE HEALTH INSURANCE PORTALS.—Section 119(b)(1) of the Social Security Act (42 U.S.C. 1395w–23(f)), to the Administration on Aging (42 U.S.C. 1395w–23(f)) is amended by striking ‘‘(2) the Centers for Medicare & Medicaid Services Program Management Account—

‘‘(i) for fiscal year 2009, of $7,500,000; and

(ii) for the period of fiscal years 2010 through 2012, of $10,000,000. Amounts appropriated under this subparagraph shall remain available until expended.’’.

(b) ADDITIONAL FUNDING FOR AREA AGENCIES ON AGING.—Subsection (b)(3)(G) of the Social Security Act is amended to read as follows:

‘‘(G) REQUIRED INCLUSION OF DRUGS IN CERTAIN CATEGORIES AND CLASSES.—

(I) FORMULARY REQUIREMENTS.—In general.—Subject to clause (II), a PDP sponsor offering a prescription drug plan shall be required to include all covered part D drugs in the categories and classes identified by the Secretary under clause (II).’’.

(II) EXCEPTIONS.—The Secretary may establish exceptions that permit a PDP sponsor offering a prescription drug plan to exclude from its formulary a particular covered part D drug in a category or class that is otherwise required to be included in the formulary under subsection (I) (or to otherwise limit access to such a drug, including through prior authorization or utilization management).

(c) IDENTIFICATION OF DRUGS IN CERTAIN CATEGORIES AND CLASSES.—

(I) IN GENERAL.—Subject to clause (iv), the Secretary shall identify, as appropriate, categories and classes of drugs for which the Secretary determines are of clinical concern.

(II) CRITERIA.—The Secretary shall use criteria established by the Secretary in making any determination under clause (I).

(III) IMPLEMENTATION.—The Secretary shall establish the criteria under clause (II)(I) and any exceptions under clause (II)(II) through the procedures and any regulations prescribed under clause (I) which includes a public notice and comment period.

(IV) REQUIREMENT FOR CERTAIN CATEGORIES AND CLASSES ESTABLISHED.—Until such time as the Secretary establishes the criteria under clause (II)(I) the...
disclosure to other agencies.—Offi-
cers, employees, and contractors of the So-
cial Security Administration may disclose—
(i) the taxpayer identity information and
the amount of the premium subsidy ad-
justment or premium increase with respect to a
taxpayer described in subparagraph (A) to of-
ficers, employees, and contractors of the
Commissioner of Social Security Services,
subject to the extent that such disclosure is nec-

ecessary for the collection of the premium sub-

sidy amount or the increased premium amount,

(ii) return information with respect to a taxpayer
described in subparagraph (A) to of-
ficers and employees of the Department of
Health and Human Services to the extent
necessary to resolve administrative appeals
of premium subsidy adjustment or in-
creased premium, and

(iv) return information with respect to a
taxpayer described in subparagraph (A) to of-
ficers and employees of the Office of
Personnel Management and the Rail-
road Retirement Board, to the extent that
such disclosure is necessary for the collec-
tion of the premium subsidy amount or the
increased premium amount,

(III) return information with respect to a
taxpayer described in subparagraph (A) to of-
ficers and employees of the Department of
Health and Human Services to the extent
necessary to resolve administrative appeals
of premium subsidy adjustment or in-
creased premium, and

(IV) any other information the Commis-
sioner of Social Security determines nec-
essary for the determination of the premium
increase in the base beneficiary premium
under this paragraph.

(f) rule of construction.—The formula
used to determine the monthly subsidy
amount specified under subparagraph (B)
shall only be used for the purpose of deter-
mining such monthly adjustment amount
under such subparagraph.

(2) collection of monthly adjustment

amount.—section 1860d–13(c) of the Social
Security Act (42 U.S.C. 1395w–113(c)) is
amended—

(A) in paragraph (1), by striking “(2)”
and “(3)” and inserting “(2), (3), and (4)”;
and
(B) by adding at the end the following new

paragraph:

(4) collection of monthly adjustment

amount.—(A) in general.—Notwithstanding
any provision of this subsection or section
1854(d)(2), subject to subparagraph (B), the
amount of the income-related increase in the
base beneficiary premium for an individual
for a month after December

2009 shall be increased by the

monthly adjustment amount specified in subpara-
graph (B).

(B) monthly adjustment amount.—The
amount of the increase in the base beneficiary
premium described in this subparagraph for an individual for a month in a year is equal to the product of:

(i) the quotient obtained by dividing—

(1) the applicable percentage determined
under paragraph (3)(C) of section 1393l(1) (in-
cluding application of paragraph (5) of such
section) for the individual for the calendar
year after December

2009, by

(2) 25.5 percent; and

(ii) the base beneficiary premium (as
computed under paragraph (2)).

(C) modified adjusted gross income.—
For purposes of this paragraph, the term
modified adjusted gross income has the mean-

ing given such term in subparagraph (A)
of section 1393l(1)(4), determined for the
taxable year applicable under subparagraphs
(B) and (C) of such section.

(D) determination by commissioner of social
security.—The Commissioner of Social
Security shall make any determination necessary to carry out the income-related in-
crease in the base beneficiary premium under this paragraph.

(E) Procedures to assure correct in-
come-related increase in base beneficiary
premium.—

(i) disclosure of base beneficiary pre-

mium.—Not later than September 15 of each
year beginning with 2010, the Secretary shall disclose to the Commission of Social Secu-
rity the amount of the base beneficiary pre-
mium (as computed under paragraph (2)) for
the purpose of carrying out the income-re-
lated increase in the base beneficiary pre-
mium under this paragraph with respect to
the following year.

(ii) additional disclosure.—Not later
than August 1 of each year beginning with 2010, the Secretary shall disclose to the Com-
misioner of Social Security the following
information for the purpose of carrying out the
income-related increase in the base benefici-
y premium under this paragraph with respect to
the following year:

(1) The modified adjusted gross income
threshold applicable under paragraph (2) of
section 1393l(1) (including application of para-
graph (5) of such section).

(2) The applicable percentage determined
under paragraph (3)(C) of section 1393l(1) (in-
cluding application of paragraph (5) of such
section).

(3) The monthly adjustment amount
specified in subparagraph (B).

(4) Any other information the Commis-
sioner of Social Security determines nec-
essary for the determination of the amount of the in-
crease in the base beneficiary premium
under this paragraph.

(F) rule of construction.—The formula
used to determine the monthly subsidy
amount specified under subparagraph (B)
shall only be used for the purpose of deter-
mining such monthly adjustment amount
under such subparagraph.

(2) collection of monthly adjustment

amount.—section 1860d–13(c) of the Social
Security Act (42 U.S.C. 1395w–113(c)) is
amended—

(A) in paragraph (1), by striking “(2)”
and “(3)” and inserting “(2), (3), and (4)”;
and
(B) by adding at the end the following new

paragraph:

(4) collection of monthly adjustment

amount.—(A) in general.—Notwithstanding
any provision of this subsection or section
1854(d)(2), subject to subparagraph (B), the
amount of the income-related increase in the
base beneficiary premium for an individual
for a month after December

2009 shall be increased by the

monthly adjustment amount specified in subpara-
graph (B).

(B) monthly adjustment amount.—The
amount of the increase in the base beneficiary
premium described in this subparagraph for an individual for a month in a year is equal to the product of:

(i) the quotient obtained by dividing—

(1) the applicable percentage determined
under paragraph (3)(C) of section 1393l(1) (in-
cluding application of paragraph (5) of such
section) for the individual for the calendar
year after December

2009, by

(2) 25.5 percent; and

(ii) the base beneficiary premium (as
computed under paragraph (2)).

(C) modified adjusted gross income.—
For purposes of this paragraph, the term
modified adjusted gross income has the mean-

ing given such term in subparagraph (A)
of section 1393l(1)(4), determined for the
taxable year applicable under subparagraphs
(B) and (C) of such section.

(D) determination by commissioner of social
security.—The Commissioner of Social
Security shall make any determination necessary to carry out the income-related in-
crease in the base beneficiary premium under this paragraph.

(E) Procedures to assure correct in-
come-related increase in base beneficiary
premium.—

(i) disclosure of base beneficiary pre-

mium.—Not later than September 15 of each
year beginning with 2010, the Secretary shall disclose to the Commission of Social Secu-
rity the amount of the base beneficiary pre-
mium (as computed under paragraph (2)) for
the purpose of carrying out the income-re-
lated increase in the base beneficiary pre-
mium under this paragraph with respect to
the following year.

(ii) additional disclosure.—Not later
than August 1 of each year beginning with 2010, the Secretary shall disclose to the Com-
misioner of Social Security the following
information for the purpose of carrying out the
income-related increase in the base benefici-
y premium under this paragraph with respect to
the following year:

(1) The modified adjusted gross income
threshold applicable under paragraph (2) of
section 1393l(1) (including application of para-
graph (5) of such section).

(2) The applicable percentage determined
under paragraph (3)(C) of section 1393l(1) (in-
cluding application of paragraph (5) of such
section).
SEC. 3311. IMPROVED MEDICARE PRESCRIPTION DRUG PLAN AND MA–PD PLAN COMPLAINT SYSTEM.

(a) In General.—The Secretary shall develop and maintain a complaint system, that is widely known and easy to use, to collect and maintain information on MA–PD plan and MA–PD plan complaints that are received (including by telephone, letter, e-mail, or any other means) by the Secretary (including by a regional office of the Department of Health and Human Services, the Medicare Beneficiary Ombudsman, a subcontractor, a carrier, a fiscal intermediary, and a Medicare administrative contractor under section 1862 of the Social Security Act (42 U.S.C. 1395kk)) through the date on which the complaint is resolved. The system shall be able to report and initiate appropriate interventions, based on substantiated complaints and to guide quality improvement.

(b) Model Electronic Complaint Form.—The Secretary shall develop a model electronic complaint form to be used for reporting plan complaints under the system. Such form shall be prominently displayed on the front page of the Plan website and on the Internet website of the Medicare Beneficiary Ombudsman.

(c) Reporting.—The Secretary shall submit to Congress annual reports on the system. Such reports shall include an analysis of the number and types of complaints reported in the system, geographic variations in such complaints, the timeliness of agency or plan responses to such complaints, and the resolution of such complaints.

(d) Definitions.—In this section:

(1) MA–PD PLAN.—The term ‘‘MA–PD plan’’ has the meaning given such term in section 1860D–41(a)(14) of such Act (42 U.S.C. 1395w–151(a)(9)).

(2) PRESCRIPTION DRUG PLAN.—The term ‘‘prescription drug plan’’ has the meaning given such term in section 1860D–41(a)(14) of such Act (42 U.S.C. 1395w–151(a)(9)).

(3) Secretary.—The term ‘‘Secretary’’ means the Secretary of Health and Human Services.

(4) SYSTEM.—The term ‘‘system’’ means the plan complaint system developed and maintained under subsection (a).

SEC. 3312. UNIFORM EXCEPTIONS AND APPEALS PROCESS FOR PRESCRIPTION DRUG PLANS AND MA–PD PLANS.

(a) In General.—Section 1860D–4(b)(3) of the Social Security Act (42 U.S.C. 1395w–102(b)(3)) is amended by adding at the end the following new subparagraph:

‘‘(ii) in a uniform exceptions and appeals process—

(H) provision of a single, uniform exceptions and appeals process (including, to the extent the Secretary determines feasible, a single, uniform form model for use under such process) with implementation of a determination of prescription drug coverage for an enrollee under the plan; and

(I) provision for instant access to such process by enrollees through a toll-free telephone number and an Internet website.’’.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to exceptions and appeals on or after January 1, 2011.

SEC. 3313. OFFICE OF THE INSPECTOR GENERAL STUDIES AND REPORTS.

(a) STUDY AND ANNUAL REPORT ON PART D FORMULARIES.—

(1) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct a study to determine the extent to which the various formularies used by prescription drug plans and MA–PD plans under part D include drugs commonly used by full-benefit dual eligible individuals (as defined in section 1927(c)(6) of the Social Security Act (42 U.S.C. 1396u–5(c)(6))).

(2) ANNUAL REPORT.—Not later than July 1 of each year (beginning with 2011), the Inspector General shall (i) submit to Congress a report on the study conducted under paragraph (1), together with recommendations as the Inspector General determines appropriate.

(b) STUDY AND REPORT ON PRESCRIPTION DRUG PRICES UNDER MEDICARE PART D AND MEDICARE.—

(1) STUDY.—

(A) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct a study on drug prices for covered part D drugs under the Medicare prescription drug program under part D of title XVIII of the Social Security Act and for covered outpatient drugs under title XIX. Such study shall include the following:

(I) A comparison, with respect to the 200 most frequently dispensed covered part D drugs under such program and covered outpatient drugs under such title, of the prices paid for covered part D drugs by PDP sponsors of prescription drug plans and Medicare Advantage organizations offering MA–PD plans; and

(II) the prices paid for covered outpatient drugs by a State plan under title XVIII.

(B) An Assessment of—

(I) the financial impact of any discrepancies in such prices on the Federal Government;

(II) the financial impact of any discrepancies on enrollees under part D or individuals eligible for medical assistance under a State plan; and

(III) the financial impact of any discrepancies on enrollees under part D or individuals eligible for medical assistance under a State plan who are beneficiaries of a contract under section 1927 of the Social Security Act.

(c) Notification.—The report submitted under paragraph (1) shall be provided to PDP sponsors of prescription drug plans.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to costs incurred on or after January 1, 2011.
process, to fully reimburse PDP sponsors with respect to prescription drug plans and MA organizations with respect to MA–PD plans for the reduction in beneficiary cost sharing associated with the application of subparagraph A:

"(iv) The Secretary shall develop an estimate of the additional increased costs attributable to the reduction in beneficiary cost sharing for increased drug utilization and financing and administrative costs and shall use such estimate to adjust payments to PDP sponsors with respect to prescription drug plans under this part and MA organizations with respect to MA–PD plans under part C; and

"(v) The Secretary shall establish procedures for reimbursement of part D eligible individuals who are covered under such a plan for costs which are incurred before the date of initial implementation of subparagraph A and which would be reimbursed under such a plan if such implementation occurred as of January 1, 2010.

"(C) No Effect on Subsequent Years.—The increase under subparagraph A shall only apply with respect to the plan year beginning on January 1, 2010, and the initial coverage limit for plan years beginning on or after January 1, 2011, shall be determined as if subparagraph A had never applied.

Subtitle E—Ensuring Medicare Sustainability

SEC. 3401. REVISION OF CERTAIN MARKET BASKET UPDATES AND INCORPORATION OF PRODUCTIVITY IMPROVEMENTS INTO MARKET BASKET UPDATES 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)), as amended by section 1886(m) of the Affordable Care Act (42 U.S.C. 1395ww(m)), is amended—

(1) in clause (i)(XX), by striking “clause (vii)” and inserting “clauses (vii), (ix), (xi), and (xii)”;

(2) in the first sentence of clause (viii), by inserting “such applicable percentage increase (determined without regard to clause (ix), (x), or (xii))” after “one-quarter”; and

(3) in the first sentence of clause (ix)(i), by inserting “(determined without regard to clause (vii), (x), or (xii))” after “clause (i)” the second time it appears; and

(4) by adding at the end the following new clauses:

"(xii) For 2012 and each subsequent fiscal year, after determining the applicable percentage increase described in clause (i) being less than 0.0 for a fiscal year, and may result in payment rates for such fiscal year being less than such payment rates for the preceding fiscal year.

"(xiii) Clause (xii) shall be applied with respect to any of fiscal years 2012 through 2019 by substituting ‘0.0 percentage points’ for ‘0.2 percentage point’, if for such fiscal year—

"(i) the excess (if any) of—

"(aa) the total percentage of the non-elderly insured population for such preceding rate year (as estimated by the Secretary); exceeds

"(ii) 5 percentage points.’.

(b) SKILLED NURSING FACILITIES.—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)) is amended—

(1) by striking “FACTOR.—For purposes” and

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

"(4) OTHER ADJUSTMENT.—

(A) In General.—For purposes of subparagraph C(1)(ii), the other adjustment described in this subparagraph is—

"(I) the total percentage of the non-elderly insured population for such preceding rate year (as estimated by the Secretary); exceeds

"(II) the total percentage of the non-elderly insured population for such preceding rate year, 0.2 percentage point.

"(B) Adjustment.—For fiscal year 2012 and each subsequent fiscal year, after determining the percentage described in clause (i) for such fiscal year, the Secretary shall reduce such percentage by the productivity adjustment described in section 1886(b)(3)(B)(ix)(II). The application of the preceding sentence may result in such percentage being less than 0.0 for a fiscal year, and may result in payment rates under this subsection for a fiscal year being less than such payment rates for the preceding fiscal year.

(3) IMPLEMENTATION FOR RATE YEAR 2010 AND SUBSEQUENT YEARS.—

(A) In General.—For purposes of subparagraph C(1)(ii), the other adjustment described in this subparagraph is—

"(I) for each of fiscal years 2010 and 2011, 0.25 percentage point; and

"(II) for each of rate years 2012 through 2019, 0.2 percentage point.

(4) REDUCTION OF OTHER ADJUSTMENT.—After establishing the increase factor described in clause (i) for a fiscal year, the Secretary shall reduce such increase factor—

"(I) for each of fiscal years 2010 through 2019 by substituting ‘0.0 percentage points’ for ‘0.2 percentage point’, if for such rate year—

"(ii) the excess (if any) of—

"(aa) the total percentage of the non-elderly insured population for such preceding rate year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); exceeds

"(bb) the total percentage of the non-elderly insured population for such preceding rate year (as estimated by the Secretary); exceeds

"(III) 5 percentage points.’.

(c) HOME HEALTH CARE.—Section 1885(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)) is amended—

(1) in clause (ii)(V), by striking “clause (v)” and inserting “clauses (v) and (vi)”;

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

"(V) Adjustments.—After determining the home health market basket percentage
increase under clause (iii), and after application of clause (v), the Secretary shall reduce such percentage—

‘‘(i) for 2015 and each subsequent year, by the productivity adjustment described in section 1886(b)(3)(B)(xii)(II); and

‘‘(ii) for each of 2011 and 2012, by 1 percentage point.

The application of this clause may result in the home health market basket percentage increase under clause (iii) being less than 0.0 for a year, and may result in payment rates under the payment system under this subsection for a year being less than such payment rates for the preceding year.

(1) HOSPITALS.—Section 1886 of the Social Security Act, as amended by sections 3001, 3008, 3025, and 3133, is amended by adding at the end the following new subdivisions—

‘‘(e) PROSPECTIVE PAYMENT FOR PSYCHIATRIC HOSPITALS.—

‘‘(1) REFERENCE TO ESTABLISHMENT AND IMPLEMENTATION OF SYSTEM.—For provisions related to the establishment and implementation of a prospective payment system for payments under this title for inpatient hospital services furnished by psychiatric hospitals (as described in clause (i) of subsection (d)(1)(B) and psychiatric units (as described in the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

‘‘(vii) the total percentage of the non-elderly insured population for each such preceding fiscal year (as estimated by the Secretary); exceeds

‘‘(iv) After determining the market basket percentage increase under clauses (i)(VII) or (ii)(III), as applicable, being less than 0.0 for a year, and may result in payment rates under the payment system under this subsection for a year being less than such payment rates for the preceding fiscal year.

‘‘(v) Clause (iv)(IV) shall be applied with respect to any of fiscal years 2014 through 2019 by substituting 0.0 percentage points for ‘0.5 percentage point’; and

‘‘(vi) for each year beginning in 2012 and any subsequent year, any update to a base rate for days during the rate year for a psychiatric hospital or unit, respectively, shall be reduced—

‘‘(i)(I) for the rate year beginning in 2012 and each subsequent rate year, by the productivity adjustment described in section 1886(b)(3)(B)(xii)(II); and

‘‘(ii) subject to subparagraph (B), for each of the rate years beginning in 2010 through 2019, by the other adjustment described in paragraph (3).’’;

‘‘(B) SPECIAL RULE.—The application of this paragraph may result in such update being less than 0.0 for a rate year, and may result in payment rates under the system described in section 1886(b)(3)(B)(xii)(II); and

‘‘(vii) the total percentage of the non-elderly insured population for each such preceding fiscal year (based on the most recent estimates available from the Director of the Congressional Budget Office before a vote in either House on the Patient Protection and Affordable Care Act that, if determined in the affirmative, would clear such Act for enrollment); over

‘‘(ii) by inserting ‘‘subject to subparagraph (B) and the succeeding sentence of this paragraph’’; after ‘‘increase’’; and

‘‘(iii) by adding at the end the following new subparagraph—

‘‘(C) for 2011 and each subsequent year, after determining the percentage increase under subparagraph (B) for the year, reduce such percentage increase by the productivity adjustment described in section 1886(b)(3)(B)(xii)(II); and

‘‘(iv) by adding at the end the following flush sentence—

‘‘The application of subparagraph (C) may result in the percentage increase under subparagraph (B) being less than 0.0 for a year, and may result in payment rates under the payment system under this subsection for a year being less than such payment rates for the preceding year.

(2) AMBULATORY SURGICAL CENTER SERVICES.—Section 1833(i)(2)(D) of the Social Security Act (42 U.S.C. 1395l(i)(2)(D)) is amended—

‘‘(1) by redesigning clause (v) as clause (vi); and

‘‘(2) by inserting after clause (iv) the following new clause:

‘‘(C) in implementing the system described in clause (i) for 2011 and each subsequent year, any annual update under such system for the year, after application of clause (iv), shall be reduced by the productivity adjustment described in section 1886(b)(3)(B)(xii)(II).’’

‘‘(ii) the excess (if any) of—

‘‘(aa) the total percentage of the non-elderly insured population for each such preceding fiscal year (as estimated by the Secretary); unless

‘‘(ii) by striking ‘‘the’’ and inserting ‘‘subject to subparagraph (B) and the succeeding sentence of this paragraph’’; after ‘‘increase’’; and

‘‘(iii) by adding at the end the following new subparagraph—

‘‘(C) in implementing the system described in section 1886(b)(3)(B)(xii)(II); and

‘‘(ii) by inserting ‘‘subject to subparagraph (B) and the succeeding sentence of this paragraph’’; after ‘‘increase’’; and

‘‘(iii) by adding at the end the following new subparagraph—

‘‘(D) in implementing the system described in section 1886(b)(3)(B)(xii)(II); and

‘‘(ii) the excess (if any) of—

‘‘(aa) the total percentage of the non-elderly insured population for each such preceding fiscal year (as estimated by the Secretary); exceeds

‘‘(B) by inserting ‘‘subject to subparagraph (B) and the succeeding sentence of this paragraph’’; after ‘‘increase’’; and

‘‘(C) in implementing the system described in section 1886(b)(3)(B)(xii)(II); and

‘‘(ii) the excess (if any) of—

‘‘(aa) the total percentage of the non-elderly insured population for each such preceding fiscal year (as estimated by the Secretary); exceeds

‘‘(B) in subparagraph (I), as inserted by subparagraph (A)—

‘‘(i) by striking ‘‘(ii)’’ and inserting ‘‘subject clause (II) and clause (i);’’ and

‘‘(ii) by striking ‘‘minus 1.0 percentage point’’; and

‘‘(iii) by adding at the end the following new subparagraph—

‘‘(C) the hospital daily, outpatient, or skilled nursing facility payment system under this section for the fiscal year being less than such payment rates for the preceding fiscal year.”’
(b) by striking ‘‘through 2013’’ and inserting ‘‘and 2016’’; and
(2) by adding at the end the following new clause:
‘‘(iv) After determining the adjustment to the fee schedules under clause (i), the Secretary shall reduce such adjustment—
‘‘(I) for 2011 and each subsequent year, by the productivity adjustment described in section 1886(b)(3)(B)(x)(II); and
‘‘(II) for each of 2011 through 2015, by 1.75 percentage points.

Subclause (I) shall not apply in a year where the adjustment to the fee schedules determined under clause (i) is 0.0 or a percentage decrease for a year. The application of the productivity adjustment under subclause (i) shall result in an adjustment to the fee schedules under clause (i) being less than 0.0 for a year. The application of subclause (II) may result in an adjustment to the fee schedules under clause (i) being less than 0.0 for a year, and may result in payment rates for a year being less than such payment rates for the preceding year.’’.

(m) certain durable medical equipment.

Section 1834(a)(14) of the Social Security Act (42 U.S.C. 1395m(a)(14)) is amended—
(1) by striking ‘‘2011, 2012, and 2013,’’; and
(2) by inserting ‘‘and’’ after the semicolon at the end;
(b) by striking subparagraphs (L) and (M) and inserting the following new subparagraph:
‘‘(L) for 2011 and each subsequent year—
‘‘(i) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year; reduced by—
‘‘(II) the productivity adjustment described in section 1886(b)(3)(B)(x)(II); and
‘‘(3) by adding at the end the following flush sentence:
‘‘The application of subparagraph (L)(ii) may result in the covered item update under this paragraph being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.’’.

(n) prosthetic devices, orthotics, and prosthetics.

Section 1834(b)(14)(A) of the Social Security Act (42 U.S.C. 1395m(b)(14)) is amended—
(1) in subparagraph (A)—
(A) in clause (i), by striking ‘‘and’’ at the end;
(B) in clause (x)—
(i) by striking ‘‘a subsequent year’’ and inserting ‘‘through such year’’;
(ii) by inserting ‘‘and’’ after the semicolon at the end;
(C) by adding at the end the following new clause:
‘‘(xx) for 2011 and each subsequent year—
‘‘(I) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—
‘‘(II) the productivity adjustment described in section 1886(b)(3)(B)(x)(II); and
‘‘(3) by adding at the end the following flush sentence:
‘‘The application of subparagraph (A)(x)(II) may result in the applicable percentage increase in such paragraph (A) being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.’’.

(o) Other items.

Section 1842(e)(1) of the Social Security Act (42 U.S.C. 1395u(e)(1)) is amended—
(1) in the first sentence, by striking ‘‘Subject to’’ and inserting ‘‘(A) Subject to’’;
(2) by striking the second sentence and inserting the following new subparagraph:
‘‘(B) Any fee schedule established under this paragraph for such item or service shall be updated—
‘‘(i) for years before 2011—
‘‘(I) subject to subclause (II), by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year; and
‘‘(II) for each of 2011 through 2015, by 1.75 percentage points.
‘‘(II) the productivity adjustment described in section 1886(b)(3)(B)(x)(II); and
‘‘(3) by adding at the end the following flush sentence:
‘‘The application of subparagraph (B)(ii)(II) may result in the update under this paragraph being less than 0.0 or a percentage decrease for a year, and may result in payment rates under any fee schedule established under this paragraph for a year being less than such payment rates for the preceding year.’’.

(p) No application prior to April 1, 2011.

Section 1301(c) of the Patient Protection and Affordable Care Act, to reduce Medicare per capita growth rate for a year, by requiring the Secretary to develop and submit during the first year following the determination year (in this section referred to as ‘‘a proposal year’’) a proposal concentrating recommendations to reduce Medicare per capita growth rate to the extent required by this section; and

(q) by requiring the Secretary to implement such proposals unless Congress enacts legislation pursuant to this section.

(b) Developing.

Section 1886(c)(1) of the Social Security Act (42 U.S.C. 1395u(c)(1)) is amended—
(1) by striking ‘‘2011, 2012, and 2013,’’; and
(2) by inserting ‘‘and’’ after the semicolon at the end;
(b) by striking subparagraphs (L) and (M) and inserting the following new subparagraph:
‘‘(L) for 2011 and each subsequent year—
‘‘(i) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—
‘‘(II) the productivity adjustment described in section 1886(b)(3)(B)(x)(II); and
‘‘(3) by adding at the end the following flush sentence:
‘‘The application of subparagraph (L)(ii) may result in the covered item update under this paragraph being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.’’.

(n) Prosthetic Devices, Orthotics, and Prosthetics.

Section 1834(b)(14) of the Social Security Act (42 U.S.C. 1395m(b)(14)) is amended—
(1) in paragraph (1)—
(A) in clause (ix), by striking ‘‘and’’ at the end;
(B) by adding at the end the following new clause:
‘‘(x) for 2011 and each subsequent year—
‘‘(I) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—
‘‘(II) the productivity adjustment described in section 1886(b)(3)(B)(x)(II); and
‘‘(3) by adding at the end the following flush sentence:
‘‘The application of subparagraph (A)(x)(II) may result in the applicable percentage increase in such paragraph (A) being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.’’.

(o) Other Items.

Section 1842(e)(1) of the Social Security Act (42 U.S.C. 1395u(e)(1)) is amended—
(1) in the first sentence, by striking ‘‘Subject to’’ and inserting ‘‘(A) Subject to’’;
(2) by striking the second sentence and inserting the following new subparagraph:
‘‘(B) Any fee schedule established under this paragraph for such item or service shall be updated—
‘‘(i) for years before 2011—
‘‘(I) subject to subclause (II), by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year; and
‘‘(II) for each of 2011 through 2015, by 1.75 percentage points.
‘‘(II) the productivity adjustment described in section 1886(b)(3)(B)(x)(II); and
‘‘(3) by adding at the end the following flush sentence:
‘‘The application of subparagraph (B)(ii)(II) may result in the update under this paragraph being less than 0.0 or a percentage decrease for a year, and may result in payment rates under any fee schedule established under this paragraph for a year being less than such payment rates for the preceding year.’’.

(p) No Application Prior to April 1, 2011.

Section 1301(c) of the Patient Protection and Affordable Care Act, to reduce Medicare per capita growth rate for a year, by requiring the Secretary to develop and submit during the first year following the determination year (in this section referred to as ‘‘a proposal year’’) a proposal concentrating recommendations to reduce Medicare per capita growth rate to the extent required by this section; and

(q) by requiring the Secretary to implement such proposals unless Congress enacts legislation pursuant to this section.

(b) Developing.

Section 1886(c)(1) of the Social Security Act (42 U.S.C. 1395u(c)(1)) is amended—
(1) by striking ‘‘2011, 2012, and 2013’’; and
(2) by inserting ‘‘and’’ after the semicolon at the end;
(b) by striking subparagraphs (L) and (M) and inserting the following new subparagraph:
‘‘(L) for 2011 and each subsequent year—
‘‘(i) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—
‘‘(II) the productivity adjustment described in section 1886(b)(3)(B)(x)(II); and
‘‘(3) by adding at the end the following flush sentence:
‘‘The application of subparagraph (L)(ii) may result in the covered item update under this paragraph being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.’’.

(n) Prosthetic Devices, Orthotics, and Prosthetics.

Section 1834(b)(14) of the Social Security Act (42 U.S.C. 1395m(b)(14)) is amended—
(1) in paragraph (1)—
(A) in clause (ix), by striking ‘‘and’’ at the end;
(B) by adding at the end the following new clause:
‘‘(x) for 2011 and each subsequent year—
‘‘(I) the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year, reduced by—
‘‘(II) the productivity adjustment described in section 1886(b)(3)(B)(x)(II); and
‘‘(3) by adding at the end the following flush sentence:
‘‘The application of subparagraph (A)(x)(II) may result in the applicable percentage increase in such paragraph (A) being less than 0.0 for a year, and may result in payment rates under this subsection for a year being less than such payment rates for the preceding year.’’.

(o) Other Items.

Section 1842(e)(1) of the Social Security Act (42 U.S.C. 1395u(e)(1)) is amended—
(1) in the first sentence, by striking ‘‘Subject to’’ and inserting ‘‘(A) Subject to’’;
payments under parts C and D, such as re-
ductions in direct subsidy payments to Medi-
care Advantage and prescription drug plans
specified under paragraph (1) and (2) of sec-
tion 1860D–13(a)(4), and reductions in payments to Medi-
care Advantage plans under clauses (i) and (ii) of section
1860D–13(a)(10) that are related to admin-
istrative expenses (including profits) for basic
coverage, denying high bids or removing high bids for prescription drug coverage from
the calculation of the national average
monthly bid amount under section 1860D–
13(a)(2), and reductions in payments to Medi-
care Advantage plans under subsections (A) and (B) of
section 1862(a) that are related to admin-
istrative expenses (including profits) and
performance bonuses for Medicare Ad-

care Advantage programs. Any such
recommendation shall not affect the
beneficiary premium percentage speci-
fied under 1860D–13(a).

(6) TRANSMISSION OF BOARD PROPOSAL TO
PRESIDENT.—

(A) IN GENERAL.—

(i) The Board shall include rec-

ommendations related to the Medicare pro-

gram.

(ii) ADDITIONAL CONSIDERATIONS.—In de-

veloping and submitting each proposal under this section in a proposal year, the Board
shall, to the extent feasible—

(1) improve the health care delivery sys-

tem and medical care expenditure trends,

(2) improve the economic competitiveness of Medicare providers, and

(3) include recommendations that target

reductions in Medicare program spending to sources of excess cost growth.

(iii) CONSIDER THE EFFECTS THAT WILL

improve Medicare beneficiaries’ access to necessary and evidence-based

and suppliers, with actual or projected negative cost margins or payment updates; and

(iv) CONSIDER THE EFFECT OF THE RE-

commendations on providers of services and

of Medicare beneficiaries who are dually eligible for Medicare and the Medicaid program under

(3) NO INCREASE IN TOTAL MEDICA

REVENUE.—Each proposal submitted under this section shall be designed in such a

manner that the projected increase in Medicare program spending, after.

(d) Consultation with MedPac.—The Board shall submit a draft copy of each pro-
posal to be submitted under this section to the Medicaid Payment Advisory Commission
established under section 1805 for its review. The Board shall submit such draft copy by
not later than September 1 of the determina-
tion year.

(e) Review and comment by the Sec-

tary.—The Board shall submit a draft copy of each proposal to be submitted to Congress
by March 1 of the submission year. The Secretary shall submit a report to Congress on the results of such re-

view, unless the Secretary submits a pro-

posal under paragraph (5)(A) in that year.

(f) Consultation.—In carrying out its
duties under this section, the Board shall en-
gage in regular consultations with the Medi-
care and CHIP Payment and Access Com-
mission under section 1900.

(2) TRANSMISSION OF BOARD PROPOSAL TO
PRESIDENT.—

(A) IN GENERAL.—

(i) Except as provided in clause (ii) and subsection (f)(3)(B), the Board shall transmit a proposal under this section to the President on January 15 of each year (beginning with 2014).

(ii) EXCEPTION.—The Board shall not sub-
mit a proposal under clause (i) in a proposal year if the Board

(i) a year for which the Chief Actuary of the Centers for Medicare & Medicaid Serv-
ices makes a determination in the deter-
mation required paragraph (3)(B)). By not

(ii) IN GENERAL.—For purposes of this sec-
tion, the Medicare per capita target growth rate for implementation year shall be calculated as the projected 5-year average (ending with such year) of the growth in Medicare program spending per unduplicated enrollee.

(iii) REQUIREMENT.—The Board shall submit a draft copy of each proposal under this section to the Medicaid Payment Advisory Commission established under section 1805 for its review.
“(ii) the projected excess for the implementation year expressed as a percent) determined under subparagraph (A).

(8) PER CAPITA RATE OF GROWTH IN NATIONAL HEALTH EXPENDITURES.—In each determination year (beginning in 2018), the Chief Actuary of the Centers for Medicare & Medicaid Services shall project the per capita rate of growth in national health expenditures for the implementation year. Such rate of growth for an implementation year shall be calculated as the projected 5-year average increase in national health care expenditures for that implementation year.

2. CONGRESSIONAL CONSIDERATION.—

(a) INTRODUCTION.—

(A) In general.—On the day on which a proposal is submitted by the President to the House of Representatives and the Senate under subsection (c)(4), the legislative proposal (described in subsection (c)(3)(B)(iv)) contained in the proposal shall be introduced (by request) in the Senate by the majority leader of the Senate or by Members of the Senate designated by the majority leader of the Senate and shall be introduced (by request) in the House by the majority leader of the House or by Members of the House designated by the majority leader of the House.

(B) If either House is not in session on the day on which such legislative proposal is submitted, the legislative proposal shall be introduced in that House, as provided in paragraph (A), on the first day thereafter on which that House is in session.

(C) Any member.—If the legislative proposal is not introduced in either House within 5 days on which that House is in session after the day on which the legislative proposal is submitted, then any Member of that House may introduce the legislative proposal.

(b) REFERRAL.—The legislation introduced under this paragraph shall be referred by the Presiding Officers of the respective Houses to the Committee on Finance in the Senate and to the Committee on Energy and Commerce of the House of Representatives.

(c) COMMITTEE CONSIDERATION OF PROPOSAL.—

(A) REPORTING BILL.—Not later than April 1 of any proposal year in which a proposal is introduced pursuant to paragraph (1) is received by one House from the other House, the Committee on Finance in the Senate or the Committee on Energy and Commerce in the House of Representatives shall report the bill referred to the Committee on Finance in the Senate or to the Committee on Energy and Commerce in the House of Representatives.

(B) Calculations.—In determining whether a committee amendment meets the requirement of subparagraph (A), the reductions in Medicare program spending during the 3-month period immediately preceding the implementation year shall be counted to the extent that such reductions are a result of the implementation provisions in the committee amendment for a change in the payment rate for an item or service that was effective during such period pursuant to such amendment.

(C) COMMITTEE JURISDICTION.—Notwithstanding rule XV of the Standing Rules of the Senate, a committee amendment described in subparagraph (A) may include matter not within the jurisdiction of the Committee on Finance in the Senate if that matter is relevant to a proposal contained in the bill submitted under subsection (c)(3).

(D) DISCHARGE.—If, with respect to the House, a committee has not reported the bill by the date required by subparagraph (A), the committee shall be discharged from further consideration of the proposal.

(3) LIMITATION ON CHANGES TO THE BOARD RECOMMENDATIONS.—

(A) IN GENERAL.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report that would repeal or otherwise change the board recommendations of the Committee on Finance if that matter is reliniquished in subparagraph (A) may include changes in those recommendations.

(B) LIMITATION ON CHANGES TO THE BOARD RECOMMENDATION.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report that would repeal or otherwise change the board recommendations of the Board if that change would result in a proposal under subparagraphs (A)(i) and (C) of subsection (c)(2).

(C) LIMITATION ON CHANGES TO THIS SUBSESSION.—It shall not be in order in the Senate or the House of Representatives to consider any bill, resolution, amendment, or conference report that would repeal or otherwise change this subsection.

(D) W AIVER.—This paragraph may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn.

(E) APPEALS.—An affirmative vote of three-fifths of the Members, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this paragraph.

(4) EXPEDITED PROCEDURE.—

(A) AMENDMENT.—A motion to proceed to the consideration of the bill in the Senate is not debatable.

(B) AMENDMENT.—A motion to proceed to the consideration of the bill in the Senate is not debatable.

(C) CONSIDERATION.—A motion to proceed to the consideration of the bill in the Senate is not debatable.

(D) CONSIDERATION.—A motion to proceed to the consideration of the bill in the Senate is not debatable.

(E) APPEALS.—An affirmative vote of three-fifths of the Members, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this paragraph.

(F) WAIVER.—Any debatable amendment, motion, or appeal may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn.

(G) APPEALS.—An affirmative vote of three-fifths of the Members, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under this paragraph.

(H) TOTAL LIMITATION.—Clauses (i), (ii), and (iv) shall apply only to a bill received by one House from the other House if the—

(i) is related only to the program under the heading "Medicare, introduction pursuant to paragraph (1) is received by one House from the other House, after such a bill is passed by the receiving House, the vote on passage of the bill received from the other House as amended by the language of the receiving House.

(iv) DISPOSITION.—Upon disposition of a bill introduced pursuant to paragraph (1) that is received by one House from the other House, the bill introduced pursuant to paragraph (1) is received by one House from the other House, after such a bill is passed by the receiving House, the vote on passage of the bill shall be limited to 1 hour, to be equally divided between those favoring and those opposing the motion or appeal.

(iv) TOTAL LIMITATION.—Clauses (i), (ii), and (iv) shall apply only to a bill received by one House from the other House if the—

(i) is related only to the program under the heading "Medicare, introduction pursuant to paragraph (1) is received by one House from the other House, after such a bill is passed by the receiving House, the vote on passage of the bill shall be limited to 1 hour, to be equally divided between those favoring and those opposing the motion or appeal.

(v) TOTAL LIMITATION.—Clauses (i), (ii), and (iv) shall apply only to a bill received by one House from the other House if the—

(i) is related only to the program under the heading "Medicare, introduction pursuant to paragraph (1) is received by one House from the other House, after such a bill is passed by the receiving House, the vote on passage of the bill shall be limited to 1 hour, to be equally divided between those favoring and those opposing the motion or appeal.
"(iii) FINAL DISPOSITION.—After 10 hours of consideration, the Senate shall proceed, without any further debate on any question, to vote on the final disposition thereof to the exclusion of all other questions. Such recommendation shall be agreed to before the Senate at that time or necessary to resolve the difference between the Houses and to the exclusion of all other motions, except a motion to reconsider or to reconsider the previous plenary call on demand to establish the presence of a quorum (and motions required to establish a quorum) immediately before the final disposition thereof to the exclusion of all other questions.

"(iv) LIMITATION.—Clauses (i) through (iii) shall only apply to a conference report, message or the amendments thereto if the conference report, message, or amendment thereto—

"(I) is related only to the program under this title; and

"(II) satisfies the requirements of subparagraphs (A)(1) and (C) of subsection (c)(2).

"(F) VETO.—If the President vetoes the bill, debate on a veto message in the Senate under this subsection shall be 1 hour equally divided between the majority and minority leaders or their designees.

"(5) RULES OF THE SENATE AND HOUSE OF REPRESENTATIVES.—This subsection and subsection (f)(2) are enacted by Congress—

"(A) as an exercise of the rulemaking power of the Senate and the House of Representatives, respectively, and is designed to be part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of a bill under this section, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

"(B) with full recognition of the constitutional right of either House to change the rules so as to reflect 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.

"(6) IMPLEMENTATION OF PROPOSAL.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall, except as provided in paragraph (3), implement the recommendations contained in a proposal submitted by the President to Congress pursuant to this section on August 15 of the year in which the proposal is so submitted. This subsection and subsection (f)(2) are enacted by Congress—

"(B) as an exercise of the rulemaking power of the Senate and the House of Representatives, respectively, and is designed to be part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of a bill under this section, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

"(B) with full recognition of the constitutional right of either House to change the rules so as to reflect 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.

"(e) IMPLEMENTATION OF PROPOSAL.—

"(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall, except as provided in paragraph (3), implement the recommendations contained in a proposal submitted by the President to Congress pursuant to this section on August 15 of the year in which the proposal is so submitted. This subsection and subsection (f)(2) are enacted by Congress—

"(A) as an exercise of the rulemaking power of the Senate and the House of Representatives, respectively, and is designed to be part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of a bill under this section, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

"(B) with full recognition of the constitutional right of either House to change the rules so as to reflect 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.

"(2) PROCEDURE.—

"(A) REPEAL.—A joint resolution described in paragraph (1) shall be referred to the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

"(B) DISCHARGE.—In the Senate, if the committee to which is referred a joint resolution described in paragraph (1) has reported such joint resolution (or an identical joint resolution) at the end of 20 days after the joint resolution described in paragraph (1) has not reported such joint resolution (or an identical joint resolution) at the end of 20 days after the joint resolution described in paragraph (1) is introduced, such committee may by a majority vote of a quorum dispose of such joint resolution upon a petition supported in writing by 30 Members of the Senate, and such joint resolution shall be placed on the calendar.

"(C) CONSIDERATION.—

"(i) IN GENERAL.—In the Senate, when the committee to which a joint resolution is referred has reported, or when a resolution, as the case may be, that begins after such August 15.

"(ii) In the case of a recommendation relating to payments to plans under parts C and D, such recommendation shall apply to plan years beginning on the first day of the first calendar year that begins after such August 15.

"(iii) In the case of any other recommendation, such recommendation shall be addressed to the regular regulatory process timeframe and shall apply as soon as practicable.

"(B) INTRIM RULEMAKING.—The Secretary shall implement any recommendation described in paragraph (1).
and the Administrator of the Health Resources and Services Administration, all of whom shall serve ex officio as nonvoting members of the Board.

(9) COMPENSATION.—(A) IN GENERAL.—The Chairperson shall be appointed by the President, by and with the advice and consent of the Senate, from among the members of the Board.

(10) PRACTICAL SERVICES.—The Board shall maintain a principal office and such field offices as it determines necessary, and may meet and exercises any of its powers at any other place.

(11) QUORUM.—A majority of the appointed members present shall constitute a quorum for the transaction of business, but a lesser number of members may hold hearings.

(12) COMPENSATION.—The Chairperson shall be compensated at a rate equal to the annual rate of basic pay prescribed for level V of the Executive Schedule under section 3138 of title 5, United States Code.

(13) STAFF.—The Chairperson may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel in positions not exceeding the rate of pay for level V of the Executive Schedule under section 3136 of such title.

(14) FISCAL SERVICES.—The Board may use the United States mails in the same manner and under the same conditions as other depts and agencies of the Federal Government.

(15) GIFTS.—The Board may accept, use, and dispose of gifts or donations of services or property.

(16) OFFICES.—The Board shall maintain a principal office and such field offices as it determines necessary, and may meet and exercise any of its powers at any other place.

(17) COMPENSATION OF MEMBERS AND CHAIRPERSON.—Each appointed member, other than the Chairperson, shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level II of the Executive Schedule under section 3132 of title 5, United States Code.
COVERAGE POLICIES UNDER THE MEDICARE PROGRAM.—

The terms ‘Medicare’ and ‘Medicare beneficiary’ mean, respectively, the Medicare program established under this title, including parts A, B, C, and D, and an individual who is entitled to, or enrolled for, benefits under part A or enrolled for benefits under part B.

(a) FISCAL YEAR.—The amount appropriated under this paragraph for the fiscal year is increased by the amount appropriated under paragraph (1) for the fiscal year preceding the fiscal year for which the amount is appropriated under paragraph (1) for the fiscal year.

COVFR. 14011. Medicare program spending under parts A, B, and D.

(b) RETARIAL PROPOSAL.—If the Independent Medicare Advisory Board or Secretary proposes legislation and administrative action as the Comptroller General determines appropriate.

(c) CONFORMING AMENDMENTS.—Section 1899A of the Social Security Act (42 U.S.C. 1395b–6) is amended—

(1) by redesigning paragraphs (4) through (8) as paragraphs (5) through (9), respectively;

(2) by inserting after paragraph (3) the following:

(a) PURPOSE.—The purposes of this section are to—

(i) enable the Director to identify, develop, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices (referred to as ‘best practices’) in health care quality, safety, and value; and

(ii) ensure that the Director is accountable for implementing a model to provide such research in a collaborative manner with other related Federal agencies.

(b) GENERAL FUNCTIONS OF THE CENTER.—

(i) The Center for Quality Improvement and Patient Safety.

(ii) The Center for Quality Improvement and Patient Safety of the Agency for Healthcare Research and Quality (referred to in this section as the ‘Center’), or any other relevant agency or department designated by the Director, shall—

(i) carry out its functions using research from a variety of disciplines, which may include activities for the examination of strategies to share best quality improvement practices and to promote excellence in the delivery of health care services; and

(ii) build capacity at the State and community level to lead quality and safety efforts through education, training, and mentorship programs to ensure that the activities under paragraphs (1) through (9).

(c) RESEARCH FUNCTIONS OF CENTER.—

(i) In General.—The Center shall support, such as through a contract or other mechanism, program of research to facilitate adoption of best practices.
that improve the quality, safety, and efficiency of health care delivery services. Such support may include establishing a Quality Improvement Network Research Program for the purpose of testing, scaling, and disseminating of interventions to improve quality and efficiency in health care. Recipients of funding under the Program may include national, State, multi-State, or multi-site quality improvement networks.

(2) RESEARCH REQUIREMENTS.—The research conducted pursuant to paragraph (1) shall—

(A) address the priorities identified by the Secretary in the national strategic plan established under section 399HH;

(B) identify, when such evidence is insufficient to identify strategies and methodologies, taking into consideration areas of insufficient evidence identified by the entity with a contract under section 1866(a) of the Social Security Act in the report required under section 399J;

(C) address concerns identified by health care institutions and providers and communicate through the Center pursuant to subsection (d);

(D) reduce preventable morbidity, mortality, or costs of morbidity and mortality by building capacity for patient safety research;

(E) support the discovery of processes for the reliable, safe, efficient, and responsive delivery of health care, taking into account discoveries from clinical research and comparative effectiveness research;

(F) allow communication of research findings and translate evidence into practice recommendations that are adaptable to a variety of settings, and which, as soon as practicable after the establishment of the Center, shall include—

(i) the implementation of a national application of Intensive Care Unit improvement programs for the adult, including geriatric, pediatric, and neonatal patient populations;

(ii) practical methods for addressing health care associated infections, including Methicillin-Resistant Staphylococcus Aureus and Vancomycin-Resistant Enterococcus infections and other emerging infectious diseases;

(iii) practical methods for reducing preventable hospital admissions and readmissions;

(iv) expand demonstration projects for improving the quality of children’s health care and the use of health information technology, such as through Pediatric Quality Improvement Collaboratives and Learning Networks, consistent with provisions of section 1139A of the Social Security Act for assessing and improving quality, where applicable;

(H) identify and mitigate hazards by—

(i) analyzing events reported to patient safety reporting systems and patient safety organizations; and

(ii) using the results of such analyses to develop scientific methods of response to such events;

(I) include the conduct of systematic reviews of existing practices that improve the quality, safety, and efficiency of health care delivery, as well as new research on improving such practices; and

(J) include the examination of how to measure and evaluate the progress of quality and patient safety activities.

(d) DISSEMINATION OF RESEARCH FINDINGS.—

(1) PUBLIC AVAILABILITY.—The Director shall make the research findings of the Center available to the public through multiple media and appropriate formats to reflect the varying needs of health care providers and consumers and diverse levels of health literacy.

(2) LINKAGE TO HEALTH INFORMATION TECHNOLOGY.—The Secretary shall ensure that research conducted by the Center are shared with the Office of the National Coordinator of Health Information Technology and used to inform the activities of the Health Information Technology Extension program under section 3012, as well as any relevant standards, certification criteria, or implementation specifications.

(e) Technical assistance.—The Director shall identify and regularly update a list of processes or systems on which to focus research and disseminating activities of the Center, taking into account—

(1) the cost to Federal health programs;

(2) consumer assessment of health care experience;

(3) provider assessment of such processes or systems and opportunities to minimize distress and injury to the health care workforce;

(4) the potential impact of such processes or systems on health status and function of patients, including vulnerable populations including children and seniors;

(5) the areas of insufficient evidence identified under subsection (c)(2)(B) and (C);

(6) the evolution of meaningful use of health information technology, as defined in section 3000.

(f) COORDINATION.—The Center shall coordinate its activities with activities conducted by the Agency for Healthcare Research and Quality (referred to in this section as the ‘Center’), shall award—

(1) technical assistance grants or contracts to eligible entities to provide technical support to institutions that deliver health care and health care providers (including rural and urban providers of services and supplies with limited infrastructure and financial resources) and support quality improvement activities, providers of services and suppliers with poor performance scores, and providers of services and suppliers for whom disparities in care (in care among subgroups of patients) so that such institutions and providers understand, adapt, and implement the models and practices identified in the research conducted by the Center, including the Quality Improvement Networks Research Program; and

(2) implement or contracts to eligible entities to implement the models and practices described under paragraph (1).

(b) ELIGIBLE ENTITIES.—

(1) TECHNICAL ASSISTANCE AWARD.—To be eligible to receive a technical assistance grant or contract under subsection (a)(1), an entity—

(A) may be a health care provider, health care provider association, professional society, health care worker organization, Indian health organization, quality improvement organization, patient safety organization, or local quality improvement collaborative, the Joint Commission, academic health center, university, physician-based research network, or primary care extension program established under section 399W, a Federal Indian Health Service program or a health program operated by an Indian tribe (as defined in section 1407(d) of the Indian Health Care Improvement Act), or any other entity identified by the Secretary; and

(B) shall have demonstrated expertise in providing information and technical support and assistance to health care providers regarding quality improvement.

(c) APPLICATION.—

(1) TECHNICAL ASSISTANCE AWARD.—To receive a technical assistance grant or contract under subsection (a)(1), an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing—

(A) a plan for a sustainable business model that may include a system of—

(i) charging fees to institutions and providers that receive technical support from the entity; and

(ii) reducing or eliminating such fees for such institutions and providers that serve low-income populations;

(B) such other information as the Director may require.

(d) IMPLEMENTATION AWARD.—To receive a grant or contract under subsection (a)(2), an eligible entity shall submit an application to the Secretary at such time, in such manner, and containing—

(A) a plan for implementation of a model or practice identified in the research conducted by the Center including—

(i) financial cost, staffing requirements, and timeline for implementation; and

(ii) pre- and projected post-implementation quality measure performance data in targeted improvement areas identified by the Secretary; and

(B) such other information as the Director may require.

(e) MATCHING FUNDS.—The Director may not award a grant or contract under this section to an entity unless the entity agrees that it will make available (directly or through contributions from other public or private entities) non-Federal contributions toward the activities to be carried out under the grant or contract equal to $1 for each $5 of Federal funds provided under the grant or contract. Such non-Federal matching funds may be provided directly or through contributions from other public or private entities and may be in cash or in-kind, fairly evaluated, including plant, equipment, or services.

(f) EVALUATION.—

(1) IN GENERAL.—The Director shall evaluate the performance of each entity that receives a grant or contract under this section. The evaluation of an entity shall include a study of—

(A) the success of such entity in achieving the implementation, by the health care delivery systems and providers assisted by such entity, the models of the programs and practices identified in the research conducted by the Center under section 933;

(B) the perception of the health care institution and providers assisted by such entity regarding the value of the entity; and

(C) the impact on the quality of patient health outcomes and lower cost resulting from the assistance provided by such entity.

(2) EFFECT OF EVALUATION.—Based on the outcome of the evaluation of the entity under paragraph (1), the Director shall determine whether to renew a grant or contract with such entity under this section.
technology regional extension centers under section 3021(c) and the primary care extension program established under section 399W regarding the dissemination of quality improvement, information system, and reform, and best practices information.”.

SEC. 2502. ESTABLISHING COMMUNITY HEALTH TEAMS TO SUPPORT THE PATIENT-CENTERED MEDICAL HOME.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the "Secretary") shall establish a program to provide grants to or enter into contracts with eligible entities to establish community-based interdisciplinary, interprofessional teams (referred to in this section as “health teams”) to support primary care practices, including obstetrics and gynecology practices, within the hospital service area associated with the eligible entities. Grants or contracts shall be used to—

(1) establish health teams to provide support services to primary care providers; and

(2) provide capitated payments to primary care providers as determined by the Secretary.

(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant or contract under subsection (a), an entity shall—

(1)(A) be a State or State-designated entity; or

(B) be an Indian tribe or tribal organization, as defined in section 4 of the Indian Health Care Improvement Act; and

(2) exhibit achieving long-term financial sustainability within 3 years;

(3) submit a plan for incorporating prevention initiatives and patient education and care coordination into the delivery of health care that is integrated with community-based prevention and treatment resources, where available;

(4) agree that the health team established by the entity includes an interdisciplinary, interprofessional team of health care providers, as determined by the Secretary; such team may include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral and mental health providers (including substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians’ assistants;

(5) agree to provide services to eligible individu- als with chronic conditions, as described in section 1945 of the Social Security Act (as added by section 270B), in accordance with the standards established under subsection (c) of such section; and

(6) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) REQUIREMENTS FOR HEALTH TEAMS.—A health team established pursuant to a grant or contract under subsection (a) shall—

(1) establish contractual agreements with primary care providers to provide support services;

(2) support patient-centered medical homes, defined as a mode of care that includes—

(A) personal physicians;

(B) whole person orientation;

(C) coordinated and integrated care;

(D) safe and high-quality care through evidence-informed medicine, appropriate use of health information technology, and continuous quality improvements;

(E) expanded access to care; and

(F) recognizes added value from additional components of patient-centered care;

(3) collaborate with local primary care pro- viders, the State and community health centers, and eligible entities in accordance with the eligible entities’ priority needs to align resources to coordinate disease prevention, chronic disease management, transitioning between health care providers and settings and case management for patients, including children, with priority given to those amenable to prevention and patient education and with chronic diseases or conditions identified by the Secretary;

(4) in collaboration with local health care providers, develop and implement interdisciplinary care plans that integrate clinical and community preventive and health promotion services for patients, including children, with a priority given to those amenable to prevention and with chronic diseases or conditions identified by the Secretary;

(5) incorporate with health care providers, pa- tients, caregivers, and authorized representatives in program design and oversight;

(6) provide support necessary for local pri- mary care practitioners to—

(A) coordinate and provide access to high-quality health care services;

(B) coordinate and provide access to preven- tive and health promotion services;

(C) provide access to appropriate specialty care and inpatient services;

(D) provide quality-driven, cost-effective, culturally appropriate, and patient- and family-centered health care;

(E) provide access to pharmacist-managed medication management services, including medication record sharing;

(F) provide coordination of the appropriate use of complementary and alternative (CAM) services through such services;

(G) promote effective strategies for treat- ment planning, monitoring health outcomes and resource use, sharing information, treat- ment decision support, and organizing care to avoid duplication of service and other medical management approaches intended to improve quality and value of health care services;

(H) provide local access to the continuum of health care services in the most appro- priate setting, including access to individu- als that implement the care plans of pa- tients and coordinate care, such as integrative health care practitioners;

(I) collect and report data that permits evaluation of the success of the collaborative effort on patient outcomes, including collec- tion of data on patient experience of care, and identification of areas for improvement; and

(J) establish a coordinated system of early identification and referral for children at risk for developmental problems such as those at risk for developmental problems such as such as through the use of infolines, health information technology, or other means as determined by the Secretary.

(7) provide 24-hour care management and support during transitions in care settings including—

(A) a transitional care program that pro- vides an individualized transitional care coordinator, assists with the development of discharge plans and medication reconciliation upon ad- mission to and discharge from the hospitals, nursing home, or other institution setting;

(B) discharge planning and counseling sup- port to providers, patients, caregivers, and authorized representatives;

(C) ensuring that post-discharge care plans include medication management, as appro- priate;

(D) referrals for mental and behavioral health services, which may include the use of infolines; and

(E) transitional health care needs from adolescence to adulthood;

(9) demonstrate a capacity to implement and maintain health information technology that is certified under section 3001 of the Public Health Service Act (42 U.S.C. 300j-3) to facilitate coordination among members of the applicable care team and af- filiated primary care practices; and

(10) where applicable, report to the Sec- retary information on grant or contract measures used under section 399J of the Public Health Service Act.

(d) REQUIREMENT FOR PRIMARY CARE PROVIDERS.—Any provider who contracts with a care team shall—

(1) provide a care plan to the care team for each patient participant;

(2) provide access to participant health records; and

(3) meet regularly with the care team to ensure integration of care.

(e) REPORTING TO SECRETARY.—An entity that receives a grant or contract under subsection (a) shall submit to the Secretary a report that describes and evaluates, as re- quested by the Secretary, the activities car- ried out by the entity under subsection (c).

(f) DEFINITION OF PRIMARY CARE.—In this section, the term “primary care” means the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and prac- ticing in the context of family and commu- nity.

SEC. 3503. MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASE.

Title IX of the Public Health Service Act (42 U.S.C. 299 et seq.), as amended by section 3501, is further amended by inserting after subsection (b) the following:

“SEC. 935. GRANTS OR CONTRACTS TO IMPLE- MENT MEDICATION MANAGEMENT SERVICES IN TREATMENT OF CHRONIC DISEASES.

“(a) IN GENERAL.—The Secretary, acting through the Patient Safety Research Center established under section 399W (referred to in this section as the ‘Center’), shall establish a program to provide grants or contracts to eligi- ble entities to implement medication man- agement (referred to in this section as ‘MTM’ services provided by licensed pharmaci- stics, as a collaborative, multidiscipli- nary, inter-professional approach to the treat- ment of chronic disease targeted individuals, to improve the quality of care and reduce overall cost in the treatment of chronic diseases. The Secretary shall submit a report to Congress on the program under this section not later than May 1, 2010.

“(b) ELIGIBLE ENTITIES.—To be eligible to receive a grant or contract under subsection (a), an entity shall—

“(1) provide a setting appropriate for MTM services, as recommended by the experts de- scribed in subsection (c);

“(2) submit to the Secretary a plan for achieving long-term financial sustainability; and

“(3) where applicable, submit a plan for co- ordinating MTM services through local com- munity health teams established in section 3902 of the Patient Protection and Affordable Care Act or in collaboration with primary care extension programs established in section 399W.

“(c) MTM SERVICES TO TARGETED INDIVID- UALS.—The MTM services referred to in subsection (a) shall be—

“(A) in collaboration with the assistance of a grant or contract awarded under subsection (a) shall, as allowed by State law including applicable collaborative pharmacy practice agreements, include—

“(i) performing or obtaining necessary as- sessments of the health and functional status of each patient receiving such MTM serv- ices;

“(ii) formulating a medication treatment plan according to therapeutic goals agreed...
upon by the prescriber and the patient or caregiver or authorized representative of the patient;

(3) selecting, initiating, modifying, recommending changes to, or administering medication therapy;

(4) monitoring, which may include access to, ordering, or performing laboratory assessments to assess the response of the patient to therapy, including safety and effectiveness;

(5) performing an initial comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events, quarterly targeted medication reviews for ongoing monitoring, and a drug interaction monitoring schedule developed collaboratively with the prescriber;

(6) documenting the care delivered and communicating essential information about such care, including a summary of the medication review, and the recommendations of the pharmacist to other appropriate health care providers of the patient in a timely fashion;

(7) providing education and training designed to enhance the understanding and appropriate medication use by the patient, caregiver, and other authorized representative;

(8) providing information, support services, and strategies designed to enhance patient adherence with therapeutic regimens;

(9) coordinating and integrating MTM services within the broader health care management services provided to the patient; and

(10) such other patient care services allowed under pharmacist scopes of practice in use in other Federal programs that have implemented MTM services.

SEC. 3504. DESIGN AND IMPLEMENTATION OF REGIONALIZED SYSTEMS FOR EMERGENCY CARE.

(a) IN GENERAL.—Title XII of the Public Health Service Act (2 U.S.C. 300d et seq.) is amended—

(1) in section 1203—

(A) in the section heading, by inserting "FOR TRAUMA SYSTEMS" after "GRANTS"; and

(B) in subsection (a), by striking "Administrator of the Health Resources and Services Administration" and inserting "Assistant Secretary for Preparedness and Response";

(2) by inserting after section 1203 the following:

"SEC. 1204. COMPREHENSIVE GRANTS FOR REGIONALIZED SYSTEMS FOR EMERGENCY CARE RESPONSES.

(1) IN GENERAL.—The Assistant 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 pilot projects that design, implement, and evaluate innovative models of regionalized, comprehensive, and accountable emergency care and trauma care, including the following:

(A) improves interfacility decision making by applying key elements of prehospital care, hospital, and interfacility data management systems and the coordination of such tracking with emergency medical dispatch, regional medical direction or transport coordinating bodies, regional communications and hospital databases.

(B) eligible entity: Region.—In this section:

(A) A State or a partnership of 1 or more States, or a similar entity (whether an initial facility or a higher-level facility) in a timely fashion;

(B) such other information as the Secretary may require.

(2) REQUIREMENT OF MATCHING FUNDS.—

(1) IN GENERAL.—The Secretary may not make a grant under this section unless the State (or consortia of States) involved agrees, with respect to the costs to be incurred by the State (or consortia) in carrying out the purpose for which such grant will be made, to make available non-Federal contributions (in cash or in kind under paragraphs (1) and (2) toward such costs in an amount
equal to not less than $1 for each $3 of Federal funds provided in the grant. Such contributions may be made directly or through donations from public or private entities.

(2) AMENDED.—Non-Federal contributions required in paragraph (1) may be in cash or in kind, fairly evaluated, including equipment or services (and excluding any Federal contribution required in paragraph (1)). 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 population in a medically underserved area (as defined in section 330(b)(3)).

(g) Report.—Not later than 90 days after the completion of a pilot project under subsection (a), the recipient of such contract or grant described in paragraph (1) shall submit to the Secretary a report containing the results of an evaluation of the program, including an identification of—

(1) the impact of the regional, accountable emergency care and trauma system on patient health outcomes for various critical care categories, such as trauma, stroke, cardiac emergencies, neurological emergencies, and pediatric emergencies;

(2) the system characteristics that contributed to the efficiency of the program (or lack thereof);

(3) methods of assuring the long-term financial sustainability of the emergency care and trauma system;

(4) the State and local legislation necessary to implement and to maintain the system;

(5) the barriers to developing regionalized, accountable emergency care and trauma systems, as well as the methods to overcome such barriers; and

(6) recommendations on the utilization of available funding for future regionalization efforts.

(h) DISSEMINATION OF FINDINGS.—The Secretary shall, as appropriate, disseminate to the public and to the appropriate Committees of the Congress, the information contained in a report made under subsection (g), and—

(1) the applicable percentages described in subsection (a)(1) if the trauma center qualifies for funds under a Low Income Pool Grant for trauma centers, including by addressing trauma systems, essential personnel and other fixed costs, and expenses associated with uncompensated care grant to a trauma center—

(A) in subsection (a), by striking "appropriate $24,000,000 for each of fiscal years 2010 through 2014."; and

(B) by inserting after subsection (a) the following:

SEC. 498D. SUPPORT FOR EMERGENCY MEDICAL RESEARCH.

(a) EMERGENCY MEDICAL RESEARCH.—The Secretary shall support Federal programs administered by the National Institutes of Health, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and other agencies involved in improving the emergency care and traumatic injury system to expand and accelerate research in emergency medical care systems and emergency medicine, including—

(1) the basic science of emergency medicine;

(2) the model of service delivery and the components of such models that contribute to patient outcomes and enhances patient safety;

(3) the translation of basic scientific research into improved practice; and

(4) the development of timely and efficient delivery of health services;

(b) PEDIATRIC EMERGENCY MEDICAL RESEARCH.—The Secretary shall support Federal programs administered by the National Institutes of Health, the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and other agencies to coordinate and expand research in pediatric emergency medical care systems and pediatric emergency medicine, including—

(1) an examination of the gaps and opportunities in pediatric emergency care research and a strategy for the optimal organization and funding of such research;

(2) the role of pediatric emergency services as an integrated component of the overall health system;

(3) system-wide pediatric emergency care planning, preparedness, coordination, and funding;

(4) pediatric training in professional education; and

(5) research in pediatric emergency care, specifically on the efficacy, safety, and health outcomes of medications used for infants, children, and adolescents in emergency care settings in order to improve patient safety.

(c) IMPACT RESEARCH.—The Secretary shall support research to determine the estimated economic impact of, and savings that result from, disease community or coordinated emergency care systems.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2014.

SEC. 4960. TRAUMA CARE CENTERS AND SERVICE AVAILABILITY.

(a) TRAUMA CARE CENTERS.—

(1) General.—In this section—

(A) TRAUMA CARE CENTERS.—Section 1241 of the Public Health Service Act (42 U.S.C. 300d–41) is amended by striking subsection (a) and inserting the following:

B) by inserting after subsection (a) the following:

(2) MINIMUM QUALIFICATIONS OF TRAUMA CENTERS.—

(1) PARTICIPATION IN TRAUMA CARE SYSTEM OPERATING UNDER CERTAIN PROFESSIONAL GUIDELINES.—Except as provided in paragraph (2), the Secretary may not award a grant to a trauma center under subsection (a) unless the center participates in a trauma system that substantially complies with section 1213.

(2) EXEMPTION.—Paragraph (1) shall not apply to trauma centers that are located in States with no existing trauma care system.

(3) QUALIFICATION FOR SUBSTANTIAL UNCOMPENSATED CARE AWARDS.—The Secretary shall award substantial uncompensated care grants under subsection (a)(1) to trauma centers meeting at least 1 of the criteria in paragraphs (1) and (2) of subsection (b) of section 1213.

(A) CATEGORY A.—The criteria for category A are as follows:

(i) At least 30 percent of the visits in the emergency department of the hospital in which the trauma center is located were charity or self-pay patients.

(ii) At least 50 percent of the visits in such emergency department were Medicaid (under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.)) and charity and self-pay patients combined.

(B) CATEGORY B.—The criteria for category B are as follows:

(i) At least 35 percent of the visits in the emergency department were charity or self-pay patients.

(ii) At least 50 percent of the visits in the emergency department were Medicaid and charity and self-pay patients combined.

(iii) At least 30 percent of the visits in the emergency department were charity or self-pay patients.

(iv) At least 50 percent of the visits in the emergency department were Medicaid and charity and self-pay patients combined.

(v) TRAUMA CENTERS IN 115 WAIVER STATES.—Notwithstanding paragraph (3), the Secretary may award a substantial uncompensated care grant to a trauma center under subsection (a)(1) if the trauma center qualifies for funds under a Low Income Pool Grant for trauma centers through a waiver approved under section 1115 of the Social Security Act (42 U.S.C. 1315).

(vi) DESIGNATION.—The Secretary may not award a grant to a trauma center under subsection (a)(1) unless such trauma center—

(A) submits to the Secretary a plan satisfactory to the Secretary that demonstrates a continued commitment to serving trauma patients regardless of their ability to pay; and

(B) has policies in place to assist patients who cannot pay for part or all of the care they receive, including a sliding fee scale, and to ensure fair billing and collection practices.

(2) CONSIDERATIONS IN MAKING GRANTS.—Section 1242 of the Public Health Service Act (42 U.S.C. 300d–42) is amended by striking subsections (a) and (b) and inserting the following:

(2) SUBSTANTIAL UNCOMPENSATED CARE AWARDS.—

(A) IN GENERAL.—The Secretary shall establish an award basis for each eligible trauma center for grants under section 1241(a)(1) according to the percentage described in paragraph (2), subject to the requirements of section 1241(b)(3).

(B) PECENTAGES.—The applicable percentages are as follows:

(1) With respect to a category A trauma center, 100 percent of the uncompensated care costs to trauma center.

(2) With respect to a category B trauma center, not more than 75 percent of the uncompensated care costs.

(3) With respect to a category C trauma center, not more than 50 percent of the uncompensated care costs.
{(b) CORE MISSION AWARDS.—{(1) IN GENERAL.—In awarding grants under section 1241(a)(2), the Secretary shall—

(A) reserve 25 percent of the amount allocated under paragraphs (1) and (2) of section 1241(b) for Level III and Level IV trauma centers; and

(B) reserve 25 percent of the amount allocated for core mission awards for large urban Level I trauma centers.

(2) Treatment of Requests.—(i) that have at least 1 graduate medical education fellowship in trauma or trauma related specialties for which demand is exceeding supply,

(ii) for which—

(I) annual uncompensated care costs exceed $10,000,000; or

(II) less than 10 percent of emergency department visits are charity or self-pay or Medicaid patients; and

(iii) that are not eligible for substantial uncompensated care awards under section 1241(a)(1).

(3) EMERGENCY AWARDS.—In awarding grants under section 1241(a)(3), the Secretary shall—

(1) give preference to any application submitted by a trauma center that provides trauma care in a geographic area in which the availability of trauma care has significantly decreased or will significantly decrease if the center is forced to close or downsize or if demand for trauma services exceeds capacity; and

(2) reallocate any emergency awards funds not obligated due to insufficient, or lack of applications to the signifi-
cantly decreased or will significantly de-
crease the grant period.

(3) CERTAIN AGREEMENTS.—Section 1243 of the Public Health Service Act (42 U.S.C. 300d–43) is amended by striking subsections (a), (b), and (c) and inserting the following:

(1) IN GENERAL.—In awarding grants under section 1241(a) to provide trauma care services in underserved areas as defined by the State, the Secretary shall—

(A) make available—

(i) 50 percent of such funds for category A trauma center grantees;

(ii) 35 percent of such funds for category B trauma center grantees; and

(iii) 15 percent of such funds for category C trauma center grantees; and

(B) provide available funds within each category in an additional fiscal year.

(4) LIMITATION.—Section 1245 of the Public Health Service Act (42 U.S.C. 300d–45) is amended to read as follows:

SEC. 1245. AUTHORIZATION OF APPROPRIA-
TIONS.

"In this part, the term 'uncompensated care costs' means unreimbursed costs from serving privately insured patients, without regard to payment under section 1923 of the Social Security Act, all of which are attributable to emergency care and trauma care, including costs related to subsequent inpatient admissions to the hospital."

(5) RESTRICTIONS.—The recipient of a grant under subsection (b) shall—

(A) provide trauma care services to trauma center grantees; and

(B) maintain access to trauma services at trauma center grantees.

(6) LIMITATION.—The recipient of a grant under subsection (b) shall—

(A) maintain access to trauma services at trauma center grantees; and

(B) maintain access to trauma services at trauma center grantees.

(7) AUTHORITY.—The recipient of a grant under subsection (b) shall—

(A) maintain access to trauma services at trauma center grantees; and

(B) maintain access to trauma services at trauma center grantees.

(8) LIMITATION.—The recipient of a grant under subsection (b) shall—

(A) maintain access to trauma services at trauma center grantees; and

(B) maintain access to trauma services at trauma center grantees.

(9) AUTHORITY.—The recipient of a grant under subsection (b) shall—

(A) maintain access to trauma services at trauma center grantees; and

(B) maintain access to trauma services at trauma center grantees.

(10) LIMITATION.—The recipient of a grant under subsection (b) shall—

(A) maintain access to trauma services at trauma center grantees; and

(B) maintain access to trauma services at trauma center grantees.

(11) AUTHORITY.—The recipient of a grant under subsection (b) shall—

(A) maintain access to trauma services at trauma center grantees; and

(B) maintain access to trauma services at trauma center grantees.

(12) LIMITATION.—The recipient of a grant under subsection (b) shall—

(A) maintain access to trauma services at trauma center grantees; and

(B) maintain access to trauma services at trauma center grantees.

(13) AUTHORITY.—The recipient of a grant under subsection (b) shall—

(A) maintain access to trauma services at trauma center grantees; and

(B) maintain access to trauma services at trauma center grantees.

(14) LIMITATION.—The recipient of a grant under subsection (b) shall—

(A) maintain access to trauma services at trauma center grantees; and

(B) maintain access to trauma services at trauma center grantees.

(15) AUTHORITY.—The recipient of a grant under subsection (b) shall—

(A) maintain access to trauma services at trauma center grantees; and

(B) maintain access to trauma services at trauma center grantees.

(16) LIMITATION.—The recipient of a grant under subsection (b) shall—

(A) maintain access to trauma services at trauma center grantees; and

(B) maintain access to trauma services at trauma center grantees.

(17) AUTHORITY.—The recipient of a grant under subsection (b) shall—

(A) maintain access to trauma services at trauma center grantees; and

(B) maintain access to trauma services at trauma center grantees.

(18) LIMITATION.—The recipient of a grant under subsection (b) shall—

(A) maintain access to trauma services at trauma center grantees; and

(B) maintain access to trauma services at trauma center grantees.

(19) AUTHORITY.—The recipient of a grant under subsection (b) shall—

(A) maintain access to trauma services at trauma center grantees; and

(B) maintain access to trauma services at trauma center grantees.

(20) LIMITATION.—The recipient of a grant under subsection (b) shall—

(A) maintain access to trauma services at trauma center grantees; and

(B) maintain access to trauma services at trauma center grantees.
“(3) LESS THAN $30,000,000.—If the amount of appropriations for this part in a fiscal year is less than $30,000,000, the Secretary shall divide such funding evenly among only those States that have or more trauma centers eligible for funding under section 1241(b)(3).

“(4) $30,000,000 OR MORE.—If the amount of appropriations for this part in a fiscal year is $30,000,000 or more, the Secretary shall divide such funding evenly among all States.

SEC. 1292. AUTHORIZATION OF APPROPRIATIONS.

“For the purpose of carrying out this part, there is authorized to be appropriated $100,000,000 for each of fiscal years 2010 through 2015.”

SEC. 3506. PROGRAM TO FACILITATE SHARED DECISIONMAKING.

Part D of title IX of the Public Health Service Act, as amended by section 3503, is further amended by adding at the end the following:

“SEC. 3506. PROGRAM TO FACILITATE SHARED DECISIONMAKING.

“(a) PURPOSE.—The purpose of this section is to facilitate collaborative processes between patients, caregivers or authorized representatives, and clinicians that engage the patient, caregiver or authorized representative and other patients, caregivers, authorized representatives, and clinicians that engage the patient, caregiver or authorized representative.

“(b) DEFINITIONS.—In this section:

“(1) PATIENT DECISION AID.—The term ‘patient decision aid’ means an educational tool that helps patients, caregivers or authorized representatives understand and communicate their preferences regarding the treatment options, and to decide with their health care provider what treatments are best for them based on their treatment options.

“(2) PREFERENCE SENSITIVE CARE.—The term ‘preference sensitive care’ means medical care for which the clinical evidence does not clearly support one treatment option over another that the appropriate course of treatment depends on the values of the patient or the preferences of the patient, caregiver or authorized representatives regarding the benefits, harms and scientific evidence for each treatment option, the use of such care should be informed by the preferences of the patient, caregiver or authorized representatives.

“(c) ESTABLISHMENT OF INDEPENDENT STANDARDS FOR DECISION AIDS FOR PREFERENCE SENSITIVE CARE.—

“(1) CONTRACT WITH ENTITY TO ESTABLISH STANDARDS AND CERTIFY PATIENT DECISION AIDS.—

“(A) IN GENERAL.—For purposes of supporting consensus-based standards for patient decision aids for preference sensitive care, the Secretary shall enter into contracts with entities, including the National Academies of Sciences, Engineering, and Medicine, to establish and identify consensus-based standards to evaluate patient decision aids for preference sensitive care.

“(B) ENDORSE PATIENT DECISION AIDS.—The Secretary shall enter into contracts with entities to provide guidance to providers and to develop and disseminate best practices and other information to support and accelerate adoption, implementation, and effective use of patient decision aids and shared decisionmaking by providers.

“(C) PERIOD OF CONTRACT.—A contract shall be in effect for a period of five years.

“(2) REVIEW AND CONSULTATION.—In making the determination under subsection (a), the Secretary shall consider the following:

“(A) Grant application summaries of the benefits and risks of preference sensitive care.

“(B) Grant application summaries of the benefits and risks of preference sensitive care.

“(C) shall, where appropriate, explain why

“(D) Shared decisionmaking participation grants.

“(1) IN GENERAL.—The Secretary shall provide grants to eligible entities to support the development and implementation of shared decisionmaking techniques and to assess the use of such techniques.

“(2) REQUIREMENTS FOR PATIENT DECISION AIDS.—Patient decision aids developed and produced pursuant to a grant or contract under paragraph (1) shall:

“(A) be designed to engage patients, caregivers, and authorized representatives in informed decisionmaking with health care providers.

“(B) present evidence and make recommendations concerning the relative safety, relative effectiveness (including possible trade-offs on functional outcomes, status), and relative cost of treatment or, where appropriate, palliative care options.

“(C) to educate providers on the use of such materials, including through academic curricula.

“(D) Requirements for patient decision aids.

“(1) IN GENERAL.—The Secretary shall ensure that the activities under this section are intended to facilitate collaborative processes between patients, caregivers, and authorized representatives.

“(2) GUIDANCE.—The Secretary may issue guidance to eligible grantees under this subsection on the use of patient decision aids.

“(3) Shared decisionmaking participation grants.

“(a) IN GENERAL.—The Secretary shall provide grants to eligible entities to support the development and implementation of shared decisionmaking techniques and to assess the use of such techniques.

“(b) Funding.—For purposes of carrying out this section there are authorized to be appropriated such sums as may be necessary for fiscal year 2010 and each subsequent fiscal year.

SEC. 3507. PRESENTATION OF PRESCRIPTION DRUG BENEFIT AND RISK INFORMATION.

“(a) IN GENERAL.—The Secretary of Health and Human Services shall ensure that prescription drug benefit and risk information is presented in a standardized format that is consistent with the following:

“(1) Display of quantitative summaries of the benefits and risks of prescription drugs in a standardized format (such as a table or drug facts box) to the promotion of labeling or print advertising of such drugs would promote health care decision-making by clinicians and patients and consumers.

“(b) REVIEW AND CONSULTATION.—In making the determination under subsection (a), the Secretary shall ensure that the information is presented in a standardized format and that such information is relevant to the needs of consumers and diverse levels of health literacy.

“(c) Appropriate use of patient decision aids.

“(1) Grant application summaries of the benefits and risks of preference sensitive care.

“(2) Grant application summaries of the benefits and risks of preference sensitive care.

“(3) Grant application summaries of the benefits and risks of preference sensitive care.

“(d) Funding.—For purposes of carrying out this section there are authorized to be appropriated such sums as may be necessary for fiscal year 2010 and each subsequent fiscal year.

SEC. 3507. PRESENTATION OF PRESCRIPTION
and risks of prescription drugs in a standardized format (such as a table or drug facts box) to the promotional labeling or print advertising of such drugs would improve health care decision-making by clinicians and patients and consumers, then the Secretary, not later than 3 years after the date of submission of the report under subsection (c), shall promulgate proposed regulations as necessary to implement such format.

(e) Clarification.—Nothing in this section shall be construed to restrict the existing authorities of the Secretary with respect to benefit and risk information.

SEC. 3508. DEMONSTRATION PROGRAM TO INTEGRATE HEALTH IMPROVEMENT AND PATIENT SAFETY TRAINING INTO CLINICAL EDUCATION OF HEALTH PROFESSIONALS.

(a) In General.—The Secretary may award grants to eligible entities or consortia under this section to carry out demonstration projects to develop and implement academic curricula that integrates quality improvement and patient safety in the clinical education of health professionals. Such awards shall be made on a competitive basis and pursuant to peer review.

(b) Eligibility.—To be eligible to receive a grant under subsection (a), an entity or consortium—

(1) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

(2) be or include—

(A) a health professions school;

(B) a school of public health;

(C) a school of social work;

(D) a school of nursing;

(E) a school of pharmacy;

(F) an institution with a graduate medical education program;

(G) a school of health care administration;

(3) collaborate in the development of curricula described in subsection (a) with an organization that accredits such school or institution;

(4) provide for the collection of data regarding the effectiveness of the demonstration project; and

(5) provide matching funds in accordance with subsection (c).

(c) Matching Funds.—

(1) In General.—The Secretary may award a grant to an entity or consortium under this section only if the entity or consortium agrees to make available non-Federal contributions toward costs of the project to be funded under the grant in an amount that is not less than $1 for each $5 of Federal funds provided under the grant.

(2) Determination of Amount Contributed.—Non-Federal contributions under paragraph (1) may be in cash or in-kind, fairly evaluated, including 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 contributions.

(d) Evaluation.—The Secretary shall take such action as may be necessary to evaluate the projects under this section, publish, make publicly available, and disseminate the results of such evaluations on a wide basis as is practicable.

(e) Termination.—Not later than 2 years after the date of enactment of this section, and annually thereafter, the Secretary shall submit to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives a report on—

(1) describes the specific projects supported under this section; and

(2) contains recommendations for Congress based on the evaluation conducted under subsection (d).

SEC. 3509. IMPROVING WOMEN’S HEALTH.

(a) Health and Human Services Office on Women’s Health.—

(1) Establishment.—Part A of title II of the Public Health Service Act (42 U.S.C. 202 et seq.) is amended by adding at the end the following:

“SEC. 229. Health and Human Services Office on Women’s Health.—

(a) Establishment of Office.—There is established within the Department of Health and Human Services an Office (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.

(b) Duties.—The Secretary, acting through the Office, with respect to the health concerns of women, shall—

(1) establish short-range and long-range goals and objectives within the Department of Health and Human Services and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Department that relate to disease prevention, health promotion, service delivery, research, care of women, health care professionals, and issues of particular concern to women throughout their lifespans;

(2) provide expert advice and consultation to the Secretary concerning scientific, legal, ethical, and policy issues relating to women’s health;

(3) 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;

(4) 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;

(5) establish a National Women’s Health Information Center to—

(A) facilitate the exchange of information regarding matters relating to health information, health promotion, preventive health services, research advances, and education in the appropriate offices;

(B) facilitate access to such information;

(C) assist in the analysis of issues and problems relating to the matters described in paragraphs (A) and (B); and

(D) provide technical assistance with respect to the exchange of information (including facilitating the development of materials for such technical assistance);

(6) coordinate efforts to promote women’s health programs and policies with the private sector; and

(7) through publications and any other means appropriate, provide for the exchange of information between the Office and recipients of grants, contracts, and agreements under this section, including the Office and health professionals and the general public.

(c) Grants and Contracts Regarding Duties.—

(1) Authority.—In carrying out subsection (b), the Secretary may make grants to, and enter into cooperative agreements, research and development contracts with, Federal, public and private entities, agencies, and organizations, for the purpose of—

(A) carrying out the activities carried out under this section;

(B) disseminating information developed as a result of such projects;

(C) providing technical assistance and training, service delivery, and policy development, for issues of particular concern to women;

(D) identifying projects in women’s health that should be conducted or supported by the Centers;

(2) projects carried out with financial assistance provided under paragraph (1) and for the dissemination of information developed as a result of such projects.

(3) Termination.—Not later than 1 year after the date of enactment of this section, and every second year thereafter, the Secretary shall prepare and submit to the appropriate committees of Congress a report describing the activities carried out under this section during the period for which the report is being prepared.

(d) Authorization of Appropriations.—

For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2019.

(2) Transfer of Functions.—There are transferred to the Office on Women’s Health (established under section 229 of the Public Health Service Act, as added by this section), all functions exercised by the Office on Women’s Health of the Public Health Service prior to the date of enactment of this section, including all personnel and compensation authority, all delegation and assignment authority, and all remaining appropriations. All orders, determinations, rules, regulations, permits, agreements, grants, contracts, certificates, licenses, registrations, privileges, and other administrative actions that—

(A) have been issued, made, granted, or allowed to become effective by the President, any Federal agency or official thereof, or by a court of competent jurisdiction, in the performance of functions transferred under this paragraph; and

(B) are in effect at the time this section takes effect, or were final before the date of enactment of this section, to which such functions are to become effective on or after such date,

shall continue in effect according to their terms until modified, terminated, superseded, or set aside, or revoked in accordance with law by the President, the Secretary, or other authorized official, a court of competent jurisdiction, or by operation of law.

(b) Centers for Disease Control and Prevention 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 director who shall be appointed by the Director of such Centers.

(2) Purpose.—The Director of the Office shall—

“A report to the Director of the Centers for Disease Control and Prevention on the current level of the Centers regarding women’s health conditions across, where appropriate, age, biological, and sociocultural contexts, in all aspects of the Centers’ work, including prevention programs, public and professional education, services, and treatment;

“Establish short-range and long-range goals and objectives within the Centers for women’s health and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Centers that relate to disease prevention, health promotion, service delivery, research, training, service delivery, and policy development, for issues of particular concern to women;

“Identify projects in women’s health that should be conducted or supported by the Centers;
“(d) AUTHORIZATION OF APPROPRIATIONS.—

For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.

(c) OFFICE OF WOMEN’S HEALTH RESEARCH.—Section 480(a) of the Public Health Service Act (42 U.S.C. 256a(a)) is amended by inserting "shall report directly to the Director’’ before the period at the end thereof.

(3) by inserting after paragraph (3), the following:

"(4) OFFICE.—Nothing in this subsection shall be construed as requiring the establishment of the Office of Women’s Health within the National Institutes of Health.".

(4) by inserting after paragraph (4), the following:

"(5) Health Resources and Services Administration Office of Women’s Health.—Title III of the Social Security Act (42 U.S.C. 291 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 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 and, as relevant and appropriate, coordinate with other appropriate offices on activities within the Administration that relate to the identification, training, health service delivery, research, and demonstration projects, for issues of particular concern to women;

(3) identify projects in women’s health that should be conducted 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) AUTHORIZATION OF APPROPRIATIONS.—

For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.

(3) by inserting after paragraph (3), the following:

"(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),

(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 support clinical trials and the 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) AUTHORIZATION OF APPROPRIATIONS.—

For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2014.

(b) NO NEW REGULATORY AUTHORITY.—

Nothing in this section and the amendments made by this section may be construed as establishing regulatory authority or modifying any existing regulatory authority.

(1) LIMITATION ON TERMINATION.—Notwithstanding any other provision of law, a Federal office of women’s health under the Office of Research on Women’s Health of the National Institutes of Health) or Federal apointive position with primary responsibility over women’s health issues (including the Associate Administrator for Women’s health, or with respect to activities carried out through the adoption of a concurrent resolution of approvers.

(2) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to limit the authority of the Secretary of Health and Human Services with respect to activities carried out through the Department of Health and Human Services on the date of enactment of this section.

SEC. 3510. PATIENT NAVIGATOR PROGRAM.

Section 340A of the Public Health Service Act (42 U.S.C. 236a) is amended—
(1) by striking subsection (d)(3) and inserting the following:

"(3) LIMITATIONS ON GRANT PERIOD.—In carrying out this section, the Secretary shall ensure that the total period of a grant does not exceed 4 years.");

(2) in subsection (e), by adding at the end the following:

"(3) MINIMUM CORE PROFICIENCIES.—The Secretary shall not award a grant to an entity under this section unless such entity provides assurances that patient navigators recruited, assigned, trained, or employed using grant funds meet minimum core proficiencies, as defined by the entity that submits the application, that are tailored for the main goal of intervention of the navigator involved."); and

(3) in subsection (m)—

(A) in paragraph (1), by striking "and $3,500,000 for fiscal year 2010." and inserting "$3,500,000 for fiscal year 2010.");

(B) in paragraph (2), by striking "2010" and inserting "2015".

SEC. 3511. AUTHORIZATION OF APPROPRIATIONS.

Except where otherwise provided in this subtitle (or an amendment made by this Act title), there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2011 through 2015.

TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

Subtitle A—Modernizing Disease Prevention and Public Health Systems

SEC. 4001. NATIONAL PREVENTION, HEALTH PROMOTION AND PUBLIC HEALTH COUNCIL

(a) ESTABLISHMENT.—The President shall establish, within the Department of Health and Human Services, a council to be known as the “National Prevention, Health Promotion and Public Health Council” (referred to in this section as the “Council”).

(b) CHAIRPERSON.—The President shall appoint the Surgeon General to serve as the chairperson of the Council.

(c) COMPOSITION.—The Council shall be composed of—

(1) the Secretary of Health and Human Services;
(2) the Secretary of Agriculture;
(3) the Secretary of Education;
(4) the Chairman of the Federal Trade Commission;
(5) the Secretary of Transportation;
(6) the Secretary of Labor;
(7) the Secretary of Homeland Security;
(8) the Administrator of the Environmental Protection Agency;
(9) the Director of the Office of National Drug Control Policy;
(10) the Director of the Domestic Policy Council;
(11) the Assistant Secretary for Indian Affairs;
(12) the Chairperson of the Corporation for National and Community Service; and
(13) the head of any other Federal agency that the chairperson determines is appropriate.

(d) PURPOSES AND DUTIES.—The Council shall—

(1) provide coordination and leadership at the Federal level, and among all Federal departments and agencies, with respect to prevention, wellness and health promotion practices, the public health system, and integrative health care in the United States;

(2) after obtaining input from relevant stakeholders, develop a national prevention, health promotion, public health, and integrative health care strategy that incorporates the most effective and achievable means of improving the health status of Americans and reducing the incidence of preventable illness and disability in the United States;

(3) provide recommendations to the President and agencies for reducing the most pressing health issues confronting the United States and changes in Federal policy to achieve national wellness, health promotion, and health care goals, including the reduction of tobacco use, sedentary behavior, and poor nutrition;

(4) consider and propose evidence-based models, processes, and innovative approaches for the promotion of transformative models of prevention, integrative health, and public health on the national and community levels across the United States;

(5) establish processes for continual public input, including input from State, regional, and local leadership communities and other relevant stakeholders, including Indian tribes and tribal organizations;

(6) submit the reports required under subsection (g); and

(7) carry out other activities determined appropriate by the President.

(e) MEETINGS.—The Council shall meet at the call of the Chairperson.

(f) ADVISORY GROUP.—

(1) IN GENERAL.—The President shall establish an Advisory Council to be known as the “Advisory Group on Prevention, Health Promotion, and Integrative and Public Health” (hereafter referred to in this section as the “Advisory Group”). The Advisory Group shall be within the Department of Health and Human Services and report to the Surgeon General.

(2) COMPOSITION.—

(A) IN GENERAL.—The Advisory Group shall be composed of not more than 25 non-Federal members to be appointed by the President.

(B) REPRESENTATION.—In appointing members under subparagraph (A), the President shall ensure that the Advisory Group includes a diverse group of licensed health professionals, including integrative health practitioners who have expertise in—

(i) worksite health promotion;

(ii) community services, including community health centers;

(iii) preventive medicine;

(iv) health coaching;

(v) public health education;

(vi) geriatrics;

(vii) rehabilitation medicine.

(3) PURPOSES AND DUTIES.—The Advisory Group shall develop policy and program recommendations for the Council on lifestyle-based chronic disease prevention and management, integrative health care practices, and health promotion.

(4) NATIONAL PREVENTION AND HEALTH PROMOTION STRATEGY.—Not later than 1 year after the date of enactment of this Act, the Chairperson, in consultation with the Council, shall develop and make public a national prevention, health promotion and public health strategy, and shall review and revise such strategy periodically. Such strategy shall—

(1) set specific goals and objectives for improving the health of the United States through federally-supported prevention, health promotion, and public health programs, consistent with ongoing goal setting efforts conducted by specific agencies;

(2) establish specific and measurable actions and timelines to carry out the strategy, and determine accountability for meeting those timelines, within and across Federal departments and agencies; and

(3) make recommendations to improve Federal efforts relating to prevention, health promotion, public health, and integrative health care. Such Federal efforts are consistent with available standards and evidence.

(b) FUNDING.—There are hereby authorized to be appropriated—

(1) for fiscal year 2010, $500,000,000;

(2) for fiscal year 2011, $750,000,000;

(3) for fiscal year 2012, $1,000,000,000;

(4) for fiscal year 2013, $1,250,000,000;

(5) for fiscal year 2014, $1,500,000,000; and

(6) for fiscal year 2015, and each fiscal year thereafter, $2,000,000,000.

(c) USE OF FUND.—The Secretary shall transfer amounts in the fund within the Department of Health and Human Services to increase funding, over the fiscal years 2010 through 2015.
year 2008 level, for programs authorized by the Public Health Service Act, for prevention, wellness, and public health activities including prevention research and health screening programs, such as the Community Prevention Services, Education and Outreach Campaign for Preventive Benefits, and immunizations.

(d) TRANSFER AUTHORITY.—The Committee on Appropriations of the Senate and the Committee on Appropriations of the House of Representatives may provide for the transfer of funds in the Fund to eligible activities under this section, subject to subsection (c).

SEC. 4001. CLINICAL AND COMMUNITY PREVENTIVE SERVICES.

(a) PREVENTIVE SERVICES TASK FORCE.—Section 399U of the Public Health Service Act (42 U.S.C. 399b–4) is amended by striking subsection (a) and inserting the following:

"(1) ESTABLISHMENT AND PURPOSE.—The Director shall convene an independent Preventive Services Task Force (referred to in this subsection as the ‘Task Force’) to be composed of individuals with appropriate expertise. Such Task Force shall review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive recommendations, and the services for the purpose of developing recommendations for the health care community, and updating previous recommendations, to be published in the Guide to Clinical Preventive Services (referred to in this section as the ‘Guide’), for individuals and organizations delivering clinical services, including primary care professionals, health care systems, professional societies, employers, community organizations, non-profit organizations, government agencies, governmental public health agencies, health care quality organizations, and organizations developing national health objectives. Such recommendations shall consider clinical preventive best practice recommendations from the Agency for Healthcare Research and Quality, the National Institutes of Health, the Centers for Disease Control and Prevention, the Institute of Medicine, specialty medical associations, patient groups, and scientific societies.

"(2) DUTIES.—The duties of the Task Force shall include—

"(A) the development of additional topic areas for new recommendations and interventions within topic areas, including those related to specific sub-populations and age groups;

"(B) at least once during every 5-year period, identifying and updating clinical preventive recommendations related to existing topic areas, including new or improved techniques to assess the health effects of interventions;

"(C) collaborating with Federal Government health objectives and related target setting for health improvement;

"(D) the enhanced dissemination of recommendations;

"(E) the provision of technical assistance to those health care professionals, agencies and organizations that request help in implementing recommendations; and

"(F) the submission of yearly reports to Congress and related agencies identifying gaps in research, such as preventive services that receive an insufficient evidence statement, and recommending priority areas that deserve further examination, including areas related to populations and age groups not adequately addressed by current recommendations.

"(3) ROLE OF AGENCY.—The Agency shall provide ongoing administrative, research, and technical support for the operation of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force, ensuring adequate staff resources to those organizations requesting it for implementation of Guide recommendations.

"(4) PREVENTIVE SERVICES TASK FORCE.—The Task Force shall take appropriate steps to coordinate its work with the Community Preventive Services Task Force and the Advisory Committee on Immunization Practices, including the examination of how each task force’s recommendations interact at the nexus of clinical and community.

"(5) OPERATION.—In carrying out the duties under paragraph (2), the Task Force is not subject to the provisions of Appendix 2 of title 5, United States Code.

"(6) INDEPENDENCE.—All members of the Task Force convened under this subsection, and any recommendations made by such task force, are independent and, to the extent practicable, not subject to political pressure.

"(7) AUTHORIZATION OF APPROPRIATIONS.—This Act is authorized to be appropriated such sums as may be necessary for each fiscal year to carry out the activities of the Task Force.

(b) COMMUNITY PREVENTIVE SERVICES TASK FORCE.—

"(1) IN GENERAL.—Part P of title III of the Public Health Service Act (as amended by paragraph (2), is amended by adding at the end the following:

"SEC. 399U. COMMUNITY PREVENTIVE SERVICES TASK FORCE.

"(a) ESTABLISHMENT AND PURPOSE.—The Director of the Centers for Disease Control and Prevention shall convene an independent Community Preventive Services Task Force (referred to in this subsection as the ‘Task Force’) to be composed of individuals with appropriate expertise. The Task Force shall review the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of community preventive interventions for the purpose of developing recommendations, to be published in the Guide to Community Preventive Services (referred to in this section as the ‘Guide’), for individuals and organizations delivering population-based services, including primary care professionals, health care systems, professional societies, employers, community organizations, non-profit organizations, schools, governmental public health agencies, Indian tribes, tribal organizations and urban Indian organizations, medical groups, Congress, policy-makers, and others.

"(b) DUTIES.—The duties of the Task Force shall include—

"(1) the development of additional topic areas for new recommendations and interventions related to those topic areas, including those related to specific populations and age groups, including racial, ethnic, economic and physical environments that can have broad effects on the health and disease of populations and health disparities among sub-populations and age groups;

"(2) at least once during every 5-year period, review interventions and update recommendations related to existing topic areas, including new or improved techniques to assess the health effects of interventions, including health impact assessment and population health modeling;

"(3) collaboration with Federal Government health objectives and related target setting for health improvement;

"(4) the enhanced dissemination of recommendations;

"(5) the provision of technical assistance to those health care professionals, agencies, and organizations that request help in implementing the Guide recommendations; and

"(6) providing yearly reports to Congress and related agencies identifying gaps in research, such as preventive services that receive an insufficient evidence statement, and recommending priority areas that deserve further examination, including areas related to populations and age groups not adequately addressed by current recommendations.

"(c) ROLE OF AGENCY.—The Director shall provide ongoing administrative, research, and technical support for the operation of the Task Force, including coordinating and supporting the dissemination of the recommendations of the Task Force, ensuring adequate staff resources to those organizations requesting it for implementation of Guide recommendations.

"(d) TRANSFER AUTHORITY.—The Task Force shall take appropriate steps to coordinate its work with the U.S. Preventive Services Task Force and the Advisory Committee on Immunization Practices, including the examination of how each task force’s recommendations interact at the nexus of clinical and community.

"(e) DUTY.—In carrying out the duties under subsection (b), the Task Force shall not be subject to the provisions of Appendix 2 of title 5, United States Code.

"(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary for each fiscal year to carry out the activities of the Task Force.

(2) TECHNICAL AMENDMENTS.—

(a) Section 399R of the Public Health Service Act (as added by section 2 of the ALS Registry Act (Public Law 110–373; 122 Stat. 4047)) is redesignated as section 399S.

(b) Section 399R of such Act (as added by section 2 of the Preventably Diagnosed Conditions Awareness Act (Public Law 110–374; 122 Stat. 4651)) is redesignated as section 399T.

SEC. 4004. EDUCATION AND OUTREACH CAMPAIGN REGARDING PREVENTIVE BENEFITS.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the ‘Secretary’)) shall provide for the planning and implementation of a national public–private partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the life span. Such campaign shall include the dissemination of information that—

"(1) describes the importance of utilizing preventive services to promote wellness, reduce health disparities, and mitigate chronic disease;

"(2) promotes the use of preventive services recommended by the United States Preventive Services Task Force and the Community Preventive Services Task Force;

"(3) encourages healthy behaviors linked to the prevention of chronic diseases;

"(4) explains the preventive services covered under health plans offered through a Gateway;

"(5) describes additional preventive care supported by the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the Advisory Committee on Immunization Practices, and other appropriate agencies; and

"(6) includes general health promotion information.

(b) CONSULTATION.—In coordinating the campaign under subsection (a), the Secretary shall consult with the Institute of Medicine and other appropriate agencies to provide evidence-based scientific information for policy, program development, and evaluation.
SEC. 4101. SCHOOL-BASED HEALTH CENTERS.

(a) GRANTS FOR THE ESTABLISHMENT OF SCHOOL-BASED HEALTH CENTERS.—

(1) PROGRAM.—The Secretary of Health and Human Services shall establish and implement a national program to support the operation of a Federal Internet website to provide science-based information on guidelines for nutrition, regular exercise, obesity reduction, smoking cessation, and chronic disease prevention. Such website shall be designed to provide information to health care providers and consumers.

(2) USE.—The website developed under paragraph (1) shall be used to provide information that promotes health and disease prevention.

(b) GRANTS FOR THE OPERATION OF SCHOOL-BASED HEALTH CENTERS.—

(1) PROGRAM.—The Secretary shall establish and implement a national program to support the operation of school-based health centers.

(2) USE.—The funds provided under this section shall be used to support the operation of school-based health centers.

(c) MEDIA CAMPAIGN.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish and implement a national science-based media campaign on health promotion and disease prevention.

(2) USE.—The campaign implemented under paragraph (1) shall—

(A) be designed to provide persons with information to health care providers regarding prevention and treatment of disease; and

(B) be carried out through competitively bid contracts awarded to entities providing for the professional production and design of such campaign.

(d) WEBSITE.—The Secretary, in consultation with private-sector experts, shall maintain on the Internet a website personalized prevention plan tool.

(e) DISSEMINATION OF INFORMATION THROUGH PROVIDERS.—The Secretary, acting through the Centers for Disease Control and Prevention, shall develop and implement a plan for the dissemination of information on nutrition, regular exercise, smoking cessation, and chronic disease prevention.

(f) PERSONALIZED PREVENTION PLANS.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish an Internet website personalized prevention planning tool.

(g) USE.—The website developed under paragraph (1) shall be designed to be used as a source of the most up-to-date scientific evidence relative to the health and disease prevention for user by individuals. Such website shall contain a component that enables an individual to determine their disease risk (based on personal health and family history, BMI, and other relevant information) relating to the 5 leading disease killers in the United States, and secondary prevention through disease screening programs.

(h) USE.—The website developed under paragraph (1) shall—

(A) be designed to provide persons with information to health care providers regarding prevention and treatment of disease; and

(B) be carried out through competitively bid contracts awarded to entities providing for the professional production and design of such campaign.

(i) INFORMATION TO ENROLLEES.—Each State shall design a public awareness campaign to educate Medicaid enrollees regarding the availability and coverage of such services, with the goal of reducing incidences of obesity.

(j) REPORT.—Not later than January 1, 2011, and every 3 years thereafter through January 1, 2017, the Secretary of Health and Human Services shall report to Congress on the status and effectiveness of efforts under paragraphs (1) and (2), including summaries of the States’ awareness of coverage of obesity-related services.

(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.
“(B) evidence of local need for the services to be provided by the SBHC;

“(C) an assurance that—

“(i) SBHC services will be provided to those health care providers for whom pa-
rental or guardian consent has been obtained in cooperation with Federal, State, and local
laws governing health care service provision to children and adolescents;

“(ii) the SBHC has made and will continue to
make every reasonable effort to establish and maintain collaborative relationships with
other community providers co-located at the
school and the SBHC;

“(iii) the SBHC will comply with Federal, State,
and local laws concerning patient pri-
vacy and student records, including regu-
lations promulgated under the Health Insur-
ance Portability and Accountability Act of
1996 and section 430 of the General Education
Provisions Act; and

“(D) such other information as the Sec-
retary may require.

“(f) Process and Consideration.—In
reviewing applications:

“(1) The Secretary may give preference to
applicants who demonstrate an ability to
serve the following:

“(A) Communities that have evidenced
barriers to primary health care and mental
health and substance use disorder prevention
services for children and adolescents.

“(B) Communities with high per capita
numbers of children and adolescents who are
uninsured, underinsured, or enrolled in pub-
lic health programs.

“(C) Populations of children and adoles-
cents that have historically demonstrated
difficulty in accessing health and mental
health and substance use disorder prevention
services.

“(2) The Secretary may give consideration
to whether an applicant has received a grant
under section 410A(b) of the Public Health
Protection and Affordable Care Act.

“(e) Waiver of Requirements.—The Sec-
retary may—

“(1) under appropriate circumstances, waive
the application of all or part of the re-
quirements of this subsection with respect to
an SBHC for not to exceed 2 years; and

“(2) for good cause, waive the
requirement that the SBHC provide all
required comprehensive primary health serv-
ices for a designated period of time to be
determined by the Secretary.

“(f) Use of Funds.—

“(1) Funds.—Funds awarded under a grant
under this section—

“(A) may be used for—

“(i) acquiring and leasing equipment (in-
cluding the costs of amortizing the principle
of, and paying interest on, loans for such
equipment);

“(ii) providing training related to the pro-
vision of required comprehensive primary
health services and additional health serv-
ices;

“(iii) the management and operation of
health center programs;

“(iv) the payment of salaries for physici-
nans, nurses, and other personnel of the
SBHC; and

“(B) may not be used to provide abortions.

“(2) Waiver.—The Secretary may give
award grants which may be used to pay the
costs associated with expanding and modern-
izing existing buildings for use as an SBHC, in-
cluding the purchase of many structures and
factored buildings to install on the school
property.

“(3) Limitations.—

“(A) In general.—Any provider of services that
is determined by a State to be in viola-
tion of a State law described in subsection
(a)(3) with respect to the same grant period.

“(B) NO OVERLAPPING GRANT PERIOD.—No
entity that has received funding under sec-
tion 399G for a grant period shall be eligible
for a grant under this section for with re-
spect to the same grant period.

“(g) Matching Requirement.—

“(1) General.—Each eligible entity that
receives a grant under this section shall pro-
fide, from non-Federal sources, an amount
equal to 20 percent of the amount of the
grant (which may be provided in
kind, at the option of the
recipient) to carry out the purposes of the
grant.

“(2) Waiver.—The Secretary may waive all
or part of the matching requirement de-
scribed in paragraph (1) for any fiscal year for
the SBHC if the Secretary determines
that carrying out the matching requirement
for the SBHC would result in serious hardship or
an inability to carry out the purposes of
this section.

“(h) Supplement, Not Supplant.—Grant
funds provided under this section shall be
used to supplement, not supplant, other Fed-
eral or State funds.

“(i) Evaluation.—The Secretary shall de-
vlop and implement a plan for evaluating
SBHCs and monitoring quality performance
under the awards made under this section.

“(j) Age Appropriate Services.—An eligi-
ble entity receiving funds under this section
shall only provide age appropriate services
through a SBHC funded under this section to
an individual.

“(k) Parental Consent.—An eligible
entity receiving funds under this section shall
not provide services through a SBHC funded
under this section to an individual without
the consent of the parent or guardian of such
individual; provided, however, that such consent
shall not be required if the individual is considered
a minor under applicable State law.

“(l) Authorization of Appropriations.—

For purposes of carrying out this section, thereap
appropriated such sums as may be necessary for
each of the fiscal years 2010 through 2014.

SEC. 410Z. ORAL HEALTHCARE PREVENTION
ACT.

“(a) In General.—Title III of the Public
Health Service Act (42 U.S.C. 241 et seq.), as
amended by section 3025, is amended by add-
ing at the end the following:

“PART T—ORAL HEALTHCARE
PREVENTION ACT

“SEC. 399LL. ORAL HEALTHCARE
PREVENTION EDUCATION CAMPAIGN.

“(a) Establishment.—The Secretary, act-
ing through the Director of the Centers for
Disease Control and Prevention and in con-
sultation with professional oral health orga-
nizations, shall, subject to the availability of
appropriations, establish a 5-year national,
public education campaign (referred to in this
section as the ‘campaign’) that is fo-

enced on oral healthcare prevention and edu-
cation, including prevention of oral disease
such as early childhood and other peri-
odontal diseases.

“(b) Requirements.—In establishing the
campaign, the Secretary shall—

“(1) ensure that activities are targeted to-
wards specific populations such as children,
pregnant women, parents, the elderly, indi-
viduals with disabilities, and ethnic and ra-
nial groups; and

“(2) utilize science-based strategies to con-
vey oral health prevention messages that
include, but are not limited to, community
water fluoridation and dental sealants.

“(c) PLANNING AND IMPLEMENTATION.—Not
later than 2 years after the date of enact-
ment of this section, the Secretary shall issue a
request for applications. During the 2-year period referred to in
the previous sentence, the Secretary shall con-
duct planning activities with respect to the
campaign.

“SEC. 399LL-1. RESEARCH-BASED DENTAL
CARES DISEASE MANAGEMENT.

“(a) In General.—The Secretary, acting
through the Director of the Centers for Dis-
ease Control and Prevention, shall award
grant to each of the 50 States and territories
and urban Indian organizations (as
defined in section 4 of the Indian Health
Care Improvement Act) a health sys-
}


tem to fund dental care services for children in
those children and adolescents for whom pa-
sent of the matching requirement de-


to the same grant period.

“SEC. 4102. ORAL HEALTHCARE PREVENTION
ACT.”

“(a) In General.—Title III of the Public
Health Service Act (42 U.S.C. 241 et seq.), as
amended by section 3025, is amended by add-
ing at the end the following:

“PART T—ORAL HEALTHCARE
PREVENTION ACT

“SEC. 399LL. ORAL HEALTHCARE
PREVENTION EDUCATION CAMPAIGN.

“(a) Establishment.—The Secretary, act-
ing through the Director of the Centers for
Disease Control and Prevention and in con-
sultation with professional oral health orga-
nizations, shall, subject to the availability of
appropriations, establish a 5-year national,
public education campaign (referred to in this
section as the ‘campaign’) that is fo-

enced on oral healthcare prevention and edu-
cation, including prevention of oral disease
such as early childhood and other peri-
odontal diseases.

“(b) Requirements.—In establishing the
campaign, the Secretary shall—

“(1) ensure that activities are targeted to-
wards specific populations such as children,
pregnant women, parents, the elderly, indi-
viduals with disabilities, and ethnic and ra-
nial groups; and

“(2) utilize science-based strategies to con-
vey oral health prevention messages that
include, but are not limited to, community
water fluoridation and dental sealants.

“(c) PLANNING AND IMPLEMENTATION.—Not
later than 2 years after the date of enact-
ment of this section, the Secretary shall issue a
request for applications. During the 2-year period referred to in
the previous sentence, the Secretary shall con-
duct planning activities with respect to the
campaign.

“SEC. 399LL-1. RESEARCH-BASED DENTAL
CARES DISEASE MANAGEMENT.

“(a) In General.—The Secretary, acting
through the Director of the Centers for Dis-
ease Control and Prevention, shall award
grant to each of the 50 States and territories
and urban Indian organizations (as
defined in section 4 of the Indian Health
Care Improvement Act) a health sys-
}
Centers for Disease Control and Prevention, shall enter into cooperative agreements with States, territorial, and Indian tribes or tribal organizations (as those terms are defined in section 575 of the Public Health Service Act) to establish oral health leadership and program guidance, oral health data collection and interpretation, (including determines whether oral health among vulnerable populations), a multi-dimensional delivery system for oral health, and to implement science-based programs (including dental sealants and fluoride varnish water fluoridation) to improve oral health.

(2) AUTHORIZATION OF APPROPRIATIONS.—There are appropriated such sums as necessary to carry out this subsection for fiscal years 2010 through 2014.

(d) UPDATING NATIONAL ORAL HEALTH SURVEILLANCE ACTIVITIES.

(1) PRAMS.—

(A) IN GENERAL.—The Secretary of Health and Human Services (referred to in this subsection as the ‘Secretary’) shall carry out activities to update and improve the Pregnancy Risk Assessment Monitoring System (referred to in this section as ‘PRAMS’) as it relates to oral healthcare.

(B) STATE REPORTS AND MANDATORY MEASUREMENTS.—

(i) IN GENERAL.—Not later than 5 years after the date of enactment of this Act, and every 5 years thereafter, a State shall submit to the Secretary a report concerning activities conducted within the State under PRAMS.

(ii) MEASUREMENTS.—The oral healthcare measurements developed by the Secretary for use under PRAMS shall be mandatory to the Secretary a report concerning activities conducted within the State under PRAMS.

(2) NATIONAL HEALTH AND NUTRITION EXAMINATION SURVEY.—The Secretary shall develop oral healthcare components that shall include tooth-level surveillance for inclusion in the National Health and Nutrition Examination Survey. Such components shall be updated by the Secretary at least every 6 years. For purposes of this paragraph, the term ‘tooth-level surveillance’ means a clinical examination where an examiner looks at each dental surface, on each tooth for decay, as defined under subsection (w)(1), and may experiment with the use of person-based or web-based programs that meet the standards established under subparagraph (B); or

(iii) Ensure that health risk assessments—

(1) are accessible to beneficiaries; and

(2) provide appropriate support for the completion of health risk assessments by beneficiaries.

(3) The Secretary shall establish guidelines for interactive telephone or web-based program that meets the standards established under subparagraph (A) and approved by the Secretary may be used to meet the requirement under paragraph (1)(A).

(4) Any health risk assessment that meets the guidelines under subparagraph (A) and is approved by the Secretary may be used to meet the requirement under paragraph (1)(A).

(5) The Secretary may coordinate with community-based entities (including State Health Insurance Programs, Area Agencies on Aging, Aging and Disability Resource Centers, and the Administration on Aging) to

(i) ensure that health risk assessments are accessible to beneficiaries; and

(ii) provide appropriate support for the completion of health risk assessments by beneficiaries.

(6) To the extent practicable, the Secretary shall encourage the use of, integration with, and coordination of health information technology (including use of technolo that is compatible with electronic medical records and personal health records) and may experiment with the use of person-based program to aid in the development of appropriate, evidence-based measurement of and adherence to provider recommendations in order to improve the health status of beneficiaries.

(d) PERSONALIZED PREVENTION PLAN SERVICES.

(1) IN GENERAL.—Section 1861(s)(2)(K) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)) is amended by striking ‘subsection (ww)(1)) at any time during the 12-month period after the date that the beneficiary’s coverage begins under part B and shall be eligible to receive personalized prevention plan services under this subsection that the beneficiary has not received such services within the preceding 12-month period.

(2) CONFORMING AMENDMENTS.—Clauses (i) and (ii) of section 1861(s)(2)(K) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)) are each amended by striking ‘subsection (ww)(1)) and inserting ‘section 1861(s)(2)(K)’.

(b) PERSONALIZED PREVENTION PLAN SERVICES DEFINED.—Section 1861(s)(2)(K) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)) is amended by adding at the end the following new subsection:

‘Annual Wellness Visit

(hhh)(1) The term ‘personalized prevention plan services’ means the creation of a plan for an individual—

(1) that is completed prior to or as part of the visit that the individual that is completed prior to or as part of the visit that the individual

(ii) takes into account the results of the health risk assessment (that meets the guidelines established by the Secretary under paragraph (4)(A)) of the individual that is completed prior to or as part of the visit that the individual

(iii) may be furnished—

(A) a physician;

(B) a practitioner described in clause (i) of section 1842(b)(18)(C); or

(C) a nonphysician (including a health educator, registered dietitian, or nutrition professional) or a team of medical professionals, as determined appropriate by the Secretary, under the supervision of a physician.

(3) A physician;
(ii) The Secretary shall establish procedures to make beneficiaries aware of the option to select an initial preventive physical examination or personalized prevention plan services within a period of 12 months after the date that a beneficiary’s coverage begins under part B, which shall include information regarding any relevant differences between the services described in paragraphs (A) and (B) of section 1861(ddd)(3) that are appropriate for the individual and are furnished by an outpatient department of a hospital, and in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population, the amount determined under paragraph (1) of section 1861(ddd)(3) that are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual.)

(2) by inserting at the end the following new subsection: "(1) The term ‘preventive services’ means the following: ‘(A) the screening and preventive services described in subsection (ww)(2) (other than the service described in subparagraph (M) of such subsection).’

(3) by inserting after subparagraph (T), by inserting ‘‘(or’’ (or

(c) CONFORMING AMENDMENTS.—Section 3304(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by section 4105(c)(1), is amended—

(A) the coverage of any preventive service described in subparagraph (A) and (B) of section 1861(ddd)(3) that are appropriate for the individual and, in the case of such services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population, the amount determined under paragraph (1) of section 1861(ddd)(3) that are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual (1) by such Task Force.’’. effective Date.—The amendments made by this section shall apply with respect to items and services furnished on or after January 1, 2011.

SEC. 4106. EVIDENCE-BASED COVERAGE OF PREVENTIVE SERVICES IN MEDICARE.

(a) AUTHORITY TO MODIFY OR ELIMINATE COVERAGE OF CERTAIN PREVENTIVE SERVICES.—Section 1859 of the Social Security Act (42 U.S.C. 1395fmm) is amended by adding at the end the following new subsection:

(3) The term ‘preventive services’ means the following: ‘‘(A) The screening and preventive services described in subsection (ww)(2) (other than the service described in subparagraph (M) of such subsection).’’

(b) CONSTRUCTION.—Nothing in the amendments made by this section shall apply to items and services furnished on or after January 1, 2011.

SEC. 4107. IMPROVING ACCESS TO PREVENTIVE SERVICES FOR ELIGIBLE ADULTS IN MEDICAID.

(a) CLARIFICATION OF INCLUSION OF SERVICES.—Section 1955(a)(3) of the Social Security Act (42 U.S.C. 1396a(a)(3)) is amended to read as follows: ‘‘(13) other diagnostic, screening, preventive, and rehabilitative services, including—

(1) in paragraph (1) (by striking the comma at the end and inserting ‘‘; and’’ and (ii) in paragraph (1) (by striking the comma at the end and inserting ‘‘; and’’ and (iii) by inserting after subparagraph (H) the following new subparagraph:

(4) Waiver of Application of Deductible.—The first sentence of section 1861(hhh)(1) is amended by striking ‘‘and diagnostic mammography’’ and inserting ‘‘, diagnostic mammography, or personalized prevention plan services (as defined in section 1861(hhh)(1)) is amended by striking ‘‘and diagnostic mammography’’ and inserting ‘‘, diagnostic mammography, or personalized prevention plan services (as defined in section 1861(hhh)(1)) by inserting ‘‘(2)(FF) (including administration of the health risk assessment),’’ after ‘‘(2)(EE),’’.


(1) in subparagraph (F), by striking ‘‘and’’ before ‘‘(9)’’; and (2) by adding at the end the following new subparagraph: ‘‘(I) in clause (i), by inserting ‘‘(if such subparagraph were applied, by substituting ‘100 percent’ for ‘80 percent’’’; and (II) in clause (ii), by striking ‘‘80 percent’’ and inserting ‘‘100 percent’’; and

(3) by inserting before the semicolon at the end the following: ‘‘, and (Y) with respect to preventive services described in subparagraph (A), are recommended with a grade of A or B by the United States Preventive Services Task Force for any indication or population and are appropriate for the individual (1) by such Task Force.’’. effective Date.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2011.

SEC. 4108. removing barriers to PREVENTIVE SERVICES IN MEDICARE.

(a) Definition of Preventive Services.—Section 1905(a)(13) of the Social Security Act (42 U.S.C. 1396d(a)(13)) is amended to—

(1) in the heading, by inserting ‘‘; Preventive services’’ after ‘‘; treatment services under title XVIII of the Social Security Act.’’

(b) Construction.—Nothing in the amendments made by this section shall apply to items and services furnished on or after January 1, 2011.
“(B) with respect to an adult individual, approved vaccines recommended by the Advisory Committee on Immunization Practices (an advisory committee established by the Secretary through the Board of Directors of the Centers for Disease Control and Prevention) and their administration; and

(C) any medical or remedial services (provided by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of functional ability); and

(ii) is authorized to receive payment for tobacco use that is furnished—

(A) by or under the supervision of a physician;

(B) by any other health care professional who—

(1) is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished; and

(2) to the extent practicable, establish and validate clinical criteria based, widely available, and easily accessible to Medicaid beneficiaries.

(3) Such term shall not include coverage for drugs or services described in subparagraph (B) if prescribed for purposes of promotional, or other tobacco use that is furnished to or by pregnant women who use tobacco products or who are being treated for tobacco use that is furnished by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of functional ability; and

(ii) is authorized to receive payment for tobacco use that is furnished—

(A) by or under the supervision of a physician;

(B) by any other health care professional who—

(1) is legally authorized to furnish such services under State law (or the State regulatory mechanism provided by State law) of the State in which the services are furnished; and

(2) to the extent practicable, establish and validate clinical criteria based, widely available, and easily accessible to Medicaid beneficiaries.
(1) IN GENERAL.—The Secretary of Health and Human Services (referred to in this section as the "Director"), acting through the Director of the Centers for Disease Control and Prevention (referred to in this section as the "Director"), shall award competitive grants to State government agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community prevention programs in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence base of effective prevention programming.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

(1) be—

(A) a State governmental agency;
(B) a local governmental agency;
(C) a national network of community-based organizations;
(D) a State or local non-profit organization; or
(E) an Indian tribe; and
(2) submit to the Director an application at such time, in such a manner, and containing such information as the Director may require, including a description of the program to be carried out under the grant.

(c) REQUIREMENTS.—The application submitted under paragraph (2) shall—

(A) describe the community or communities that will benefit from the program; and
(B) demonstrate a capability for implementing the program.

(d) USE OF FUNDS.—(1) IN GENERAL.—An eligible entity shall use amounts received under a grant under this section to carry out programs described in this section.

(2) USES.—The amount received under a grant under this section may be used for the purposes of providing (A) a State governmental agency; (B) a local governmental agency; (C) a national network of community-based organizations; (D) a State or local non-profit organization; or (E) an Indian tribe; and (2) submit to the Director an application at such time, in such a manner, and containing such information as the Director may require, including a description of the program to be carried out under the grant.

(3) demonstrate a capability for implementing the program.

(e) NO EFFECT ON ELIGIBILITY FOR, OR AMOUNT OF, MEDICAID OR OTHER BENEFITS.—Any incentives provided to a Medicaid beneficiary participating in a program described in subsection (a)(3) shall not be taken into account for purposes of determining the beneficiary’s eligibility for, or amount of, benefits under the Medicaid program or any program funded in whole or in part with Federal funds.

(f) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated for the 5-year period beginning on January 1, 2011, $100,000,000, to the Secretary to carry out this section. Amounts appropriated under this subsection shall remain available until expended.

(g) DEFINITIONS.—In this section:

(1) MEDICAID BENEFICIARY.—The term "Medicaid beneficiary" means an individual who is eligible for medical assistance under a State plan or waiver under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) and is enrolled in such plan or waiver.

(2) STATE.—The term "State" has the meaning provided in title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).
provide public health community interventions, screenings, and where necessary, clinical referrals for individuals who are between 55 and 64 years of age.

(2) GRANTEES.—An entity eligible to receive a grant under paragraph (1), an entity shall—

(A) be—

(i) a State health department;

(ii) a local health agency; or

(iii) an Indian tribe;

(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require including a description of the program to be carried out under the grant;

(C) develop a strategy for improving the health of the 55-to-64-year-old population through community-based public health interventions; and

(D) receive the capacity, if funded, to develop the relationships necessary with relevant health agencies, health care providers, community-based organizations, and insurers to carry out the activities described in paragraph (3), such relationships to include the identification of a community-based clinical partner, such as a community health center or rural health clinic.

(3) USE OF FUNDS.—

(A) IN GENERAL.—A State or local health department shall use amounts received under a grant under this subsection to carry out a program to provide the services described in this paragraph to individuals who are between 55 and 64 years of age.

(B) PUBLICATION.—

(i) IN GENERAL.—In developing and implementing such activities, a grantee shall collaborate with the Centers for Disease Control and Prevention and the Administration on Aging, and relevant local agencies and organizations.

(ii) TYPES OF INTERVENTION ACTIVITIES.—

Intervention activities conducted under this subparagraph may include efforts to improve nutrition, increase physical activity, reduce tobacco use and substance abuse, improve mental health, and promote healthy lifestyles among the target population.

(C) COMMUNITY PREVENTIVE SCREENINGS.

(i) IN GENERAL.—In addition to community-wide public health interventions, a State or local health department shall use amounts received under a grant under this subsection to conduct screenings to identify risk factors for cardiovascular disease, cancer, stroke, and diabetes among individuals living in rural areas who are between 55 and 64 years of age.

(ii) TYPES OF SCREENING ACTIVITIES.—

Screening activities conducted under this subparagraph may include—

(I) mental health/behavioral health and substance use disorders;

(II) physical activity, smoking, and nutrition;

(III) any other measures deemed appropriate by the Secretary.

(iii) MONITORING.—Grantees under this section shall, in consultation with the Centers for Disease Control and Prevention, establish the baseline data for monitoring the targeted population.

(D) CLINICAL REFERRAL/TREATMENT FOR CHRONIC DISEASES.—

(i) IN GENERAL.—A State or local health department shall use amounts received under a grant under this subsection to ensure that individuals between 55 and 64 years of age who are found to have chronic disease risk factors through the screening activities described in paragraph (C) receive clinical referral/treatment for follow-up services to reduce such risk.

(ii) MECHANISM.—

(1) CRITERION AND DETERMINATION OF STATUS.—With respect to each individual with risk factors for or having heart disease, stroke, diabetes, or any other condition for which such individual was screened under subparagraph (C), a grantee under this section shall determine whether or not such individual is eligible for a public or private health insurance program.

(ii) INSURED INDIVIDUALS.—An individual determined to be covered under a health insurance program under subclause (I) shall be referred by the grantee to the existing providers under such program or, if such individual does not have a current provider, to a provider the grantee may select to work with respect to the program involved.

(iii) UNINSURED INDIVIDUALS.—With respect to an individual determined to be uninsured under subclause (I), the grantee’s community-based clinical partner described in paragraph (4)(D) shall assist the individual in determining the availability of public coverage options and identify other appropriate programs.

(iii) PUBLIC HEALTH INTERVENTION PROGRAM.—A State or local health department shall use amounts received under a grant under this subsection to carry out a program to provide the program described in this paragraph to individuals who are between 55 and 64 years of age.

(4) PILOT PROGRAM EVALUATION.—The Secretary shall conduct an annual evaluation of the effectiveness of programs under this subsection. In determining such effectiveness, the Secretary shall compare the prevalence of uncontrolled chronic disease risk factors among low-income Medicare enrollees (or individuals nearing enrollment, including those who are 65 and 66 years of age) who reside in States or localities receiving grants under this section as compared with national and historical data for those States and localities for the same population.

(5) AUTHORIZATION OF APPROPRIATIONS.—

There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for each of fiscal years 2010 through 2014.

(b) EVALUATION AND PLAN FOR COMMUNITY-BASED PREVENTION AND WELLNESS PROGRAMS FOR MEDICARE BENEFICIARIES.

(1) IN GENERAL.—The Secretary shall conduct an evaluation of community-based prevention and wellness programs and develop a plan for promoting healthy lifestyles and chronic disease self-management for Medicare beneficiaries.

(2) MEDICARE EVALUATION AND PREVENTION AND WELLNESS PROGRAMS FOR MEDICARE BENEFICIARIES.

(A) IN GENERAL.—The Secretary shall evaluate community prevention and wellness programs including those that are sponsored by the Administration on Aging, are evidence-based, and have demonstrated potential to help Medicare beneficiaries (particularly beneficiaries who have attained 65 years of age) reduce their risk of disease, disability, and injury by making healthy lifestyle choices, including exercise, diet, and self-management of chronic diseases.

(B) EVALUATION.—

(i) EVIDENCE REVIEW.—The evaluation required under subparagraph (A) shall consist of the following:

(1) REVIEW AND RATING.—The Secretary shall review relevant scientific literature, best practice guidelines, and resources that are relevant to programs that promote healthy lifestyles and reduce risk factors for the Medicare population.

(ii) PHYSICAL ACTIVITY, NUTRITION, AND OBESITY.

(iii) CHRONIC DISEASE SELF-MANAGEMENT.

(iv) MENTAL HEALTH.

(i) INDEPENDENT EVALUATION OF EVIDENCE-BASED COMMUNITY PREVENTION AND WELLNESS PROGRAMS FOR MEDICARE BENEFICIARIES.—The Administration on Aging, in consultation with the Assistant Secretary for Aging, shall, to the extent feasible and practical, conduct an existing evaluation of community prevention and wellness programs that are sponsored by the Administration on Aging to assess the extent to which Medicare beneficiaries who participate in such programs—

(ii) IMPROVE THEIR ABILITY TO MANAGE THEIR CHRONIC CONDITIONS;

(iii) IMPROVE THEIR UTILIZATION OF HEALTH SERVICES; AND

(iv) MAINTAIN HEALTHY BEHAVIORS.

(3) REPORT.—Not later than September 30, 2013, the Secretary shall submit to Congress a report that includes—

(A) recommendations for such legislation and administrative action as the Secretary determines appropriate to promote healthy lifestyles and chronic disease self-management for Medicare beneficiaries;

(B) any relevant findings relating to the evidence review under paragraph (2)(B)(i); and

(C) the results of the evaluation under paragraph (2)(B)(i).

(4) FUNDING.—For purposes of carrying out this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplemental Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395s), in such proportion as the Secretary determines appropriate, of $800,000 to the Centers for Medicare & Medicaid Services Program Management Account. Amounts transferred under the preceding sentence shall remain available until expended.

(5) ADMINISTRATION.—Chapter 33 of title 42, United States Code shall not apply to the provisions.
rooms, hospitals, and other medical settings. The standards shall ensure that such equipment is accessible to, and usable by, individuals with accessibility needs, and shall allow independent entry to, use of, and exit from the equipment by such individuals to the maximum extent possible.

"(b) Medical Diagnostic Equipment Coverage.—In the case of a State plan that describes the interventions as the Secretary may require, including such manner, and containing such information, or incentives for immunization;

"(c) Review and Amendment.—The Architectural and Transportation Barriers Compliance Board, in consultation with the Commissioner of the Food and Drug Administration, shall periodically review and, as appropriate, amend the standards in accordance with the Administrative Procedure Act (2 U.S.C. 551 et seq.)."

SEC. 4204. IMMUNIZATIONS.

(a) State Authority to Purchase Recommended Vaccines for Adults.—Section 317 of the Public Health Service Act (42 U.S.C. 247b) is amended by adding at the end the following:

"(l) Authority to Purchase Recommended Vaccines for Adults.—

"(1) IN GENERAL.—The Secretary may negotiate and enter into contracts with manufacturers of vaccines for the purchase and delivery of vaccines for adults as provided for under subsection (e).

"(2) State Purchase.—A State may obtain additional quantities of such adult vaccines (subject to amounts specified to the Secretary by the State in advance of negotiations) through the purchase of vaccines from manufacturers authorized by the applicable provider specified by the Secretary under this subsection.

"(b) Demonstration Program to Improve Immunization Coverage.—Section 317 of the Public Health Service Act (42 U.S.C. 247b), as amended by section (a), is further amended by adding at the end the following:

"(m) Demonstration Program to Improve Immunization Coverage.—

"(1) General.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a demonstration program to award grants to States to improve the provision of recommended immunizations for children, adolescents, and adults through the use of evidence-based, population-based interventions for high-risk populations.

"(2) State Plan.—To be eligible for a grant under subsection (a), a State shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a statement of the measures that the State intends to undertake to implement the requirements of this section, and a statement of the measures that the State intends to implement with respect to the use of evidence-based, population-based interventions for high-risk populations.

"(b) Technical Amendments.—Section 403(q)(5)(A) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)(A)) is amended—

"(1) in subitem (i), by inserting at the beginning "except as provided in clause (H)(i)(III),": and

"(2) in subitem (ii), by inserting at the beginning "except as provided in clause (H)(i)(III),":

"(c) Labeling Requirements.—Section 403(q)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)) is amended by adding at the end the following:

"(1) General Requirements for Restaurants and Retail Food Establishments.—

"(A) In General.—The Secretary shall promulgate regulations establishing, in a clear and conspicuous manner—

"(B) A summary of the findings and recommendations by government agencies, deferred in a restaurant or similar retail food establishment that is part of a chain with 20 or more locations doing business under the same name (regardless of the type of ownership of the locations) and offering for sale substantially the same menu items, the restaurant or similar retail food establishment shall disclose the information described in subclauses (ii) and (iii).

"(ii) Information Required to Be Disclosed by Restaurants and Retail Food Establishments.—Except for food described in subclause (vi), in the case of food that is a restaurant menu item that is offered for sale in a restaurant or similar retail food establishment that is part of a chain with 20 or more locations doing business under the same name (regardless of the type of ownership of the locations), and offering for sale substantially the same menu items, the restaurant or similar retail food establishment shall disclose the information described in subclauses (ii) and (iii).

"(D) Rule of Construction Regarding Access to Immunizations.—Nothing in this section (including any amendments made by this Act) shall be construed to contravene children’s access to immunizations.

"(e) GAO Study and Report on Medicare Beneficiary Access to Vaccines.—

"(1) Study.—The Comptroller General of the United States (in this section referred to as the ‘‘Comptroller General’’) shall conduct a study on the adequacy of Medicare beneficiary access to vaccines and on the availability of vaccines covered under such Medicare benefi- ciaries who were 65 years of age or older to access routinely recommended vaccines covered under the prescription drug program under part D of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), and the period since the establishment of such program. Such study shall include the following:

"(A) An analysis and determination of—

"(i) the number of Medicare beneficiaries who were 65 years of age or older who were eligible for a routinely recommended vaccination that was covered under part D; and

"(ii) the number of Medicare beneficiaries who actually received a routinely recommended vaccination that was covered under part D; and

"(B) any barriers to access by such benefi- ciaries to routinely recommended vaccinations that were covered under part D.

"(2) FDA Study.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall conduct a study to determine whether routine vaccination coverage rates among high-risk populations within the State.

"(3) Report.—Not later than June 1, 2011, the Comptroller General shall submit to the appropriate committees of jurisdiction of the House of Representatives and the Senate a report containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

"(3) Funding.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated $1,000,000 for fiscal year 2010 to carry out this subsection.

SEC. 4205. NUTRITION LABELING OF STANDARD MENU ITEMS AT CHAIN RESTAURANTS.

(a) Technical Amendments.—Section 403(q)(5)(A) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)(A)) is amended—

"(1) in subitem (i), by inserting at the begin- ning "except as provided in clause (H)(i)(III),": and

"(2) in subitem (ii), by inserting at the be- ginning "except as provided in clause (H)(i)(III),":

"(b) Labeling Requirements.—Section 403(q)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 343(q)(5)) is amended by adding at the end the following:

"(1) General Requirements for Restaurants and Retail Food Establishments.—

"(A) In General.—The Secretary shall promulgate regulations establishing, in a clear and conspicuous manner—

"(B) A summary of the findings and rec-ommendations by government agencies, de-
enable the public to understand, in the context of a total daily diet, the significance of the nutrition information that is provided on the menu board.

(II) IN GENERAL.—An authorized official of any restaurant or similar retail food establishment and to the consumer upon request, the nutrition information required under clauses (C) and (D) of subparagraph (I); and

(IV) on the menu or menu board, a prominent, clear, and conspicuous statement regarding the availability of the information described in item (III).

(iii) SELF-SERVICE FOOD AND FOOD ON DISPLAY.—Except as provided in subclause (vii), in the case of a vending machine, a list at a readily accessible location in the machine (such as at a salad bar, line, cafeteria line, or similar self-service facility, and for self-service beverages or food that is on display and that is visible to customers, a restaurant or similar retail food establishment shall place adjacent to each food offered a sign that lists calories per displayed food item or per serving.

(iv) REASONABLE BASIS.—For the purposes of this clause, a restaurant or similar retail food establishment shall have a reasonable basis for its nutrient content disclosures, including analyses, surveys, tests, and other reasonable means, as described in section 101.10 of title 21, Code of Federal Regulations (or any successor regulation) or in a related guidance of the Food and Drug Administration.

(v) MENU VARIABILITY AND COMBINATION MEALS.—The Secretary shall establish by regulation standards for determining and disclosing the nutrient content for standard menu items that come in different flavors, varieties, or combinations, but which are listed as a single menu item, such as soft drinks, ice cream, pizza, doughnuts, or children's combination meals, through means determined by the Secretary, including range estimates and other methods.

(vi) ADDITIONAL INFORMATION.—If the Secretary determines that a nutrient, other than a nutrient required under subclause (i)(III), should be disclosed for the purpose of providing information to assist consumers in maintaining healthy dietary practices, the Secretary may require, by regulation, disclosure of the nutrient.

(iv) Nutritional analyses, and other reasonable means, as described in section 101.10 of title 21, Code of Federal Regulations (or any successor regulation) or in a related guidance of the Food and Drug Administration.

(v) Menu variability and combination meals.—The Secretary shall establish by regulation standards for determining and disclosing the nutrient content for standard menu items that come in different flavors, varieties, or combinations, but which are listed as a single menu item, such as soft drinks, ice cream, pizza, doughnuts, or children's combination meals, through means determined by the Secretary, including range estimates and other methods.

(vi) Additional information.—If the Secretary determines that a nutrient, other than a nutrient required under subclause (i)(III), should be disclosed for the purpose of providing information to assist consumers in maintaining healthy dietary practices, the Secretary may require, by regulation, disclosure of the nutrient.

(vii) NONAPPLICABILITY TO CERTAIN FOODS.—

(I) IN GENERAL.—Subclauses (i) through (vi) do not apply to—

(aa) items that are not listed on a menu or menu board (such as condiments and other foods that are not listed on the table or counter for general use);

(bb) daily specials, temporary menu items appearing on the menu for less than 60 days per calendar year, or custom orders; or

(cc) such other food that is part of a customary market test appearing on the menu for less than 90 days under terms and conditions established by the Secretary.

(II) WRITTEN FORM.—Subparagraph (5)(C) shall apply to any regulations promulgated under subclauses (ii)(B) and (vi).

(III) VENDING MACHINES.—

(I) IN GENERAL.—In the case of an article of food sold from a vending machine that—

(aa) is a prospective purchase for examination by the Nutrition Facts Panel before purchasing the article or does not otherwise provide visible nutrition information at the point of purchase; and

(bb) is operated by a person who is engaged in the business of owning or operating 20 or more vending machines, the vending machine operator shall provide a sign indicating to each person who purchases food or the selection button that includes a clear and conspicuous statement disclosing the number of calories contained in the article.

(II) Voluntary provision of nutrition information.—

(A) IN GENERAL.—An authorized official of any restaurant or similar retail food establishment or vending machine operator not subject to the requirements of this clause may elect to provide information in a manner other than that specified by the Secretary by regulation.

(B) REGULATIONS.—In promulgating regulations, the Secretary shall—

(aa) consider standardization of recipes and methods of preparation, reasonable variability in serving size and formulation of menu items, space on menus and menu boards, inadvertent human error, training of food service workers, variations in ingredient contents, and other factors, as the Secretary determines; and

(bb) specify the format and manner of the nutrient content disclosure requirements under this subparagraph.

(II) REPORTING.—The Secretary shall submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a quarterly report that describes the Secretary's progress toward promulgating final regulations under this subparagraph.

(xii) Definition.—In this clause, the term ‘‘menu’’ or ‘‘menu board’’ means the primary written menu of the restaurant or similar retail food establishment in which a consumer makes an order selection.

(c) NATIONAL UNIFORMITY.—Section 403(a)(4) of the Federal Food, Drug, and Cosmetic Act (as amended by section 403(q)(5)(H)(A)) is amended by striking ‘‘except a requirement for nutrition labeling of food which is exempt under subsection (i) or (ii) of section 408(q)(5)(A)’’ and inserting ‘‘except a requirement for nutrition labeling of food which is exempt under subsection (i) or (ii) of section 408(q)(5)(A)’’.

(d) RULE OF CONSTRUCTION.—Nothing in the amendments made by this section shall be construed—

(1) to preempt any provision of State or local law, unless such provision establishes or continues in effect nutrient content disclosure requirements that are no less stringent than the requirements of this section;

(2) to apply to any State or local requirement respecting a statement in the labeling of food that provides for a warning concerning the safety of the food or component of the food; or

(3) except as provided in section 403(q)(5)(H)(A)(iv) of the Federal Food, Drug, and Cosmetic Act (as added by subsection (b)), to apply to any restaurant or similar retail food establishment other than a restaurant or similar retail food establishment described in section 403(q)(5)(H)(A) of such Act.

SEC. 4206. DEMONSTRATION PROJECT CONCERNING INDIVIDUALIZED WELLNESS PLAN.

Section 330 of the Public Health Service Act (42 U.S.C. 245b) is amended by adding at the end the following:

(3) DEMONSTRATION PROGRAM FOR INDIVIDUALIZED WELLNESS PLANS.—

(I) IN GENERAL.—The Secretary shall establish a pilot program to test the impact of providing at-risk populations who utilize community health centers funded under this section an individualized wellness plan that is designed to reduce risk factors for preventable conditions as identified by a comprehensive risk-factor assessment.

(II) AGREEMENTS.—The Secretary shall enter into agreement with not more than 10 community health centers funded under this section to conduct activities under the pilot program under paragraph (1).

(III) WELLNESS PLANS.—

(A) IN GENERAL.—An individualized wellness plan prepared under the pilot program under this subparagraph may include one or more of the following as appropriate to the individual's identified risk factors:

(i) Nutritional counseling.

(ii) A physical activity plan.

(iii) Alcohol and smoking cessation counseling and services.

(iv) Stress management.

(v) Dietary supplements that have health claims approved by the Secretary.

(vi) Compliance assistance provided by a community health center employee.

(B) RISK FACTORS.—Wellness plan risk factors shall include—

(i) weight;

(ii) tobacco and alcohol use;

(iii) exercise rates;

(iv) overweight or obese status; and

(v) blood pressure.

(C) COMPARISONS.—Individualized wellness plans shall make comparisons between the individual's risk factors and a control group of individuals with respect to the risk factors described in subparagraph (B).

(4) AUTHORIZATION OF APPROPRIATIONS.—

There is authorized to be appropriated to carry out this subsection, such sums as may be necessary.

SEC. 4207. REASONABLE BREAK TIME FOR NURSING MOTHERS.

Section 7 of the Fair Labor Standards Act of 1938 (29 U.S.C. 207) is amended by adding at the end the following:

(1) an employee shall provide—

(A) a reasonable break time for an employee to express breast milk for nursing child for 1 year after the child’s birth each time such employee has need to express the milk; and

(B) a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public, which may be used by an employee to express breast milk.

(2) an employer shall not be required to accommodate an employee receiving reasonable break time under paragraph (1) for any work time spent for such purpose.

(3) an employer that employs less than 50 employees shall not be subject to the requirements of this subsection, if such requirements would impose an undue hardship.
by causing the employer significant di-
ficulty or expense when considered in rela-
tion to the size, financial resources, nature, or structure of the employer’s business.

"(4) Nothing in this subsection shall pre-
empt a State law that provides greater pro-
tections to employees than the protections provided for under this subsection.

Subtitle D—Support for Prevention and Public Health Innovation

SEC. 4301. RESEARCH ON OPTIMIZING THE DELIVERY OF PUBLIC HEALTH SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services (referred to in this sec-
tion as the "Secretary"), acting through the Direc-
tor of the Centers for Disease Control and Prevention, shall provide funding for re-
search in the area of public health services and
systems.

(b) REQUIREMENTS OF RESEARCH.—Research
supported under this section shall include—

(1) examining evidence-based practices re-
ating to prevention, with a particular focus on
disparities in health outcomes among races,
ethnicity, sex, primary language, and dis-
ability measures;

(2) developing standards for the measure-
ment of sex, primary language, and dis-
ability status;

(3) developing standards for the collection of
data described in paragraph (1) that, at a mini-
mum—

(i) collects self-reported data by the ap-
licant, recipient, or participant; and

(ii) collects data from a parent or legal
guardian if the applicant, recipient, or par-
ticipant is a minor or legally incapacitated;

(4) survey health care providers and es-

tablish other procedures in order to assess
access to care and treatment for individuals
with disabilities and to identify—

(i) locations where individuals with dis-
abilities access primary, acute (including in-
tensive), and long-term care;

(ii) the number of providers with access-
able facilities and equipment to meet the
needs of the individuals with disabilities,
including medical diagnostic equipment that
meets the standards of the Americans with
Disabilities Act of 1990; and

(iii) the number of employees of health
care providers trained in disability aware-
ness and patient care of individuals with dis-
abilities;

(5) requiring that any reporting require-
ment imposed for purposes of measuring
quality under any ongoing or federally con-
sorted or supported health care or public health
program, activity, or survey includes
requirements for the collection of data on in-
dividuals receiving health care items or serv-
ces under such programs activities by race,
ethnicity, sex, primary language, and dis-
ability status;

(6) DATA MANAGEMENT.—In collecting data
described in paragraph (1), the Secretary,
acting through the National Coordinator for
Health Information Technology shall—

(A) develop national standards for the
management of data collected; and

(B) develop policies and systems for data
management.

(b) DATA SHARING.—The Secretary shall
make the analyses described in (b) available to—

(1) the Office of Minority Health;

(2) the National Center on Minority Health and Health Disparities;

(3) the Agency for Healthcare Research
and Quality;

(4) the Centers for Disease Control and
Prevention;

(5) the Centers for Medicare and Medicaid
Services;

(6) the Indian Health Service and epide-
miology centers funded under the Indian
Health Care Improvement Act;

(7) the Office of Rural Health;

(8) agencies within the Department of
Health and Human Services; and

(9) any other entities as determined
appropriate by the Secretary.

(2) DATA ANALYSIS.—The Secretary shall report data and analyses described in
(a) and (b) through—

(A) public postings on the Internet
websites of the Department of Health and
Human Services; and

(B) any other reporting or dissemination
methods determined appropriate by the
Secretary.

(3) AVAILABLE DATA.—The Secretary
may make data described in (a) and (b) avail-
able for additional research, including

dissemination to other Federal agencies,
non-governmental entities, and the public,
in accordance with any Federal agency’s data
sharing mechanisms determined appropriate
by the Secretary.

(4) LIMITATIONS ON USE OF DATA.—Noth-
ing in this section shall be construed to per-
mit the use of information collected under
this section in a manner that would ad-
versely affect any individual.

(5) PROTECTION AND SHARING OF DATA.—

(a) PROTECTION.—The Secretary shall
ensure through the promulgation of regu-
lations or otherwise that—

(A) all data collected pursuant to sub-
section (a) is protected

(i) under privacy protections that are as
least as broad as those that the Secretary
applies to other health data under the regu-
lations promulgated under section 264(c) of
the Health Insurance Portability and Ac-
countability Act of 1996 (Public Law 104-191;
110 Stat. 2033); and

(ii) from all inappropriate internal use by
any entity that collects, stores, or receives
the data, including use of such data in deter-
mining eligibility for (or continuation of elig-
ibility in) health plans, and from other inap-
propriate uses, as defined by the Secretary;
and
(b) all appropriate information security
 safeguards are used in the collection, anal-
ysis, and sharing of data collected pursuant to
subsection (a).

(2) DATA SHARING.—The Secretary shall
establish procedures for sharing data col-
lected pursuant to subsection (a), measures
relating to such data, and analyses of such
data, with other relevant Federal and State
agencies including the agencies, centers, and
entities within the Department of Health and
Human Services specified in subsection (a).

(3) DATA ON RURAL UNDERSERVED
POPULATIONS.—The Secretary shall ensure
that data collected in this section regarding racial and ethnicity measures are also collected regarding
underserved rural and frontier populations.

(4) AUTHORIZATION OF APPROPRIATIONS.—
For the purpose of carrying out this section,
there are authorized to be appropriated such
sums as may be necessary for each of fiscal
years 2010 through 2014.

(b) REQUIREMENT FOR IMPLEMENTATION.—
Notwithstanding any other provision of this
section, data may not be collected under
this section unless funds are directly appro-
priated for such purpose in an appropriations
Act.

(1) CONSULTATION.—The Secretary shall
consult with the Director of the Office of
Personnel Management, the Secretary of De-
fense, the Director of the Office of
Personnel Management, the Director of the
Bureau of the Census, the Commissioner of Social Security, and the
heads of other relevant Federal agencies in
carrying out this section.

(b) ADDRESSING HEALTH CARE DISPARITIES
IN MEDICAID AND CHIP.—

(1) STANDARDIZED COLLECTION REQUIRE-
MENTS INCLUDED IN STATE PLANS.—

(A) MEDICAID.—Section 1902(a) of the So-
cial Security Act (42 U.S.C. 1396(a)), as
amended by section 2001(d), is amended—

(i) in paragraph (4), by striking “and” at the end;

(ii) in paragraph (7), by striking the pe-
lod after “and”; and

(iii) by inserting after paragraph (7) the
following new paragraph:

"(D) any other demographic data as
deemed appropriate by the Secretary regard-
ing health disparities."

(2) COLLECTION STANDARDS.—In collecting
data described in paragraph (1), the Sec-

tary or designee shall—

(A) use Office of Management and Budget
standards, at a minimum, for race and eth-
nicity measures;

(B) develop standards for the measure-
ment of sex, primary language, and dis-
ability status;

(C) develop standards for the collection of
data described in paragraph (1) that, at a mini-
mum—

(i) collects self-reported data by the ap-
licant, recipient, or participant; and

(ii) collects data from a parent or legal

"offensive elements or content that should not be displayed.
""
Title III of the Public Health Service Act (42 U.S.C. 231 et seq.), by section 3102, is further amended by adding at the end the following:

"PART U—EMPLOYER-BASED WELLNESS PROGRAMS

SEC. 399ML. TECHNICAL ASSISTANCE FOR EMPLOYER-BASED WELLNESS PROGRAMS.

"In order to expand the utilization of evidence-based prevention and health promotion approaches in the workplace, the Director shall—

(1) provide employers (including small, medium, and large employers as determined by the Director) with technical assistance, consultation, tools, and other resources in evaluating such employers' employer-based wellness programs, including—

(A) measuring the participation and methods to increase participation of employees in such programs;

(B) developing standardized measures that assess policy, environmental and systems changes necessary to have a positive health impact on employees' health behaviors, health outcomes, and health care expenditures; and

(C) evaluating such programs as they relate to changes in the health status of employees, the availability of services, the productivity of employees, the rate of workplace injury, and the medical costs incurred by employees; and

(2) build evaluation capacity among workplace staff by training employers on how to evaluate employer-based wellness programs by ensuring evaluation resources, technical assistance, and consultation are available to workplace staff as needed through such mechanisms as web portals, call centers, or other means."

SEC. 4305. ADVANCING RESEARCH AND TREATMENT FOR PAIN CARE MANAGEMENT.

"(a) INSTITUTE OF MEDICINE CONFERENCE ON PAIN.—(1) CONVENING.—Not later than 1 year after funds are appropriated to carry out this section, the Secretary shall convene an Institute of Medicine conference on pain (in this subsection referred to as "the Conference").

(2) PURPOSES.—The purposes of the Conference shall be to—

(A) increase the recognition of pain as a significant public health problem in the United States;

(B) 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 inadequacies in the assessment, diagnosis, treatment, and management of pain;

(C) identify barriers to appropriate pain care;

(D) establish an agenda for action in both the public and private sectors that will reduce barriers and improve the state of pain care research, education, and clinical care in the United States.

(3) OTHER APPROPRIATE ENTITY.—If the Institute of Medicine has convened an agreement under paragraph (1), the Secretary of Health and Human Services may—
enter into such agreement with another appropriate entity.

(4) REPORT.—A report summarizing the Conference’s findings and recommendations shall be submitted to the Congress not later than June 30, 2011.

(5) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this subsection, there is authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 and 2011.

(b) PAIN RESEARCH AT NATIONAL INSTITUTES OF HEALTH.—Section 402A of the Public Health Service Act (42 U.S.C. 294 et seq.) is amended by adding at the end the following:

**SEC. 402A. PAIN RESEARCH.**

(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.

(2) 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 could be undertaken to address the research needs of the NIH, to influence the research agenda of the private sector, or to expand collaborative, cross-cutting research.

(3) CONFERENCE.—The conference established by subsection (a) shall be submitted to the Congress not later than one year after the date of enactment of this subsection, or at such time as the Secretary determines to be appropriate.

(4) PAIN MANAGEMENT.—

(A) develop a summary of advances in pain care research supported or conducted by Federal agencies relevant to the diagnosis, prevention, and treatment of pain and diseases and disorders associated with pain;

(B) identify critical gaps in basic and clinical research on the symptoms and causes of pain;

(C) make recommendations to ensure that the activities of the National Institutes of Health and other Federal agencies are free of unnecessary duplication;

(D) make recommendations on how best to disseminate information on pain care; and

(E) make recommendations on how to expand partnerships between public entities and private entities to expand collaborative, cross-cutting research.

(5) REVIEW.—The Secretary shall review the necessity of the Committee at least once every 2 years.

(c) PAIN CARE EDUCATION AND TRAINING.—Part D of title VII of the Public Health Service Act (42 U.S.C. 294 et seq.) is amended by adding at the end the following new section:

**SEC. 759. PROGRAM FOR EDUCATION AND TRAINING IN PAIN CARE.**

(1) IN GENERAL.—The Secretary may make awards of grants, cooperative agreements, and contracts to health professions schools, hospices, and other public and private entities and private entities and private entities and private entities and private entities to expand collaborative, cross-cutting research.

(2) REVIEW.—The Secretary shall review the necessity of the Committee at least once every 2 years.

(3) CERTAIN TOPICS.—An award may be made under subsection (a) only if the applicant for the award agrees that the program carried out with the award will include information and education on:

(A) recognized means for assessing, diagnosing, treating, and managing pain and related signs and symptoms, including the medically appropriate use of controlled substances;

(B) applicable laws, regulations, rules, and policies on controlled substances, including descriptions of applicable laws, regulations, and policies, or the enforcement thereof, which may create barriers to patient access to appropriate and effective pain care;

(C) interdisciplinry approaches to the delivery of pain care, including delivery through specialized centers providing comprehensive pain care treatment expertise;

(D) cultural, linguistic, literacy, geographic, and other barriers to care in underserved populations; and

(E) recent research developments, and improvements in the provision of pain care.

(4) EVALUATION OF PROGRAMS.—The Secretary shall directly or through grants or cooperative agreements evaluate the effectiveness of programs implemented under subsection (a) in order to determine the effectiveness of such programs on knowledge and practice of pain care.

(5) PAIN CARE DEFINED.—For purposes of this section the term ‘pain care’ means the assessment, diagnosis, treatment, or management of pain regardless of causation or body location.

(6) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out section 759 $25,000,000 for the period of fiscal years 2010 through 2014.

**SEC. 4030. FUNDING FOR CHILDHOOD OBESITY PREVENTION AND RESEARCH ACT.**

**SEC. 4040. FUNDING FOR CHILDHOOD OBESITY PREVENTION AND RESEARCH ACT.**

**SEC. 4045. FUNDING FOR CHILDHOOD OBESITY PREVENTION AND RESEARCH ACT.**

**SEC. 4050. FUNDING FOR CHILDHOOD OBESITY PREVENTION AND RESEARCH ACT.**

**SEC. 4055. FUNDING FOR CHILDHOOD OBESITY PREVENTION AND RESEARCH ACT.**

**SEC. 4402. EFFECTIVENESS OF FEDERAL HEALTH AND WELLNESS INITIATIVES.**

To determine whether existing Federal health and wellness initiatives are effective in achieving their stated goals, the Secretary of Health and Human Services shall—

(1) conduct an evaluation of such programs as they relate to changes in health status of the American public and specifically on the health status of the Federal workforce, including absenteeism of employees, the productivity of employees, the rate of workplace injury, and the medical costs incurred by employees, and health conditions, including obesity, hypertension, and conditions related to smoking and personal, family and other health histories;

(2) increasing the supply of a qualified health care workforce to improve access to and the delivery of health care services for all individuals; and

(3) enhancing health care workforce education and training to improve access to and the delivery of health care services for all individuals.

**SEC. 5002. DEFINITIONS.**

(a) This title.—In this title:

(1) ALLIED HEALTH PROFESSIONAL.—The term ‘allied health professional’ means an allied health professional as defined in section 798b of the Social Security Act (42 U.S.C. 295p(b)) who—

(A) graduated and received an allied health professions degree or certificate from an institution of higher education; and

(B) is employed by Federal, State, local or tribal public health agencies, or in a setting where patients might require health care services, including acute care facilities, ambulatory care facilities, personal residence, and other settings, and who is practicing in health professional shortage areas, medically underserved areas, or medically underserved populations, as recognized by the Secretary of Health and Human Services.

(2) HEALTH CARE CAREER PATHWAY.—The term ‘health care career pathway’ means a
riguous, engaging, and high quality set of courses and services that—
(A) includes an articulated sequence of academic and career courses, including 21st century skills;
(B) is aligned with the needs of healthcare industries in a region or State;
(C) prepares students for entry into the full range of postsecondary education options, including registered apprenticeships, and careers;
(D) provides academic and career counseling in student-to-counselor ratios that allow students to make informed decisions about academic and career options;
(E) meets uniform academic standards, State requirements for secondary school graduation and is aligned with requirements for entry into postsecondary education, and applications practicums;
(F) leads to 2 or more credentials, including—
(i) a secondary school diploma; and
(ii) a postsecondary degree, an apprenticeship or other occupational certification, a certificate, or a license.
(3) INSTITUTION OF HIGHER EDUCATION.—The term 'institute of higher education' has the meaning given in sections 101 and 102 of the Higher Education Act of 1965 (20 U.S.C. 1001 and 1002).
(4) LOCAL INDIVIDUAL , STATE WORKFORCE INVESTMENT BOARD, AND LOCAL WORKFORCE INVESTMENT BOARD.—
(A) LOCAL INDIVIDUAL.—The term 'local individual' has the meaning given that term in section 101 of the Workforce Investment Act of 1998 (29 U.S.C. 2801).
(B) STATE WORKFORCE INVESTMENT BOARD; LOCAL WORKFORCE INVESTMENT BOARD.—The terms 'State workforce investment board' and 'local workforce investment board', refer to a workforce investment board established under section 111 of the Workforce Investment Act of 1998 (29 U.S.C. 2821) and a local workforce investment board established under section 117 of such Act (29 U.S.C. 2832), respectively.
(5) POSTSECONDARY EDUCATION.—The term 'postsecondary education' means—
(A) a 1-year program of instruction, or not less than a 1-year program of instruction that is acceptable for credit toward an associate or a baccalaureate degree, offered by an institution of education;
(B) a certificate or registered apprenticeship program at the postsecondary level that combines technical and theoretical training through structure on the job learning with related instruction (in a classroom or through distance learning) when an individual is employed, working under the direction of qualified personnel or a mentor, and earning incremental wage increases aligned to on-the-job, resulting in the acquisition of a nationally recognized and portable certificate, under a plan approved by the Office of Apprenticeship or a State agency recognized by the Department of Labor.
(b) TITLE VII OF THE PUBLIC HEALTH SERVICE ACT.—Section 799B of the Public Health Service Act (42 U.S.C. 283b) is amended—
(1) by striking paragraph (3) and inserting the following:
"(3) PARAPROFESSIONAL AND CHILD AND ADOLESCENT MENTAL HEALTH WORKER.—The term 'paraprofessional and adolescent mental health worker' means an individual who is not a mental or behavioral health service professional, but who works at the first steps of contact with children and families who are seeking mental or behavioral health services, including substance abuse prevention and treatment services.
(25) RACIAL AND ETHNIC MINORITY GROUP ; RURAL AND ETHNIC MINORITY POPULATION.—The terms 'racial and ethnic minority group' and 'rural and ethnic minority population' have the meaning given the term 'racial and ethnic minority group' in section 1707.
(26) RURAL HEALTH CLINIC.—The term 'rural health clinic' has the meaning given that term in section 201(aa) of the Social Security Act (42 U.S.C. 1395aa).
(d) TITLE VIII OF THE PUBLIC HEALTH SERVICE ACT.—Section 801 of the Public Health Service Act (42 U.S.C. 284) is amended—
(1) by striking ''(3)'' before paragraph (B) and inserting in lieu thereof paragraph (B); and
(2) by adding at the end the following:
"(4) directly provides care to patients with disabilities, including care to patients with disabilities who are women, infants, and children; and
(3) serves as a national resource for Congress, the President, States, and localities; and
(4) develops and commissions evaluations of education and training activities to determine whether the demand for health care workers in any area is being met; and
(5) identifies barriers to improved coordination at the Federal, State, and local levels for the provision of high quality health care services with the supervision of a physician; and
(6) is accredited by the Accreditation Review Commission on Education for the Physical Assistant.''; and
(2) by adding at the end the following:
"(12) AREA HEALTH EDUCATION CENTER.—The term 'area health education center' means a public or nonprofit private organization that has a cooperative agreement or contract in effect with an entity that has responsibility for providing care (a(1) or (a)(2) of section 751, satisfies the requirements in section 751(d)(1), and has one of its principal functions of operating an area health education center. Appropriate organizations may include hospitals, health organizations with accredited primary care training programs, accredited physician assistant educational programs associated with a college or university, and universities or colleges not operating a school of medicine or osteopathic medicine.
(13) AREA HEALTH EDUCATION CENTER PROGRAM.—The term 'area health education center program' means cooperative program consisting of a program of study that has received an award under subsection (a)(1) or (a)(2) of section 751 for the purpose of planning, developing, operating, and evaluating an area health education center. The term 'area health education center' means an area health education center operated by an area health education center program. The terms 'area health education center' and 'area health education center program' are used interchangeably in this section.
(14) CLINICAL SOCIAL WORKER.—The term 'clinical social worker' means a person who has met the meaning given in the term in section 1861(hh)(1) of the Social Security Act (42 U.S.C. 1395x(hh)(1)).
(15) CULTURAL COMPETENCY.—The term 'cultural competency' shall be defined by the Secretary in a manner consistent with section 1707(d)(3).
(16) DIRECT CARE WORKER.—The term 'direct care worker' has the meaning given that term in the 2010 Standard Occupational Classifications of the Department of Labor for Home Health Aides [31–1011], Psychiatric Aides [31–1012], and Personal Care Aides [39–9021].
(17) FEDERALLY QUALIFIED HEALTH CENTER.—The term 'federally qualified health center' has the meaning given that term in section 1861(aa) of the Social Security Act (42 U.S.C. 1395x(aa)).
(18) HEALTH PROFESSIONAL SHORTAGE AREA.—The term 'frontier health professional shortage area' means an area—
(A) with a population density less than 6 persons per square mile within the service area; and
(B) with respect to which the distance or time for the population to access care is excessive.
(19) GRADUATE PSYCHOLOGY.—The term 'graduate psychology' means an accredited program in professional psychology.
(20) HEALTH DISPARITY POPULATION.—The term 'health disparity population' has the meaning given such term in section 903(d)(1).
(21) HEALTH LITERACY.—The term 'health literacy' means the degree to which an individual has the capacity to obtain, communicate, process, and understand health information and services in order to make appropriate health decisions.
(22) MENTAL HEALTH SERVICE PROFESSIONAL.—The term 'mental health service professional' means an individual with a graduate or equivalent degree or license from an accredited institution of higher education in psychiatry, psychology, school psychology, behavioral pediatrics, psychiatric nursing, social work, school social work, substance abuse disorder prevention and treatment, marriage and family counseling, school counseling, or professional counseling.
(23) ONE-STOP DELIVERY SYSTEM CENTER.—The term 'one-stop delivery system center' means a one-stop delivery system described in section 214(e)(3) of the Workforce Investment Act of 1998 (29 U.S.C. 2864(c)).
(24) PARAPROFESSIONAL AND CHILD AND ADOLESCENT MENTAL HEALTH WORKER.—The term 'paraprofessional and adolescent mental health worker' means an individual who is not a mental or behavioral health service professional, but who works at the first steps of contact with children and families who are seeking mental or behavioral health services, including substance abuse prevention and treatment services.
(25) RACIAL AND ETHNIC MINORITY GROUP; RURAL AND ETHNIC MINORITY POPULATION.—The terms 'racial and ethnic minority group' and 'rural and ethnic minority population' have the meaning given the term 'racial and ethnic minority group' in section 1707.
(26) RURAL HEALTH CLINIC.—The term 'rural health clinic' has the meaning given that term in section 201(aa) of the Social Security Act (42 U.S.C. 1395aa).
(27) RURAL AND ETHNIC MINORITY POPULATION.—The term 'rural and ethnic minority population' means a population based upon the needs of rural and ethnic minority group in the United States.
and recommend ways to address such barriers; and
(5) encourages innovations to address population needs, constant changes in technology, and other environmental factors.
(b) Establishment.—There is hereby established the National Health Care Workforce Commission (in this section referred to as the "Commission").

(c) Membership.—

(1) Number and Appointment.—The Commission shall include individuals—

(i) with national recognition for their expertise in health care labor market analysis, including health care workforce analysis; health care finance and economics; health care facility management; health care plans and integrated delivery systems; health care workforce education and training; health care philanthropy; providers of health care services; and other related fields; and

(ii) who will provide a combination of professional perspectives, broad geographic representation, and expertise in health care services and health economics research; representative of universities;

(ii) representatives of consumers;

(vi) employers; and

(VII) the State or local workforce investment boards and institutional educations (which may include elementary and secondary institutions, institutions of higher education, including 2 and 4 year institutions, or registered apprenticeship programs).

(ii) Additional Members.—The remaining membership may include additional representatives from clause (i) and other individuals as determined appropriate by the Comptroller General of the United States.

(C) Majority Non-Providers.—Individuals who are directly involved in health professions education or practice shall not constitute a majority of the membership of the Commission.

(D) Ethical Disclosure.—The Comptroller General shall establish a system for public disclosure of financial holdings of the members of the Commission of financial and other potential conflicts of interest relating to such members. Members of the Commission shall be treated as employees of the Comptroller General of the United States.

(3) Terms.—

(A) in General.—The terms of members of the Commission shall be for 3 years except that the initial terms of members shall be staggered, so as to provide for the successor to a member whose term shall have expired.

(B) Vacancies.—Any member appointed to fill a vacancy arising before the expiration of the term for which the member's predecessor was appointed shall serve only for the remainder of that term. A member may not serve a consecutive term of more than 2 years; provided that no member shall be appointed to serve more than one such term unless the President determines that such member's continued service is necessary to further the purpose of the Commission.

(C) Initial Appointments.—The Comptroller General shall make initial appointments to the Commission not later than September 30, 2010.

(D) Compensation.—While serving on the Commission (including travel time), members 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, for services performed away from home and the member's regular place of business, a member may be allowed travel expenses as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Comptroller General in the same manner as Government physicians may be provided such an allowance by an agency under section 5946 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority.

(E) Officers.—The Comptroller General may designate another member of the Commission as Vice Chairman to serve for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay as a member of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States. In addition, the Commission shall not be treated as employees of the Government Accountability Office for any purpose.

(F) Chairman, Vice Chairman.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member, as Chair and a member as Vice Chair 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 of the Commission to serve as the chair or vice chair for the remainder of that member's term.

(G) Meetings.—The Commission shall meet at the call of the Chairman, but no less than twice a year, and at the call of the Comptroller General. The meetings shall be open to the public to the extent allowed by law.

(3) Specific Topics to be Reviewed.—The topics described in this paragraph include—

(A) current health care workforce supply and distribution, including demographics, supply and demand trends, and demand and supply imbalances during the subsequent 10 and 25 year periods;

(B) health care workforce education and training capacity, including the number of students who have completed education and training, including registered apprenticeships; the number of qualified faculty; the number and location of training sites; and the education and training demands, with projected demands during the subsequent 10 and 25 year periods;

(C) the education loan and grant programs in titles VII and VIII of the Public Health Service Act (42 U.S.C. 229 et seq. and 296 et seq.), and recommendations on whether such programs should become part of the Higher Education Act of 1965 (20 U.S.C. 1001 et seq.);

(D) the implications of new and existing Federal policies which affect the health care workforce, including Medicare and Medicaid graduate medical education policies, titles VII and VIII of the Public Health Service Act (42 U.S.C. 229 et seq. and 296 et seq.), the National Health Service Corps (with recommendations for aligning such programs with national health workforce priorities and goals), and other health care workforce programs, including those supported through the Health Workforce Investment Act of 1998 (29 U.S.C. 2901 et seq.), the Carl D. Perkins Career and Technical Education Act of 2006 (20 U.S.C. 2301 et seq.), the Higher Education Act of 1965 (20 U.S.C. 1001 et seq.), and any other Federal health care workforce programs;

(E) the health care workforce needs of special populations, including underserved rural populations, medically underserved populations, gender specific needs, individuals with disabilities, and geriatric and pediatric populations with recommendations on new and existing Federal policies to meet the needs of these special populations; and

(F) recommendations creating or revising national loan repayment programs and scholarship programs to require low-income, minority medical students to serve in their home communities, as designated as medical underserved communities.

(4) High Priority Areas.—

(A) in General.—The initial high priority topic described in this paragraph include each of the following:

(i) Integrated health care workforce planning that identifies health care professional shortages and surplus, the impact of health care policies across disciplines.

(ii) An analysis of the nature, scopes of practice, and demands for health care workforce in the enhanced information technology and management workplace.

(iii) An analysis of how to align Medicare and Medicaid graduate medical education policies with national health workforce priorities and goals.

(iv) The education and training capacity, projected demands, and integration with the health care delivery system of each of the following:

(I) Nursing workforce capacity at all levels.

(II) Oral health care workforce capacity at all levels.

(III) Mental and behavioral health care workforce capacity at all levels.

(IV) Allied health and public health care workforce capacity at all levels.

(V) Emergency medical service workforce capacity, including the retention and recruitment of the volunteer workforce, at all levels.

(VI) The geographic distribution of health care providers as compared to the identified
health care workforce needs of States and regions.

(B) Future Determinations.—The Commission may require that additional topics be included under subparagraph (A). The appropriate committees of Congress may recommend to the Commission the inclusion of other topics for health care workforce development and special projects.

(5) Grant Program.—The Commission shall—

(a) review implementation progress reports and report to Congress about the State Health Care Workforce Development Grant program established in section 5102;

(b) in collaboration with the Department of Education and other relevant Federal agencies, make recommendations to the fiscal and administrative agent under section 5102(b) for grant recipients under section 5102;

(C) assess the implementation of the grants under such section; and

(D) collect performance and report information, including identified models and best practices, on grants from the fiscal and administrative agent under such section and distribute it to Federal, State, and local governments in health care, including public health and allied health.

(6) Study.—The Commission shall study effective mechanisms for financing education and training for workers in health care, including public health and allied health.

(7) Recommendations.—The Commission shall submit recommendations to Congress, the Department of Labor, and the Department of Health and Human Services about improving safety, health, and worker protections in the workplace for the health care workforce.

(8) Assessment.—The Commission shall assess and receive reports from the National Center for Health Care Workforce Analysis established under section 752(b) of the Public Service Health Act (as amended by section 5103).

(c) Consultation with Federal, State, and Local Agencies, Congress, and Other Organizations.—

(1) In General.—The Commission shall consult with Federal agencies (including the Department of Education, Labor, Education, Commerce, Agriculture, Defense, and Veterans Affairs and the Environmental Protection Agency), Congress, the Medicare Advisory Commission, the Medicaid and CHIP Payment and Access Commission, and, to the extent practicable, with State and local agencies, Indian tribes, voluntary and mutual health service organizations, professional societies, and other relevant public-private health care partners.

(2) Obtaining Official Data.—The Commission, consistent with established privacy rules, may secure directly from any department or agency of the Executive Branch in connection with the conduct of the Commission's use in making reports and recommendations.

(3) Access of the Government Accountability Office to Information.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and data of the Commission, immediately upon request.

(4) Periodic Audit.—The Commission shall be subject to periodic audit by an independent public accountant under contract to the Commission.

(d) Authorization of Appropriations.—

(1) Request for Appropriations.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General of the United States submits requests for appropriations so appropriated for the Commission shall be separate from amounts appropriated for theComptroller General.

(2) Authorization.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

(e) Gifts and Services.—The Commission may not accept gifts, bequests, or donations of property, but may accept and use donations of services for purposes of carrying out this section.

(1) Definitions.—In this section:

(A) Health care workforce.—The term ‘‘health care workforce’’ includes all health care providers, direct patient care and support responsibilities, such as physicians, nurses, nurse practitioners, primary care providers, preventive medicine physicians, optometrists, ophthalmologists, physician assistants, pharmacists, dentists, dental hygienists, and other oral healthcare professionals, allied health professionals, doctors of chiropractic, community health workers, health care paraprofessionals, direct care workers, psychologists and other behavioral and mental health professionals (including substance abuse prevention and treatment providers), social workers, physical and occupational therapists, public health professionals, clinical pharmacist, and alternative medicine providers.

(B) State Health Care Workforce Investment Area grant program.—The term ‘‘State Health Care Workforce Investment Area grant program’’ means the comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the State and local levels.

(2) Eligibility.—To be eligible to receive a planning grant, an entity shall be an eligible organization.

(A) Definition.—The term ‘‘eligible organization’’ means an entity that shall be a State workforce investment board, if it includes or modifies the members to include at least one representative from each of the following: health care employers, labor organizations, health care service organizations, public 2-year institution of higher education, public 4-year institution of

United States Code, governing appointments in the competitive service);

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the performance of the Commission's duties; (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

(4) make advance, progress, and other payments which relate to the work of the Commission;

(5) provide transportation and subsistence for persons serving without reimbursement; and

(6) prescribe such rules and regulations as the Commission determines to be necessary with respect to the organization and operation of the Commission.

(g) Powers.—

(1) Data Collection.—In order to carry out its functions under this section, the Commission shall—

(A) utilize existing information, both published and unpublished, where possible, collected and maintained by the Federal, State, and local governments in health care, including public health and allied health.

(B) carry out, or award grants or contracts for the carrying out of, original research and development, where existing information is inadequate, and

(C) adopt procedures allowing interested parties to submit information for the Commission’s use in making reports and recommendations.

(2) Access of the Government Accountability Office to Information.—The Comptroller General of the United States shall have unrestricted access to all deliberations, records, and data of the Commission, immediately upon request.

(3) Periodic Audit.—The Commission shall be subject to periodic audit by an independent public accountant under contract to the Commission.

(h) Authorization of Appropriations.—

(1) Request for Appropriations.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General of the United States submits requests for appropriations so appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

(2) Authorization.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

(i) Gifts and Services.—The Commission may not accept gifts, bequests, or donations of property, but may accept and use donations of services for purposes of carrying out this section.

(1) Definitions.—In this section:

(A) Health care workforce.—The term ‘‘health care workforce’’ includes all health care providers, direct patient care and support responsibilities, such as physicians, nurses, nurse practitioners, primary care providers, preventive medicine physicians, optometrists, ophthalmologists, physician assistants, pharmacists, dentists, dental hygienists, and other oral healthcare professionals, allied health professionals, doctors of chiropractic, community health workers, health care paraprofessionals, direct care workers, psychologists and other behavioral and mental health professionals (including substance abuse prevention and treatment providers), social workers, physical and occupational therapists, public health professionals, clinical pharmacist, and alternative medicine providers.

(B) State Health Care Workforce Investment Area grant program.—The term ‘‘State Health Care Workforce Investment Area grant program’’ means the comprehensive planning and to carry out activities leading to coherent and comprehensive health care workforce development strategies at the State and local levels.

(2) Eligibility.—To be eligible to receive a planning grant, an entity shall be an eligible organization.

(A) Definition.—The term ‘‘eligible organization’’ means an entity that shall be a State workforce investment board, if it includes or modifies the members to include at least one representative from each of the following: health care employers, labor organizations, health care service organizations, public 2-year institution of higher education, public 4-year institution of

(3) Amount and Duration.—A planning grant shall be awarded under this subsection for a period of not more than one year and the maximum award may not be more than $150,000.

(2) Eligibility.—To be eligible to receive a planning grant, an entity shall be an eligible organization.

(A) Definition.—The term ‘‘eligible organization’’ means an entity that shall be a State workforce investment board, if it includes or modifies the members to include at least one representative from each of the following: health care employers, labor organizations, health care service organizations, public 2-year institution of higher education, public 4-year institution of
higher education, the recognized State fed-
eration of labor, the State public secondary
education agency, the State P-16 or P-20
Council if such a council exists, and a philan-
thropist or other organization that is actively and
reasonably required to be included, such as
in providing learning, mentoring, and work
opportunities to recruit, educate, and train
individuals for, and retain individuals in, ca-
reers in health care and related industries.

(3) FISCAL AND ADMINISTRATIVE AGENT.—The
Governor of the State receiving a plan-
ning grant has the authority to appoint a fis-
cal and administrative agent for the
partnership.

(4) APPLICATION.—Each State partnership
described in subsection (5) shall submit an ap-
plication to the Administrator of the Admin-
istration at such time and in such manner,
and accompanied by such information as the
Administrator determines to be essential to
ensure compliance with the grant program require-
ments.

(5) REQUIRED ACTIVITIES.—A State partner-
ship receiving a planning grant shall carry out the
following:

(A) Analyze State labor market informa-
tion in order to create health care career
pathways for students and adults, including
dislocated workers.

(B) Identify current and projected high de-
demands within the State; and

(C) Describe the academic and health care
industry skill standards for high school
graduation, for entry into postsecondary edu-
cation, and for various credentials and licen-
sure.

(D) Describe State secondary and postsec-
ondary education and training policies, mod-
els, or practices for the health care sector,
including career information and guidance
counseling.

(E) Identify Federal or State policies or rules
that are coherent with the comprehensive health care workforce develop-
ment strategy and barriers and a plan to re-
solve these barriers.

(F) Participate in the Administration’s evalua-
tion and reporting activities.

(6) PERFORMANCE AND EVALUATION.—Before
the State partnership receives a planning grant, the Admin-
istrator of the Administration shall jointly de-
termine the performance benchmarks that
will be established for the purposes of the plann-
ing grant.

(7) MATCH.—Each State partnership receiv-
ing a planning grant shall provide an amount, in cash or in kind, that is not less than 15
percent of the amount of the grant, to carry
out the activities supported by the grant.

(8) REPORT.—The State partnership receiv-
ing a planning grant shall submit a report to the Administra-
tion on the State’s performance of the activities
under the grant, including the use of funds,
including matching funds, to carry out re-
quired activities, and a description of the
progress of the State workforce investment
board in meeting the performance bench-
marks.

(9) AUTHORIZATION FOR APPROPRIATIONS.—The State partnership receiv-
ing an implementation grant under subsection (c), $8,000,000 for fis-
cal year 2009, and such additional
amounts as may be necessary for each subse-
quent fiscal year.
(2) IMPLEMENTATION GRANTS.—There are authorized to be appropriated to award implementation grants under subsection (d), $150,000,000 for fiscal year 2010, and such sums as may be necessary for each subsequent fiscal year.

SEC. 5103. HEALTH WORKFORCE ASSESSMENT.

(a) IN GENERAL.—Section 761 of the Public Health Service Act (42 U.S.C. 294m) is amended—

(1) by redesignating subsection (c) as subsection (e); and

(2) by striking subsection (b) and inserting the following:

"(b) NATIONAL CENTER FOR HEALTH WORKFORCE ANALYSIS.—

"(1) ESTABLISHMENT.—The Secretary shall establish the National Center for Health Workforce Analysis (referred to in this section as the National Center).

"(2) PURPOSES.—The National Center, in coordination to the extent practicable with the National Health Workforce Commission (established in section 5301 of the Patient Protection and Affordable Care Act), and relevant regional and State centers and agencies, shall—

"(A) provide for the development of information describing and analyzing the health care workforce and workforce related issues;

"(B) carry out the activities under section 762(a).

"(c) annually evaluate programs under this title;

"(D) develop and publish performance measures and benchmarks for programs under this title; and

"(E) establish, maintain, and publicize a national Internet registry of each grant awarded under this title and a database to collect data from longitudinal evaluations (as described in subsection (d)(2)) on performance measures (as developed under sections 749(d)(3), 757(d)(3), and 762(a)(3)).

"(3) COLLABORATION AND DATA SHARING.—

"(A) in paragraph (1), by striking "or" at the end;

"(B) in paragraph (2), by striking the period at the end and inserting "; and"

"(3) ELIGIBLE ENTITIES.—To be eligible to obtain an increase under this section, an entity shall—

"(A) by paragraph (1) and inserting the following:

"(1) IN GENERAL.—The National Center—

"(a) MEDICAL SCHOOLS AND PRIMARY HEALTH CARE WORKFORCE.—

"(1) IN GENERAL.—The Secretary shall award grants to, or enter into contracts with, eligible entities for programs under this title;

"(2) CONTRACTS FOR HEALTH WORKFORCE ANALYSIS.—For the purpose of carrying out the activities described in subparagraph (A), the National Center may enter into contracts with, or enter into agreements with, relevant professional and educational organizations or societies for the purpose of linking data regarding grants awarded under this title.

"(b) in paragraph (1), by striking "or" at the end;

"(c) in paragraph (2), by striking the period at the end and inserting "; and"

"(c) STATE AND REGIONAL CENTERS FOR HEALTH WORKFORCE ANALYSIS.—

"(1) MEDICAL SCHOOLS AND PRIMARY HEALTH CARE WORKFORCE.—

"(A) in paragraph (1), by striking "and" at the end;

"(B) in paragraph (2), by striking the period at the end and inserting "; and"

"(2) ELIGIBLE ENTITIES.—To be eligible for a grant or contract under this subsection, an entity shall—

"(A) be a State, a State workforce investment board, a public health or health professions school, an academic health center, or an appropriate public or private nonprofit entity; and

"(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

"(d) INCREASE IN GRANTS FOR LONGITUDINAL EVALUATIONS.—

"(1) IN GENERAL.—The Secretary shall increase the amount awarded to an eligible entity under this title for a longitudinal evaluation of individuals who have received education, training, or financial assistance from programs under this title.

"(2) CAPABILITY.—A longitudinal evaluation shall be capable of—

"(A) studying practice patterns; and

"(B) collecting and reporting data on performance measures developed under sections 749(d)(3), 757(d)(3), and 762(a)(3).

"(3) GUIDELINES FOR LONGITUDINAL EVALUATION.—

"(A) in paragraph (1), by striking paragraph (1) and inserting (1) by paragraph (1) and inserting the following:

"(1) IN GENERAL.—The National Center—

"(a) MEDICAL SCHOOLS AND PRIMARY HEALTH CARE WORKFORCE.—

"(1) in paragraph (1), by striking "or" at the end;

"(b) in paragraph (2), by striking the period at the end and inserting "; and"

"(c) by adding at the end the following:

"(2) develop, publish, and implement performance measures for programs under this title, except for programs under part C or D; and

"(3) recommend appropriation levels for programs under this title, except for programs under part C or D."

Subtitle C—Increasing the Supply of the Health Care Workforce

SEC. 5201. FEDERALLY SUPPORTED STUDENT LOAN FUNDS.

(a) MEDICAL SCHOOLS AND PRIMARY HEALTH CARE WORKFORCE.—

"(1) in paragraph (1), by striking "$2,500" and inserting "$3,300"; and

"(2) in paragraph (2), by striking "$3,000" and inserting "$4,000"; and

"(3) by striking "$13,000" and all that follows "and" at the end of such subsection and inserting "$3,000"; and

"(4) by striking "$6,000" and inserting "$5,000"; and

"(5) by striking "$2,000" and inserting "$1,000"; and

"(6) by striking "$6,000" and inserting "$5,000"; and

"(7) by striking "$13,000" and all that follows "and" at the end of such subsection and inserting "$7,000".

(b) IN GENERAL.—The Secretary—

"(1) in paragraph (1), by striking "and" 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:

"(4) SENSE OF CONGRESS.—It is the sense of Congress that funds repaid under the loan program under this section should not be used for purposes other than to replenish the Treasury of the United States or otherwise used for any other purpose other than to carry out this section."; and

"(b) STUDENT LOAN GUIDELINES.—The Secretary of Health and Human Services shall not require parental financial information for an independent student to determine financial need under section 723 of the Public Health Service Act and the determination of need for such information shall be at the discretion of applicable school loan officer. The Secretary shall amend guidelines issued by the Health Resources and Services Administration in accordance with the preceding sentence.

SEC. 5202. NURSING STUDENT LOAN PROGRAM.

(a) LOAN AGREEMENTS.—Section 896(a) of the Public Health Service Act (42 U.S.C. 297b(a)) is amended—

"(1) by striking "$2,500" and inserting "$3,300"; and

"(2) by striking "$4,000" and inserting "$5,000"; and

"(3) by striking "$13,000" and all that follows "and" at the end of such subsection and inserting "$17,000 in the case of any student during fiscal years 2010 and 2011. After fiscal year 2011, such amounts shall be adjusted to provide for the change in the cost-of-attendance for the yearly loan rate and the aggregate of the loan.";
SEC. 5203. HEALTH CARE WORKFORCE LOAN REPAYMENT PROGRAMS.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294q et seq.) is amended by adding at the end the following:

"Subpart 3—Recruitment and Retention Programs

"SEC. 775. INVESTMENT IN TOMORROW'S PEDIATRIC MENTAL HEALTH CARE WORKFORCE.

"(a) ESTABLISHMENT.—The Secretary shall establish and carry out a pediatric specialty loan repayment program under which the eligible individual agrees to be employed full-time for a specified period (which shall not be less than 2 years) in providing pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care, including substance abuse prevention and treatment services.

"(b) PROGRAM ADMINISTRATION.—Through the program established under this section, the Secretary shall enter into contracts with qualified health professionals under which—

"(1) such qualified health professionals will agree to participate in a pediatric medical subspecialty, pediatric surgical specialty, or child and adolescent mental and behavioral health care in an area with a shortage of the specified health professional (as determined by the Secretary), and

"(2) the Secretary agrees to make payments on the principal and interest of underwrite the education loans of professionals described in paragraph (1) that have a remaining balance at the end of the calendar year in which such professionals commit to provide service in the public health workforce.

"(c) CONTRACT.—The written contract (referred to in this section as the 'Program') to assure an adequate public health workforce in areas of—

"(1) are or will be working in a school or other pre-kindergarten, elementary, or secondary educational setting;

"(2) have familiarity with evidence-based methods and cultural and linguistic competence health care services; and

"(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $30,000,000 for each of fiscal years 2010 through 2014 to carry out subsection (c)(1)(A) and $20,000,000 for each of fiscal years 2010 through 2013 to carry out subsection (c)(1)(B).

SEC. 5204. PUBLIC HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAM.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.), as amended by section 5203, is further amended by adding at the end the following:

"SEC. 776. 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') to assure an adequate supply of public health professionals to eliminate critical public health workforce shortages in Federal, State, local, and tribal public health agencies.

"(b) ELIGIBILITY.—To be eligible to participate in the Program under this section (referred to in this section as a 'Participant')—

"(1) must—

"(A) be accepted for enrollment, or be enrolled, as a student in an accredited academic educational institution in a State or territory offering a course of study or program leading to a public health or health professions degree or certificate; and

"(B) have accepted employment with the Federal, State, local, or tribal public health agency, or a related training fellowship, as recognized by the Secretary, to commence upon graduation;

"(c) CONTRACT.—The written contract (referred to in this section as the 'written contract') between the Secretary and an individual shall contain—

"(1) an agreement on the part of the Secretary that the Secretary will repay on behalf of the individual loans incurred by the individual in the pursuit of the relevant degree or certificate in accordance with the terms of the contract;

"(2) an agreement on the part of the individual that the individual will serve in the full-time employment of a Federal, State, local, or tribal public health agency or a related fellowship program in a position related to the course of study or program for which the contract was awarded for a period of time (referred to in this section as the 'period of obligated service') equal to the greater of—

"(A) 3 years; or

"(B) such longer period of time as determined appropriate by the Secretary and the individual;

"(3) an agreement, as appropriate, on the part of the individual to relocate to a shortage area (as determined by the Secretary) in exchange for an additional loan repayment incentive amount to be determined by the Secretary;

"(4) 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 that is conditioned thereon, is contingent on funds being appropriated for loan repayments under this section;

"(d) a statement of the damages to which the United States is entitled, under this section, for each year of obligated service of the individual who—

"(1) is not in compliance with paragraph (2); or

"(2) fails to repay an amount of any loan payments owing to the United States for the lesser of—

"(A) the individual's total obligation to repay the aggregate amount of the loans; or

"(B) the individual's total obligation to repay the aggregate amount of the loans plus 5 percent of the aggregate amount of the loans.

"(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $20,000,000 for each of fiscal years 2010 through 2014 to carry out this section.

"(f) NOT TO AFFECT OTHER SERVICES.—This section is not intended to affect other services provided by the Federal, State, local, or tribal public health agencies for the recruitment, training, or retention of public health professionals.

"SEC. 5205. PROVISION OF TRAINING AND CARE.

"(a) EDUCATION.—For purposes of paragraphs (1) and (3) of section 301(a) of the Higher Education Act of 1965 (20 U.S.C. 1003(a)), the term 'Medical Program' includes—

"(1) a program of instruction for the purpose of training for the practice of medicine in a teaching hospital determined to be of special public interest by the Secretary; and

"(2) an approved program of instruction for the purpose of training for the practice of medicine approved by the Secretary in a teaching hospital determined to be of special public interest by the Secretary.

"SEC. 5206. TRIBAL HEALTH PROFESSIONALS.

"(a) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated $200,000 for each of fiscal years 2010 through 2014 to carry out this section.

"(b) ELIGIBILITY.—To be eligible to receive payments under this section, the individual must—

"(1) be employed by, or have accepted employment with, a Tribal Health Organization (as defined in section 317 of the Public Health Service Act (42 U.S.C. 248b));

"(2) have medical, or any other training, certificate, or degree in—

"(A) dentistry;

"(B) nursing;

"(C) public health;

"(D) allied health professions;

"(3) have served as an enrolled, as a student in an accredited academic educational institution in a State or territory offering a course of study or program leading to a public health or health professions degree or certificate; and

"(d) LIMITATION.—Notwithstanding any other provision of this Act, the Secretary shall not otherwise give priority under this Act to the provision of training or care under subsection (a).
(e) POSTPONING OBLIGATED SERVICE.—With respect to an individual receiving a degree or certificate from a health professions or other related school, the date of the initiation of a period of obligated service may be postponed as approved by the Secretary.

(f) BREACH OF CONTRACT.—An individual who defaults in the performance of obligations under subparagraph (a) shall be subject to the same financial penalties as provided for under section 335E for breaches of loan repayment contracts under section 338B.

(g) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section $195,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015.

SEC. 5208. HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAM.

(a) PURPOSE.—The purpose of this section is to assure an adequate supply of allied health professionals to eliminate critical allied health workforce shortages in Federal, State, local, and tribal public health agencies or in settings where patients may require health care services, including acute care facilities, ambulatory care facilities, personal residences, and other settings recognized by the Secretary of Health and Human Services by authorizing an Allied Health Workforce Recruitment Program.

(b) ALLIED HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAM.—Section 428K of the Higher Education Act of 1965 (20 U.S.C. 1074k) is amended—

(1) in subsection (b), by adding at the end the following:

“(18) ALLIED HEALTH PROFESSIONALS.—The term ‘allied health professional’ means a professional who is employed in public and allied health positions and who is not a health care professional.”

SEC. 5209. FUNDING FOR NATIONAL HEALTH SERVICE CORPS.

Section 338B(a) of the Public Health Service Act (42 U.S.C. 254a) is amended—

(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated—

(1) for fiscal year 2010, $320,461,632.

(2) for fiscal year 2011, $344,955,394.

(3) for fiscal year 2012, $367,442.

(4) for fiscal year 2013, $341,432.

(5) for fiscal year 2014, $393,456,433.

(6) for fiscal year 2015, $1,154,510,336.

(7) for fiscal year 2016, and each subsequent fiscal year, the amount appropriated for the preceding fiscal year adjusted by the product of—

(A) one plus the average percentage increase in the costs of health professions education during the prior fiscal year; and

(B) one plus the average percentage change in the per capita personal income in health professions shortage areas designated under section 333 during the prior fiscal year, relative to the per capita personal income in such areas during the previous fiscal year.

(c) APPLICATION.—In order to receive a grant under this section, an entity shall—

(1) be an NHMC; and

(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(d) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this section, there are authorized to be appropriated $50,000,000 for each fiscal year beginning after fiscal year 2013; and

(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated $20,000,000 for each of fiscal years 2014 through 2017.

SEC. 5210. ESTABLISHING A READY RESERVE CORPS.

Section 203 of the Department of Health and Human Services Appropriations Act, 1993 (Public Law 102-394) is amended by striking “not to exceed 2,000”.

SEC. 5211. ESTABLISHING A READY RESERVE CORPS.

Section 203 of the Public Health Service Act (42 U.S.C. 204) is amended to read as follows:

SEC. 203. COMMISSIONED CORPS AND READY RESERVE CORPS.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There shall be in the service a commissioned Regular Corps and a Ready Reserve Corps for service in time of national emergency.

(2) REQUIREMENT.—All commissioned officers shall be citizens of the United States and shall be appointed without regard to the civil-service laws and compensated without regard to the Classification Act of 1923, as amended.

(b) APPOINTMENT.—Commissioned officers of the Regular Corps shall be appointed by the President and commissioned officers of the Regular Corps shall be appointed by the President with the advice and consent of the Senate.

(4) ACTIVE DUTY.—Commissioned officers of the Ready Reserve Corps shall at all times

SEC. 5208. HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAM.

(a) PURPOSE.—The purpose of this section is to assure an adequate supply of allied health professionals to eliminate critical allied health workforce shortages in Federal, State, local, and tribal public health agencies or in settings where patients may require health care services, including acute care facilities, ambulatory care facilities, personal residences and other settings recognized by the Secretary of Health and Human Services by authorizing an Allied Health Workforce Recruitment Program.

(b) ALLIED HEALTH WORKFORCE RECRUITMENT AND RETENTION PROGRAM.—Section 428K of the Higher Education Act of 1965 (20 U.S.C. 1074k) is amended—

(1) in subsection (b), by adding at the end the following:

“(18) ALLIED HEALTH PROFESSIONALS.—The term ‘allied health professional’ means a professional who is employed in public and allied health positions and who is not a health care professional.”

SEC. 5209. FUNDING FOR NATIONAL HEALTH SERVICE CORPS.

Section 338B(a) of the Public Health Service Act (42 U.S.C. 254a) is amended—

(a) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated—

(1) for fiscal year 2010, $320,461,632.

(2) for fiscal year 2011, $344,955,394.

(3) for fiscal year 2012, $367,442.

(4) for fiscal year 2013, $341,432.

(5) for fiscal year 2014, $393,456,433.

(6) for fiscal year 2015, $1,154,510,336.

(7) for fiscal year 2016, and each subsequent fiscal year, the amount appropriated for the preceding fiscal year adjusted by the product of—

(A) one plus the average percentage increase in the costs of health professions education during the prior fiscal year; and

(B) one plus the average percentage change in the per capita personal income in health professions shortage areas designated under section 333 during the prior fiscal year, relative to the per capita personal income in such areas during the previous fiscal year.

(c) APPLICATION.—In order to receive a grant under this section, an entity shall—

(1) be an NHMC; and

(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(d) AUTHORIZATION OF APPROPRIATIONS.—For purposes of carrying out this section, there are authorized to be appropriated $50,000,000 for each fiscal year beginning after fiscal year 2013; and

(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there is authorized to be appropriated $20,000,000 for each of fiscal years 2014 through 2017.

SEC. 5210. ESTABLISHING A READY RESERVE CORPS.

Section 203 of the Department of Health and Human Services Appropriations Act, 1993 (Public Law 102-394) is amended by striking “not to exceed 2,000”.

SEC. 5211. ESTABLISHING A READY RESERVE CORPS.

Section 203 of the Public Health Service Act (42 U.S.C. 204) is amended to read as follows:

SEC. 203. COMMISSIONED CORPS AND READY RESERVE CORPS.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There shall be in the service a commissioned Regular Corps and a Ready Reserve Corps for service in time of national emergency.

(2) REQUIREMENT.—All commissioned officers shall be citizens of the United States and shall be appointed without regard to the civil-service laws and compensated without regard to the Classification Act of 1923, as amended.

(b) APPOINTMENT.—Commissioned officers of the Regular Corps shall be appointed by the President and commissioned officers of the Regular Corps shall be appointed by the President with the advice and consent of the Senate.

(4) ACTIVE DUTY.—Commissioned officers of the Ready Reserve Corps shall at all times
be subject to call to active duty by the Surgeon General, including active duty for the purpose of training.

"(5) WARRANT OFFICERS.—Warrant officers may be the Secretary in 2010 the purpose of providing support to the health and delivery systems maintained by the Service and any warrant officer appointed to the Service shall be deemed to be commissioned officers of the Commissioned Corps.

"(b) FUNDING.—The Secretary shall award grants to, or enter into contracts with, an accredited public or nonprofit hospital, school of medicine or osteopathic medicine, or any other health professional program to assist regular Commissioned Corps personnel to meet both routine public health and emergency response missions.

"(c) PURPOSE AND USE OF READY RESERVE FORCES.—

"(1) PURPOSE.—The purpose of the Ready Reserve Corps is to fulfill the need to have additional Commissioned Forces personnel available on short notice (similar to the uniformed services) to assist regular Commissioned Corps personnel and to respond to public health emergencies, both foreign and domestic; and

"(2) USES.—The Ready Reserve Corps shall—

"(A) participate in routine training to meet the general and specific needs of the Commissioned Corps;

"(B) be available and ready for involuntary calls to active duty during national emergencies and public health crises, similar to the uniformed services (reserve components); and

"(C) be available for backfilling critical positions left vacant during deployment of active duty Commissioned Forces members, as well as to respond to public health emergencies, both foreign and domestic; and

"(D) be available for service assignment in isolated, hardship, and medically underserved communities (as defined in section 798B) to improve access to health services.

"(d) FUNDING.—For the purpose of carrying out the duties and responsibilities of the Commissioned Corps under this section, there are authorized to be appropriated $5,000,000 for each of fiscal years 2010 through 2014 for recruitment and training and $12,500,000 for each of fiscal years 2010 through 2014 for the Ready Reserve Corps."

Subtitle D—Enhancing Health Care Workforce Preparation and Training

SEC. 5301. TRAINING IN FAMILY MEDICINE, GENERAL INTERNAL MEDICINE, GENERAL PEDIATRICS, AND PHYSICIAN ASSISTANTSHIP.

Part C of title VII (42 U.S.C. 293k et seq.) is amended by striking section 747 and inserting the following:

"SEC. 747. PRIMARY CARE TRAINING AND ENHANCEMENT.

"(a) SUPPORT AND DEVELOPMENT OF PRIMARY CARE TRAINING PROGRAMS.—

"(1) IN GENERAL.—The Secretary may make grants to, or enter into contracts with, an accredited public or nonprofit private hospital, school of medicine or osteopathic medicine, a school of public health, or any other health professional program to assist in training primary care providers.

"(A) To improve clinical teaching and research in fields defined in subsection (a)(1)(A); or

"(B) programs that integrate academic administrative units in fields defined in subsection (a)(1)(A) to enhance interdisciplinary recruitment, training, and faculty development.

"(2) PREFERENCE IN MAKING AWARDS UNDER THIS SUBSECTION.—In making awards of grants and contracts under paragraph (1), the Secretary shall give priority to any application that agrees to expend the award for the purpose of—

"(A) establishing academic units or programs in fields defined in subsection (a)(1)(A); or

"(B) substantially expanding such units or programs.

"(3) PRIORITIES IN MAKING AWARDS.—In awarding grants or contracts under paragraph (1), the Secretary shall give priority to applicants that—

"(A) propose comprehensive training programs in primary care and medical home, including postgraduate training in primary care, management of chronic disease, and interprofessional integrated models of care that incorporate transitions in health settings and integration physical and mental health provision;

"(B) propose innovative approaches to clinical teaching and training in primary care, such as the patient centered medical home, team management of chronic disease, and interprofessional integrated models of health care that incorporate transitions in health settings and integration physical and mental health provision;

"(C) have a record of training the greatest percentage of providers, or that have demonstrated significant improvements in the percentage of providers trained, who enter and remain in primary care practice;

"(D) have a record of training individuals who are from underrepresented minority groups or from a rural or disadvantaged background;

"(E) provide training in the care of vulnerable populations such as children, older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with HIV/AIDS, and individuals with disabilities;

"(F) establish formal relationships and submit joint applications with federally qualified health centers, rural health clinics, area health education centers, or clinics located in underserved areas or that serve underserved populations;

"(G) teach trainees the skills to provide interprofessional, integrated care through collaboration among health professionals;

"(H) provide training in enhanced communication with patients, evidence-based practice, chronic disease management, prevention, health information technology, or other competencies as recommended by the Advisory Committee on Training in Primary Care Medicine and Dentistry and the National Health Workforce Commission established in section 5101 of the Patient Protection and Affordable Care Act, or

"(i) provide training in cultural competency and health literacy.

"(4) DURATION OF AWARDS.—The period during which payments are made to an entity from an award of a grant or contract under this subsection shall be 5 years.

"(B) CAPACITY BUILDING IN PRIMARY CARE.—

"(1) IN GENERAL.—The Secretary may make grants to, or enter into contracts with, an accredited public or nonprofit private hospital, school of medicine or osteopathic medicine to establish, maintain, or improve a capacity building program in primary care.

"(2) PREFERENCE IN MAKING AWARDS UNDER THIS SUBSECTION.—In making awards of grants and contracts under paragraph (1), the Secretary shall give preference to any application that agrees to expend the award for the purpose of—

"(A) establishing academic units or programs in fields defined in subsection (a)(1)(A); or

"(B) substantially expanding such units or programs.

"(3) PRIORITIES IN MAKING AWARDS.—In awarding grants or contracts under paragraph (1), the Secretary shall give priority to applicants that—

"(A) propose comprehensive training programs in primary care and medical home, including postgraduate training in primary care, management of chronic disease, and interprofessional integrated models of health care that incorporate transitions in health settings and integration physical and mental health provision;

"(B) propose innovative approaches to clinical teaching and training in primary care, such as the patient centered medical home, team management of chronic disease, and interprofessional integrated models of health care that incorporate transitions in health settings and integration physical and mental health provision;

"(C) have a record of training the greatest percentage of providers, or that have demonstrated significant improvements in the percentage of providers trained, who enter and remain in primary care practice;

"(D) have a record of training individuals who are from underrepresented minority groups or from a rural or disadvantaged background;

"(E) provide training in the care of vulnerable populations such as children, older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with HIV/AIDS, and individuals with disabilities;

"(F) establish formal relationships and submit joint applications with federally qualified health centers, rural health clinics, area health education centers, or clinics located in underserved areas or that serve underserved populations;

"(G) teach trainees the skills to provide interprofessional, integrated care through collaboration among health professionals;

"(H) provide training in enhanced communication with patients, evidence-based practice, chronic disease management, prevention, health information technology, or other competencies as recommended by the Advisory Committee on Training in Primary Care Medicine and Dentistry and the National Health Workforce Commission established in section 5101 of the Patient Protection and Affordable Care Act, or

"(i) provide training in cultural competency and health literacy.

"(4) DURATION OF AWARDS.—The period during which payments are made to an entity from an award of a grant or contract under this subsection shall be 5 years.

"(B) EXPERIENCE.—The Secretary shall give preference to any application that agrees to expend the award for the purpose of—

"(A) establishing academic units or programs in fields defined in subsection (a)(1)(A); or

"(B) substantially expanding such units or programs.

"(3) PRIORITIES IN MAKING AWARDS.—In awarding grants or contracts under paragraph (1), the Secretary shall give priority to applicants that—

"(A) propose comprehensive training programs in primary care and medical home, including postgraduate training in primary care, management of chronic disease, and interprofessional integrated models of health care that incorporate transitions in health settings and integration physical and mental health provision;

"(B) propose innovative approaches to clinical teaching and training in primary care, such as the patient centered medical home, team management of chronic disease, and interprofessional integrated models of health care that incorporate transitions in health settings and integration physical and mental health provision;

"(C) have a record of training the greatest percentage of providers, or that have demonstrated significant improvements in the percentage of providers trained, who enter and remain in primary care practice;

"(D) have a record of training individuals who are from underrepresented minority groups or from a rural or disadvantaged background;

"(E) provide training in the care of vulnerable populations such as children, older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with HIV/AIDS, and individuals with disabilities;

"(F) establish formal relationships and submit joint applications with federally qualified health centers, rural health clinics, area health education centers, or clinics located in underserved areas or that serve underserved populations;

"(G) teach trainees the skills to provide interprofessional, integrated care through collaboration among health professionals;

"(H) provide training in enhanced communication with patients, evidence-based practice, chronic disease management, prevention, health information technology, or other competencies as recommended by the Advisory Committee on Training in Primary Care Medicine and Dentistry and the National Health Workforce Commission established in section 5101 of the Patient Protection and Affordable Care Act, or

"(i) provide training in cultural competency and health literacy.

"(4) DURATION OF AWARDS.—The period during which payments are made to an entity from an award of a grant or contract under this subsection shall be 5 years.
nursing homes (as defined in section 1902(a)(17) of the Social Security Act (42 U.S.C. 1396a(e)(17)), assisted living facilities and skilled nursing facilities, intermediate care facilities for individuals with mental retardation, home and community based settings, and any other setting the Secretary determines to be appropriate.

(2) A grantee may be eligible to receive a grant under this section, an entity shall—

(1) be an institution of higher education (as defined in subsection 102 of the Higher Education Act of 1965 (20 U.S.C. 1001(c)); and

(2) have established a public-private educational partnership with a nursing home or skilled nursing facility, agency or entity providing home and community based services to individuals with disabilities, or other long-term care provider; and

(3) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

SEC. 5303. TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTRY.

Part C of Title VII of the Public Health Service Act (42 U.S.C. 293k et seq.) is amended by—

(a) redesignating section 748, as amended by section 5302 of this Act, as section 749; and

(b) inserting after section 747A, as added by section 5302, the following:

SEC. 748. TRAINING IN GENERAL, PEDIATRIC, AND PUBLIC HEALTH DENTISTRY.

(a) SUPPORT AND DEVELOPMENT OF DENTAL TRAINING PROGRAMS.—

(A) IN GENERAL.—The Secretary may make grants to, or enter into contracts with, a school of dentistry, public or nonprofit private hospital, or a public or private nonprofit agency which the Secretary has determined is capable of carrying out such grant or contract—

(1) to plan, develop, and operate a program for the training of oral health care providers who plan to teach in general, pediatric, public health dentistry, or dental hygiene; and

(2) to provide financial assistance in the form of traineeships and fellowships to dentists who plan to teach or are teaching in general, pediatric, or public health dentistry.

(2) DURATION OF AWARD.—The period during which payments are made to an entity under this section shall—

(1) be an amount equal to 10, 15, 20, 25, and 30 percent, respectively, of the individual’s or entity’s loan balance as calculated based on principal and interest owed at the initiation of the agreement.

(2) be eligible for interest payments on eligible private sector loans made to dental students, residents, fellows, or faculty to the extent that such payments are not excluded under section 221(b)(2) of the Higher Education Act of 1965 (20 U.S.C. 1070b(b)(2)).

(c) ELIGIBLE ENTITIES.—For purposes of this paragraph, the term ‘eligible entity’ means—

(1) a school of public health.

(2) a dental school or dental education center or training program for the training of oral health care professionals.

(d) USE OF FUNDS.—An eligible entity shall use amounts awarded under a grant under this section to provide assistance to eligible individuals to offset the cost of tuition and required fees for enrollment in academic programs provided by such entity.

(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $10,000,000 for the period of fiscal years 2011 through 2013.

SEC. 5304. ALTERNATIVE DENTAL HEALTH CARE PROVIDERS DEMONSTRATION PROJECT.

Subpart X of part D of title III of the Public Health Service Act (42 U.S.C. 256j et seq.) is amended by adding at the end the following:

SEC. 3406G-1. DEMONSTRATION PROGRAM.

(a) IN GENERAL.—

(1) AUTHORIZATION.—The Secretary is authorized to award grants to 15 eligible entities to enable such entities to establish a demonstration program to establish training programs to train, or to employ, alternative dental health care providers in order to increase access to dental health care services in rural and other underserved communities.

(2) DEMONSTRATION PROJECT.—The alternative dental health care providers’ includes community dental health coordinators, advance practice dental hygienists, independent dental hygienists, supervisors, primary care physicians, dental therapists, dental health aides, and any other health professional that the Secretary determines appropriate.

(b) TIMELINE.—The demonstration projects funded under this section shall begin not later than 2 years after the date of enactment of this section and conclude not later than 7 years after such date of enactment.

(c) ELIGIBLE ENTITIES.—To be eligible to receive a grant under subsection (a), an entity shall—

(1) establish a demonstration project to train, or to employ, alternative dental health care providers targeting vulnerable populations such as older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with disabilities, and individuals with HIV/AIDS, and in the risk-based clinical disease management of all populations.

(2) Qualified applicants that include educational activities in cultural competency and health literacy.

(3) Qualified applicants that conduct teaching programs targeting vulnerable populations such as older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with disabilities, and individuals with HIV/AIDS, and in the risk-based clinical disease management of all populations.

(4) Qualified applicants that intend to establish a special populations oral health care education center or training program for the didactic and clinical education of dentists, dental health professionals, and dental hygienists who plan to teach oral health care for people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, or vulnerable elderly.

(5) Qualified applicants that have a high rate for placing graduates in practice settings that serve underserved areas or health disparity populations, or who achieve a significant increase in the rate of placing graduates in such settings.

(6) Qualified applicants that conduct educational activities in cultural competency and health literacy.

(7) Qualified applicants that conduct teaching programs targeting vulnerable populations such as older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with disabilities, and individuals with HIV/AIDS, and in the risk-based clinical disease management of all populations.

(8) Qualified applicants that include educational activities in cultural competency and health literacy.

(9) Qualified applicants that conduct teaching programs targeting vulnerable populations such as older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with disabilities, and individuals with HIV/AIDS, and in the risk-based clinical disease management of all populations.

(10) Qualified applicants that intend to establish a special populations oral health care education center or training program for the didactic and clinical education of dentists, dental health professionals, and dental hygienists who plan to teach oral health care for people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, or vulnerable elderly.

(11) Qualified applicants that have a high rate for placing graduates in practice settings that serve underserved areas or health disparity populations, or who achieve a significant increase in the rate of placing graduates in such settings.

(12) Qualified applicants that conduct educational activities in cultural competency and health literacy.

(13) Qualified applicants that conduct teaching programs targeting vulnerable populations such as older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with disabilities, and individuals with HIV/AIDS, and in the risk-based clinical disease management of all populations.

(14) Qualified applicants that include educational activities in cultural competency and health literacy.

(15) Qualified applicants that conduct teaching programs targeting vulnerable populations such as older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with disabilities, and individuals with HIV/AIDS, and in the risk-based clinical disease management of all populations.

(16) Qualified applicants that intend to establish a special populations oral health care education center or training program for the didactic and clinical education of dentists, dental health professionals, and dental hygienists who plan to teach oral health care for people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, or vulnerable elderly.

(17) Qualified applicants that have a high rate for placing graduates in practice settings that serve underserved areas or health disparity populations, or who achieve a significant increase in the rate of placing graduates in such settings.

(18) Qualified applicants that conduct educational activities in cultural competency and health literacy.

(19) Qualified applicants that conduct teaching programs targeting vulnerable populations such as older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with disabilities, and individuals with HIV/AIDS, and in the risk-based clinical disease management of all populations.

(20) Qualified applicants that include educational activities in cultural competency and health literacy.

(21) Qualified applicants that conduct teaching programs targeting vulnerable populations such as older adults, homeless individuals, victims of abuse or trauma, individuals with mental health or substance-related disorders, individuals with disabilities, and individuals with HIV/AIDS, and in the risk-based clinical disease management of all populations.
'(1) be—

(A) an institution of higher education, including a community college;

(B) a public-private partnership;

(C) a geriatric care management organization;

(D) an Indian Health Service facility or a tribe or tribal organization (as such terms are defined in section 4 of the Indian Self-Determination and Education Assistance Act);

(E) a State or county public health clinic, a health facility operated by an Indian tribe or tribal organization, or urban Indian organization or tribal services; or

(F) a public hospital or health system;

(2) be within a program accredited by the Commission on Dental Accreditation or within a demonstration program in an accredited institution; and

(3) shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(d) ADMINISTRATIVE PROVISIONS.—

(1) AMOUNT OF GRANT.—Each grant under this section shall be in an amount that is not less than $4,000,000 for the 5-year period during which the demonstration project being conducted.

(2) DISBURSEMENT OF FUNDS.—

(A) PRELIMINARY DISBURSEMENTS.—Beginning 1 year after the enactment of this section, the Secretary may disburse to any entity receiving a grant under this section an amount that is not more than 20 percent of the total funding awarded to such entity under such grant, for the purpose of enabling the entity to plan the demonstration project to be conducted under such grant.

(B) SUBSEQUENT DISBURSEMENTS.—The remaining amount of grant funds not dispersed under paragraph (A) shall be dispersed such that not less than 15 percent of such remaining amount is dispersed each subsequent year.

(e) COMPLIANCE WITH STATE REQUIREMENTS.—Each entity receiving a grant under this section shall certify that it is in compliance with all applicable State licensing requirements.

(f) EVALUATION.—The Secretary shall conduct with the Director of the Institute of Medicine to conduct a study of the demonstration programs conducted under this section that shall provide analysis, based upon quantitative and qualitative data, regarding access to dental health care in the United States.

(g) CLARIFICATION REGARDING DENTAL HEALTH AIDE PROGRAM.—Nothing in this section shall prohibit a dental health aide trainee from being eligible for a grant under this section.

(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 3050. GERIATRIC EDUCATION AND TRAINING: INCOME-ELIGIBLE, COMPREHENSIVE GERIATRIC EDUCATION.

(a) WORKFORCE DEVELOPMENT: CAREER AWARDS.—Section 753 of the Public Health Service Act (42 U.S.C. 290c) is amended by adding at the end the following:

(d) GERIATRIC WORKFORCE DEVELOPMENT.

(1) IN GENERAL.—The Secretary shall award grants or contracts under this subsection to entities that operate a geriatric education center pursuant to subsection (a)(1).

(2) APPLICATION.—To be eligible for an award under paragraph (1), an entity described in such paragraph shall submit to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(3) USE OF FUNDS.—Amounts awarded under a grant or contract under paragraph (1) shall be used to—

(A) carry out the fellowship program described in paragraph (4); and

(B) carry out 1 of the 2 activities described in paragraph (5).

(f) FELLOWSHIP PROGRAM.—

(A) IN GENERAL.—Pursuant to paragraph (3), a geriatric education center that receives an award under this subsection shall use such funds to offer short-term intensive courses designed to provide initial certification as a geriatric ‘fellowship’ that focus on geriatrics, chronic care management, and long-term care that provide supplemental training for faculty members in medical, dental, and other health professions schools with programs in psychology, pharmacy, nursing, social work, dentistry, public health, allied health, or other health disciplines, as approved by the Secretary. Such a fellowship shall be open to current faculty, and appropriately credentialed volunteer faculty and practitioners, who do not have formal training in geriatrics, to upgrade their knowledge and clinical skills for the care of older adults and adults with functional limitations and to enhance their interdisciplinary teaching skills.

(B) LOCATION.—A fellowship shall be offered either at the geriatric education center that is sponsoring the course, in collaboration with other geriatric education centers, at medical schools, schools of dentistry, schools of nursing, schools of pharmacy, schools of social work, graduate programs in psychology, allied health and other health professions schools approved by the Secretary, or at medical schools, schools of dentistry, schools of nursing, schools of pharmacy, schools of social work, graduate programs in psychology, or allied health and other health professions schools approved by the Secretary, with which the geriatric education centers are affiliated.

(C) FEE CONSIDERATION.—Participation in a fellowship under this paragraph shall be accepted with respect to complying with continuing health profession education requirements with the understanding that the recipient shall agree to subsequently provide a minimum of 12 hours of voluntary instructional support through a geriatric education center that is providing clinical training to students or trainees in long-term care settings.

(G) ADDITIONAL REQUIRED ACTIVITIES DESCRIBED IN PARAGRAPH (3).—A geriatric education center that receives an award under this subsection shall use such funds to carry out 1 of the following 2 activities during the term of the award:

(A) FAMILY CAREGIVER AND DIRECT CARE PROVIDER TRAINING.—A geriatric education center that receives an award under this subsection shall carry out 1 of the following activities: (i) training courses each year, at no charge or nominal cost, to family caregivers and direct care providers that are designed to provide practical training for the care and support of elders with disabilities. The Secretary shall require such Centers to work with appropriate community partners to develop training programs content and to facilitate the availability of training courses in their service areas. All family caregiver and direct care provider training programs shall include instruction on the management of psychological and behavioral aspects of dementia, communication techniques for working with individuals who have dementia, and the appropriate use of medications for older adults.

(B) INCORPORATION OF BEST PRACTICES.—A geriatric education center that receives an award under this subsection shall develop and include material on depression and other mental disorders common among older adults, medication safety issues for older adults, the psychosocial aspects of dementia and other behavioral aspects of dementia and communication techniques with individuals who have dementia in all training courses, where appropriate.

(6) TARGETS.—A geriatric education center that receives an award under this subsection shall certify that funds provided to the Secretary for providing geriatric training to a certain number of faculty or practitioners during the term of the award, as well as other parameters established by the Secretary.

(7) AMOUNT OF AWARD.—An award under this subsection shall be in an amount not less than $4,000,000. Not more than 24 geriatric education centers may receive an award under this subsection.

(8) MAINTENANCE OF EFFORT.—A geriatric education center that receives an award under this subsection shall provide assurances to the Secretary that funds provided to the geriatric education center under this subsection will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the geriatric education center.

(9) AUTHORIZATION OF APPROPRIATIONS.—In addition to any other funding available to carry out this section, there is authorized to be appropriated for this subsection, $10,000,000 for the period of fiscal year 2011 through 2014.

(c) GERIATRIC CAREER INCENTIVE AWARDS.

(1) IN GENERAL.—The Secretary shall award grants or contracts under this section to individuals described in paragraph (2) to foster greater interest among a variety of health professionals in entering the field of geriatrics, long-term care, and chronic care management.

(2) ELIGIBLE INDIVIDUALS.—To be eligible to receive an award under paragraph (1), an individual shall—

(A) be an advanced practice nurse, a clinical social worker, a pharmacist, or student from the Health Professions Scholarship Program for practice in the field of geriatrics, long-term care, or chronic care management.

(B) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(3) DISTRIBUTION OF AWARD.—As a condition of receiving an award under this subsection, an individual shall agree that, following completion of the award period, the individual will teach full time for a period of years in geriatrics, long-term care, or chronic care management.

(4) AGGREGATION OF FUNDING.—There is authorized to be appropriated to carry out this section, $10,000,000 for the period of fiscal years 2011 through 2013.

(d) EXPANSION OF ELIGIBILITY FOR GERIATRIC ACADEMIC CAREER AWARDS; PAYMENT TO INSTITUTION.—Section 753(c) of the Public Health Service Act (290c) is amended—

(1) by inserting at the end the following:

(6) ELIGIBLE INSTITUTIONS.—To be eligible to receive an Award under paragraph (1), an individual shall—

(A) be board certified or board eligible in internal medicine, family practice, psychiatry, or licensed dentistry, or have completed any required training in a discipline and employed in an accredited health professions school that is approved by the Secretary;

(B) have completed an approved fellowship program in geriatrics or have completed an advanced training program in geriatrics as required by the discipline and any additional geriatrics training as required by the Secretary; and
"(C) have a junior (non-tenured) faculty appointment at an accredited (as determined by the Secretary) school of medicine, osteopathic medicine, nursing, social work, psychology, osteopathic pharmacy, or other allied health disciplines in an accredited health professions school that is approved by the Secretary.

(3) IN GENERAL.—No Award under paragraph (1) may be made to an eligible individual unless the individual—

(A) has submitted to the Secretary an application for an Award in such manner, and containing such information as the Secretary may require, that the individual will meet the service requirement described in paragraph (6); and

(C) provides, in such form and manner as the Secretary may require, assurances that the individual has a full-time faculty appointment in a health professions institution and documented commitment from such institution to spend 75 percent of the total time of such individual on teaching and developing skills in interdisciplinary education in gerontology and the elderly population.''; and

(5) MAINTENANCE OF EFFORT.—An eligible individual who receives an Award under paragraph (1) shall provide to the Secretary assurance that funds provided to the eligible institution under this subsection will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.''; and

(6) PAYMENT TO INSTITUTION.—The Secretary shall make payments to institutions which include schools of medicine, osteopathic medicine, nursing, social work, psychology, osteopathic pharmacy, or other allied health discipline in an accredited health professions school that is approved by the Secretary by regulation.

(c) COMPREHENSIVE GERIATRIC EDUCATION.—

(1) IN GENERAL.—Section 855 of the Public Health Service Act (42 U.S.C. 295a) is amended—

(A) in subsection (b), by striking "the Council on Social Work Education, including community-based organizations, and other organizations as determined appropriate by the Secretary.''

(B) in paragraph (2), by striking "in personnel at predoctoral level, masters level, and postdoctoral level" and inserting "the Council on Social Work Education, including community-based organizations, and other organizations as determined appropriate by the Secretary.''

(2) IN GENERAL.—Part D of title VII (42 U.S.C. 294 et seq.) is amended by—

(A) by striking the subsection heading and all that follows through the period at the end and inserting "(4) MAINTENANCE OF EFFORT.—An eligible individual who receives an Award under section (a) shall provide to the Secretary assurance that funds provided to the eligible institution under this subsection will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.''; and

(B) by adding at the end the following:

"(C) the institution will provide to the Secretary assurance that funds provided to the eligible institution under this subsection will be used only to supplement, not to supplant, the amount of Federal, State, and local funds otherwise expended by the eligible individual.''; and

(C) by adding to the end the following:

"(1) In selecting the grant recipients in social work under subsection (a)(1), the Secretary shall give priority to applicants that—

(A) are accredited by the Council on Social Work Education;

(B) have a graduation rate of not less than 80 percent for social work students; and

(C) exhibit an ability to recruit social workers from and place social workers in areas with a high need and high demand population.

(2) In selecting the grant recipients in graduate psychology under subsection (a)(2), the Secretary shall give priority to institutions which in which training focuses on the needs of vulnerable groups such as older adults and children, individuals with mental health or substance-related disorders, victims of abuse or trauma and of combat stress disorders such as posttraumatic stress disorder and traumatic brain injuries, homeless individuals, chronically ill persons, and their families.

(3) In selecting the grant recipients in training programs in child and adolescent mental health under subsections (a)(3) and (4), the Secretary shall give priority to applicants that—

(A) have demonstrated the ability to collect data on the number of students trained in child and adolescent mental health and the populations served by such students after graduation or completion of preservice or in-service training;

(B) have demonstrated familiarity with evidence-based methods in child and adolescent mental health services, including substance abuse prevention and treatment services;

(C) have programs designed to increase the number of professionals and paraprofessionals serving high-priority populations and to applicants who come from high-priority communities and plan to serve medically underserved populations, in health professional shortage areas, or in medically underserved areas;

(D) offer curriculum taught collaboratively with a family on the consumer and by family, including family-professional or family-paraprofessional partnerships; and

(E) provide services through a community mental health program described in section 1913(b)(1).

(3) AUTHORIZATION OF APPROPRIATION.—For the fiscal years 2010 through 2013, there is authorized to be appropriated to carry out this section—

(A) $8,000,000 for training in social work in subsection (a)(1); and

(B) $12,000,000 for training in graduate psychology in subsection (a)(2), of which not less than $10,000,000 shall be allocated for doctoral, postdoctoral, and internship level training;

(4) $10,000,000 for training in professional child and adolescent mental health in subsection (a)(3); and

(5) $5,000,000 for training in paraprofessional child and adolescent work in subsection (a)(4).

(b) CONFORMING AMENDMENTS.—Section 757(b)(2) of the Public Health Service Act, as redesignated by subsection (a), is amended by—

(1) in subsection (a)—

(A) by striking the subsection heading and inserting "CULTURAL COMPETENCY, PREVENTION, AND PUBLIC HEALTH AND INDIVIDUALS WITH DISABILITIES TRAINING;" and

(B) by striking paragraph (1), by striking "of" for the purpose of and all that follows through the period at the end and inserting "for the development, evaluation, and dissemination of research, demonstration projects, and model curricula for cultural competency, prevention, public health, and reducing health disparities, and aptitude for working with individuals with disabilities training for use in health professions schools and continuing education programs for other purposes determined as appropriate by the Secretary.''; and

(2) by striking subsection (b) and inserting the following:

"(b) COLLABORATION.—In carrying out subsection (a), the Secretary shall collaborate with health professional societies, licensing and accreditation entities, health professions schools, and experts in minority health and cultural competency, prevention, and reducing health and disability disparities, community-based organizations, and other organizations as determined appropriate by the Secretary.''

(1) IN GENERAL.—Part D of title VII (42 U.S.C. 293e) is amended—

(A) by striking the subsection heading and all that follows through the period at the end and inserting "mental health program described in section 1913(b)(1).

(B) by striking the subsection heading and all that follows through the period at the end and inserting "mental health program described in section 1913(b)(1)."
Secretary. The Secretary shall coordinate with curricula and research and demonstration projects developed under section 807. "(c) DISSEMINATION.—Model curricula developed under this section shall be disseminated through the Internet Clearinghouse under section 831(b)(5) and such other means as determined appropriate by the Secretary. "(2) EVALUATION.—The Secretary shall evaluate the adoption and the implementation of the curricula, and report to Congress annually on the extent to which the curricula are adopted and evaluated in the same manner as defined in section 741, as applicable, and agreements for programs developed under this section shall be disseminated through the Internet Clearinghouse under section 831(b)(5) and such other means as determined appropriate by the Secretary. "(d) AUTHORIZATION OF APPORTIONS.—There is authorized to be appropriated—

SEC. 5309. NURSE EDUCATION, PRACTICE, AND RETENTION GRANTS. (a) IN GENERAL.—Section 831 of the Public Health Service Act (42 U.S.C. 296b–1) is amended—

"(1) to promote career advancement for individuals including licensed practical nurses, licensed vocational nurses, certified nurse assistants, home health aides, diploma degree or associate degree nurses, to become baccalaureate prepared registered nurses or advanced education nurses in order to meet the needs of the registered nurse workforce; (2) developing and implementing internships and residency programs in collaboration with an accredited school of nursing, as defined by section 801(2), to encourage mentoring and the development of specialties; or (3) to assist individuals in obtaining education and training required to enter the nursing profession and advance within such profession.

"(c) ENHANCING PATIENT CARE DELIVERY SYSTEMS.—

"(1) GRANTS.—The Secretary may award grants to, and enter into contracts with, eligible entities to enhance the nursing workforce by initiating and maintaining nurse training programs pursuant to subsection (b) or (c).

"(b) GRANTS FOR CAREER LADDER PROGRAMS.—The Secretary may award grants to, and enter into contracts with, eligible entities for programs—

"(1) to promote career advancement for individuals including licensed practical nurses, licensed vocational nurses, certified nurse assistants, home health aides, diploma degree or associate degree nurses, to become baccalaureate prepared registered nurses or advanced education nurses in order to meet the needs of the registered nurse workforce; (2) developing and implementing internships and residency programs in collaboration with an accredited school of nursing, as defined by section 801(2), to encourage mentoring and the development of specialties; or (3) to assist individuals in obtaining education and training required to enter the nursing profession and advance within such profession.

"(c) ENHANCING PATIENT CARE DELIVERY SYSTEMS.—

"(1) GRANTS.—The Secretary may award grants to eligible entities to improve the retention of nurses in patient care that is directly related to nursing activities by enhancing collaboration and communication among nurses and other health care professionals, and by promoting nurse involvement in the organizational and clinical decision-making processes of a health care facility.

"(2) PRIORITY.—In making awards of grants under this subsection, the Secretary shall give preference to applicants that have not previously received an award under this subsection, and to setting a date with any:

"(d) AUTHORIZED NURSE-MIDWIFERY PROGRAMS.—Midwifery programs that are eligible for under this section are educational programs that—

"(1) have as their objective the education of midwives; and (2) are accredited by the American College of Nurse-Midwives Accreditation Commission for Midwifery Education.

"SEC. 5308. ADVANCED NURSING EDUCATION GRANTS. Section 811 of the Public Health Service Act (42 U.S.C. 296a) is amended—

"(1) in subsection (a), by striking ""AND NURSE MIDWIFERY PROGRAMS"" and substituting ""AND NURSE MIDWIFERY PROGRAMS""; and (2) by striking paragraph (3) and inserting after paragraph (2) the following:

"(3) in subsections (d), (e), and (f) as subsections (e), (f), and (g), respectively; and (4) by inserting after subsection (c), the following: ""(d) AUTHORIZED NURSE-MIDWIFERY PROGRAMS.—Midwifery programs that are eligible for under this section are educational programs that—

"(1) have as their objective the education of midwives; and (2) are accredited by the American College of Nurse-Midwives Accreditation Commission for Midwifery Education."
the individual would be unconscionable.

**treme hardship to the individual or if en-

section of liability under such paragraph if com-

the Secretary shall provide for the waiver or suspen-

ment for purposes of paragraph (1), the Sec-

in accordance with this section, to in-

crease the number of qualified nursing fac-

shy to an accredited school of nursing; or

(2) the date on which the individual en-

ters into an agreement under this sub-

section.

**AGREEMENT PROVISIONS.—**Agreements entered into pursuant to subsection (b) shall be entered into on such terms and conditions as the Secretary may determine, except that—

(1) not more than 10 months after the date on which the 6-year period described under subsection (b) begins, but in no case before the individual starts as a full-time member of the faculty of an accredited school of nursing, the Secretary shall begin making payments, for and on behalf of that individual, on the outstanding principal of, and interest on any loan of that individual obtained to pay for such degree;

(2) for an individual who has completed a master's in nursing or equivalent degree in nursing—

(A) payments may not exceed $10,000 per calendar year; and

(B) total payments may not exceed $40,000 during the 2010 and 2011 fiscal years (after fiscal year 2011, such amounts shall be ad-

justed to provide for a cost-of-attendance in-

crease for the yearly loan rate and the aggre-

gate loan); and

(3) for an individual who has completed a doctorate or equivalent degree in nursing—

(A) payments may not exceed $20,000 per calendar year; and

(B) total payments may not exceed $80,000 during the 2010 and 2011 fiscal years (adjusted for subsequent fiscal years as provided for in the same paragraph (2)(B)).

**WAIVER OR SUSPENSION OF LIABILITY.—**

(1) In GENERAL.—In the case of any agree-

ment made under subsection (b), the indi-

vidual is liable to the Federal Government for the total amount paid by the Secretary under such agreement, and for interest on such amount at the maximum legal pre-

vailing rate, if the individual fails to meet the agreement terms required under such subsection.

(2) FRAUD OR SUSPENSION OF LIABILITY.—

In the case of an individual making an agree-

ment for purposes of paragraph (1), the Sec-

retary shall provide for the waiver or suspens-

ion of such paragraph if compliance by the individual with the agreement involved is impossible or would involve ex-

treme hardship to the individual or if en-

forcement of such agreement with respect to the individual would be unconscionable.

**DATE CERTAIN FOR RECOVERY.—**Subject to paragraph (2), any amount that the Fed-

eral Government is entitled to recover under paragraph (1) shall be paid to the United States not later than the expiration of the 3-

year period beginning on the date the United States becomes aware of the failure of the fac-

ulty.

**AVAILABILITY.—**Amounts recovered under paragraph (1) shall be available to the Secretary for making loan repayments under this section and shall remain available for such purpose until expended.

**ELIGIBLE INDIVIDUAL DEFINED.—**For purposes of this section, an "eligible individual" means an individual who—

(1) is a United States citizen, national, or lawful permanent resident;

(2) holds a current license as a registered nurse; and

(3) has either already completed a mas-

ter's or doctorate nursing program at an ac-

credited school of nursing or currently en-

rolled on a full-time or part-time basis in such a program.

**PRIORITY.—**For the purposes of this section and subsection (b), funding priority will be awarded to School of Nursing Student Loans that support doctoral nursing stu-

dents or Individual Student Loan Repayment 

that support doctoral nursing students.

**AUTHORIZATION OF APPROPRIATIONS.—**

There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2014.".

**SEC. 5312. AUTHORIZATION OF APPROPRIATIONS FOR PARTS B THROUGH D OF TITLE VII.**

Section 871 of the Public Health Service Act, as redesignated and moved by section 5310, is amended as follows:

**SEC. 871. AUTHORIZATION OF APPROPRIATIONS.—**

"For the purpose of carrying out parts B, C, and D (subject to section 851(g)), there are authorized to be appropriated $338,000,000 for fiscal year 2010, and such sums as may be necessary for each of the fiscal years 2011 through 2016.".

**SEC. 5313. GRANTS TO PROMOTE THE COMMUNITY HEALTH WORKFORCE.**

(a) IN GENERAL.—Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended by adding at the end the fol-

lowing:

**SEC. 339V. GRANTS TO PROMOTE POSITIVE HEALTH BEHAVIORS AND OUT-

COMES.**

(a) GRANTS AUTHORIZED.—The Director of the Centers for Disease Control and Preven-

tion, in collaboration with the Secretary, shall award grants to entities that:—

(1) propose to target geographic areas—

(A) with a high percentage of residents who are underserved with respect to such insurance but are uninsured or underinsured;

(B) with a high percentage of residents who suffer from chronic diseases; or

(C) with a high infant mortality rate;

(2) have experience in providing health or health-related social services to individuals who are underserved with respect to such services and

(3) have documented community activity and experience with community health workers.

(b) AGREEMENTS.—Each agreement en-

tered into under this subsection shall require that the eligible individual shall serve as a full-time member of the faculty of an accredited school of nursing, for a period, in the aggregate, of at least 4 years during the 6-year period beginning on the later of—

(1) the date on which the individual re-

ceives a master's or doctorate nursing degree from an accredited school of nursing; or

(2) the date on which the individual en-

ters into an agreement under this sub-

section.

(c) AGREEMENT PROVISIONS.—Agreements entered into pursuant to subsection (b) shall be entered into on such terms and conditions as the Secretary may determine, except that—

(1) not more than 10 months after the date on which the 6-year period described under subsection (b) begins, but in no case before the individual starts as a full-time member of the faculty of an accredited school of nursing, the Secretary shall begin making payments, for and on behalf of that individual, on the outstanding principal of, and interest on any loan of that individual obtained to pay for such degree;

(2) for an individual who has completed a master's in nursing or equivalent degree in nursing—

(A) payments may not exceed $10,000 per calendar year; and

(B) total payments may not exceed $40,000 during the 2010 and 2011 fiscal years (after fiscal year 2011, such amounts shall be ad-

justed to provide for a cost-of-attendance in-

crease for the yearly loan rate and the aggre-

gate loan); and

(3) for an individual who has completed a doctorate or equivalent degree in nursing—

(A) payments may not exceed $20,000 per calendar year; and

(B) total payments may not exceed $80,000 during the 2010 and 2011 fiscal years (adjusted for subsequent fiscal years as provided for in the same paragraph (2)(B)).

(d) BREACH OF AGREEMENT.—

(1) In GENERAL.—In the case of any agree-

ment made under subsection (b), the indi-

vidual is liable to the Federal Government for the total amount paid by the Secretary under such agreement, and for interest on such amount at the maximum legal pre-

vailing rate, if the individual fails to meet the agreement terms required under such subsection.

(2) FRAUD OR SUSPENSION OF LIABILITY.—

In the case of an individual making an agree-

ment for purposes of paragraph (1), the Sec-

retary shall provide for the waiver or suspens-

ion of such paragraph if compliance by the individual with the agreement involved is impossible or would involve ex-

treme hardship to the individual or if en-

forcement of such agreement with respect to the individual would be unconscionable.

(3) DATE CERTAIN FOR RECOVERY.—Subject to paragraph (2), any amount that the Fed-

eral Government is entitled to recover under paragraph (1) shall be paid to the United States not later than the expiration of the 3-

year period beginning on the date the United States becomes aware of the fac-

ulty.

(4) AVAILABILITY.—Amounts recovered under paragraph (1) shall be available to the Secretary for making loan repayments under this section and shall remain available for such purpose until expended.

**SEC. 871. AUTHORIZATION OF APPROPRIATIONS.—**

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.
SEC. 5314. FELLOWSHIP TRAINING IN PUBLIC HEALTH.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.), as amended by section 5306, is further amended by adding at the end the following:

"SEC. 778. FELLOWSHIP TRAINING IN APPLIED PUBLIC HEALTH EPIDEMIOLOGY, PUBLIC HEALTH LABORATORY SCIENCE, PUBLIC HEALTH INFORMATICS, AND EXPANSION OF THE EPIDEMIC INTELLIGENCE SERVICE.

"(a) IN GENERAL.—The Secretary may carry out activities to address documented workforce needs of State and local public health departments in the critical areas of applied public health epidemiology and public health laboratory science and informatics and may expand the Epidemic Intelligence Service.

"(b) SPECIFIC USES.—In carrying out subsection (a), the Secretary shall provide for the expansion of existing fellowship programs operated through the Centers for Disease Control and Prevention in a manner that is designed to alleviate shortages of the type described in subsection (a).

"(c) OMEGA TRAINEES.—The Secretary may provide for the expansion of other applied epidemiology training programs that meet objectives similar to the objectives of the programs described in subsection (b).

"(d) WORK OBLIGATION.—Participation in fellowship training programs under this section shall be deemed to be service for purposes of satisfying work obligations stipulated in contracts under section 338(b).

"(e) GENERAL SUPPORT.—Amounts may be used from grants awarded under this section to expand the Public Health Informatics Fellowship Program at the Centers for Disease Control and Prevention to better support all public health systems at all levels of government.

"(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $39,500,000 for each of fiscal years 2010 through 2013, of which—

"(1) $5,000,000 shall be made available in each such fiscal year for fellowship training program activities under subsection (b) and (c); and

"(2) $5,000,000 shall be made available in each such fiscal year for laboratory fellowship training programs under subsection (b); (c) and (d).

"SEC. 272. ADMINISTRATION.

"(a) IN GENERAL.—The Surgeon General may carry out activities to address gaps in workforce needs in public health department, a free health clinic, a hospital, or a Federally-qualified health center (as defined in section 1861(aa) of the Social Security Act), or a consortium of any such entities.

"(b) MEDICALLY UNDERSERVED COMMUNITY.—The term ‘medically underserved community’ means a community identified by a State as—

"(A) that has a substantial number of individuals who are members of a medically underserved population, as defined by section 330(b)(3); and

"(B) a significant portion of which is a health professional shortage area as designated under section 332.

"SEC. 5315. UNITED STATES PUBLIC HEALTH SCIENCES TRACK.

Title II of the Public Health Service Act (42 U.S.C. 292 et seq.) is amended by adding at the end the following:

"PART D—UNITED STATES PUBLIC HEALTH SCIENCES TRACK

"SEC. 271. ESTABLISHMENT.

"(a) UNITED STATES PUBLIC HEALTH SCIENCES TRACK

"(1) IN GENERAL.—There is hereby authorized to be established a United States Public Health Sciences Track (hereafter in this part referred to as the ‘Track’) by the Secretary, with authority to grant appropriate advanced degrees in a manner that uniquely emphasizes team-based service, education, research, and public health preparedness and response. It shall be so organized as to graduate not less than—

"(A) 150 medical students annually, 10 of whom shall be awarded scholarships to the Uniformed Services University of Health Sciences;

"(B) 100 dental students annually;

"(C) 250 nursing students annually;

"(D) 100 public health students annually;

"(E) 100 behavioral and mental health professional students annually;

"(F) 100 health care informatics or patient care informatics students annually; and

"(G) 50 pharmacy students annually.

"(2) LOCATIONS.—The Track shall be located at accredited schools of public health, schools of medicine or osteopathic medicine, colleges of dentistry, or schools of nursing.

"(3) FUNDING.—There are authorized to be appropriated to the Track each such fiscal year for fellowship training programs described in subsection (b).

"(4) COMMUNITY SETTING.—The Track may be by such phases as the Secretary determines to be appropriate to fulfill cooperative enterprises in medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing personnel.

"(5) DUTIES.—The duties of the Track shall be prescribed by the Secretary. In so prescribing the number of persons to be graduated from the Track, the Secretary shall institute actions necessary to ensure the maximum number of first-year enrollments in the Track consistent with the academic capacity of the affiliated sites and the needs of the United States for medical, dental, and nursing personnel.

"(6) INTERINTEGRATED LONGITUDINAL PLAN.—The Surgeon General shall develop an integrated longitudinal plan for health professions continuing education throughout the continuum of health-related education, training, and practice. Training under such plan shall emphasize patient care and practice, research, planning, and care coordination skills. Experience with deployment of emergency preparedness and response teams shall be included during the clinical experiences.

"(7) FACULTY DEVELOPMENT.—The Surgeon General shall develop faculty development programs and curricula in decentralized venues of Health Resource Community, tertiary, and inpatient venues.

"SEC. 272. ADMINISTRATION.

"(a) IN GENERAL.—The business of the Track shall be conducted by the Surgeon General with funds appropriated for and provided by the Secretary for the purpose of enhancing the activities of the Track in education, research, and technological applications of knowledge.

"(b) FELLOWS.—

"(1) IN GENERAL.—The Surgeon General, after consultation with the National Health Care Workforce Commission, shall provide the services of such professors, instructors, and administrative and other employees as may be necessary to operate the Track, but utilize when possible, existing affiliated health profession trainee institutions. Members of the faculty and staff shall be employed under salary schedules and granted retirement and other related benefits prescribed by the Secretary so that the employees of the faculty on a comparable basis with the employees of fully accredited schools of the health professions within the United States.

"(2) TITLES.—The Surgeon General may confer academic titles, as appropriate, upon the members of the faculty.

"(c) NONAPPLICABILITY OF PROVISIONS.—The limitations in section 5373 of title 5, United States Code, shall not apply to the authority of the Surgeon General under paragraph (1) to prescribe salary schedules and other related benefits.

"(d) AGREEMENTS.—The Surgeon General may negotiate agreements with agencies of the Federal Government to utilize on a reimbursable basis appropriate existing Federal medical resources located in the United States (or locations selected in accordance with section 271(a)(2)). Under such agreements the facilities concerned will retain their identities and basic missions. The Surgeon General may make such arrangements with accredited universities and health professions training institutions in the United States. Such agreements may include provisions for educational services provided students participating in Department of Health and Human Services educational programs.

"(4) PROGRAMS.—The Surgeon General may establish the following educational programs for Track students:

"(A) Postdoctoral, postgraduate, and technological programs.

"(2) A cooperative program for medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students.

"(3) Other programs that the Surgeon General determines necessary in order to operate the Track in a cost-effective manner.

"(e) CONTINUING MEDICAL EDUCATION.—The Surgeon General shall establish programs in continuing medical education in a manner consistent with the academic capacity of the affiliated sites and the needs of the United States for medical, dental, and nursing personnel.

"(f) AUTHORITY OF THE SURGEON GENERAL.

"(1) IN GENERAL.—The Surgeon General is authorized—

"(A) to enter into contracts with, accept grants from, and make grants to any nonprofit entity for the purpose of carrying out cooperative enterprises in medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing research, consultation, and education;

"(B) to enter into agreements with entities under which the Surgeon General may furnish the services of such professional, technical, or clerical personnel as may be necessary to fulfill cooperative enterprises undertaken by the Track;

"(C) to accept, hold, administer, invest, and spend any gift, devise, or bequest of personal property made to the Track for the purpose of supporting the activities of the Track in education, research, and technological applications of knowledge; and

"(D) to enter into agreements with entities that may be utilized by the Track for the purpose of enhancing the activities of the Track in education, research, and technological applications of knowledge; and

"(E) to accept the voluntary services of guest scholars and other persons.

"(2) LIMITATION.—The Surgeon General may not enter into any contract with an entity if the contract would obligate the Track

""}
to make outlays in advance of the enactment of budget authority for such outlays.

(3) SCIENTISTS.—Scientists or other medical, dental, or nursing personnel utilized by the Surgeon General in the Track shall not be considered to be an employee of the Federal Government for the purposes of chapter 81 of title 5, relating to compensation for work-related injuries, and to be an employee for the purposes of the 2008 Defense Appropriations Act of the Track.

(4) VOLUNTEER SERVICES.—A person who provides voluntary services under the authority of subparagraph (E) of paragraph (1) shall be considered to be an employee of the Federal Government for the purposes of chapter 81 of title 5, relating to compensation for work-related injuries, and to be an employee for the purposes of the 2008 Defense Appropriations Act of the Track.

SEC. 273. STUDENTS; SELECTION; OBLIGATION.

(a) STUDENT SELECTION.—

(1) IN GENERAL.—Medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students at the Track shall be selected under procedures established by the Surgeon General. In so prescribing, the Surgeon General shall consider the recommendations of the National Health Care Workforce Commission.

(2) PRIORITY.—In developing admissions procedures under paragraph (1), the Surgeon General shall ensure that such procedures give priority to applicant medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing students from rural communities and underrepresented minority groups.

(b) CONTRACT AND SERVICE OBLIGATION.—

(1) CONTRACT.—Upon being admitted to the Track, each student must enter into a written contract with the Surgeon General that shall contain—

(A) an agreement under which—

(i) subject to subparagraph (B), the student agrees—

(A) to accept the provision of such tuition and student stipend to the student;

(ii) subject to subparagraph (B), the student agrees—

(A) to accept the provision of such tuition and student stipend to the student;

(B) a provision that any financial obligation of the United States arising out of a student’s breach of the contract; and

(C) a statement of the damages to which the United States is entitled for the student’s breach of the contract;

(B) the Surgeon General, based on the recommendations of the director of the National Health Care Workforce Commission, shall establish Federal tuition remission rates to be used by the Track to provide reimbursement to affiliated and other participating health professions institutions for the cost of educational services provided by such institutions to Track students. The agreement entered into by such participating institutions under paragraph (1)(A)(i) shall contain an agreement to accept payment in full the established remission rate under this subparagraph.

(iv) subject to subparagraph (B), the student agrees—

(A) in the case of a student who elects to participate in a high-needs specialty residency (as determined by the National Health Care Workforce Commission) for 12 months, by September 1 of each year of such participation (not to exceed a total of 12 months); and

(B) in the case of a student who, upon completion of a speciality residency program, elects to practice in a Federal medical facility (as defined in section 781(e)) that is located in a health professional shortage area (as defined in section 332), by 3 months for each year of full-time practice in such a facility (not to exceed a total of 12 months).

(c) SECOND 2 YEARS OF SERVICE.—During the third and fourth years in which a medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing student is enrolled in the Track at an affiliated or other participating health professions institution pursuant to an agreement between the Track and such institution, the student—

(i) subject to subparagraph (B), the student agrees—

(A) to accept the provision of such tuition and student stipend to the student;

II. Tuition and Stipend

(a) Tuition Remission Rates.—The Surgeon General, based on the recommendations of the National Health Care Workforce Commission, shall establish Federal tuition remission rates to be used by the Track to provide reimbursement to affiliated and other participating health professions institutions for the cost of educational services provided by such institutions to Track students. The agreement entered into by such participating institutions under paragraph (1)(A)(i) shall contain an agreement to accept payment in full the established remission rate under this subparagraph.

(b) Stipend.—The Surgeon General, based on the recommendations of the National Health Care Workforce Commission, shall establish and update Federal stipend rates for payment to students during the Track.

(c) Reductions in the Period of Obligated Service.—The period of obligated service under paragraph (1) shall be reduced—

(i) in the case of a student who elects to participate in a high-needs specialty residency (as determined by the National Health Care Workforce Commission) for 12 months, by September 1 of each year of such participation (not to exceed a total of 12 months); and

(ii) subject to subparagraph (B), the student agrees—

(A) in the case of a student who elects to participate in a high-needs specialty residency (as determined by the National Health Care Workforce Commission) for 12 months, by September 1 of each year of such participation (not to exceed a total of 12 months); and

(B) in the case of a student who, upon completion of a specialty residency program, elects to practice in a Federal medical facility (as defined in section 781(e)) that is located in a health professional shortage area (as defined in section 332), by 3 months for each year of full-time practice in such a facility (not to exceed a total of 12 months).

(d) Second 2 Years of Service.—During the third and fourth years in which a medical, dental, physician assistant, pharmacy, behavioral and mental health, public health, and nursing student is enrolled in the Track at an affiliated or other participating health professions institution pursuant to an agreement between the Track and such institution, the student—

(i) subject to subparagraph (B), the student agrees—

(A) to accept the provision of such tuition and student stipend to the student;

Sec. 274. Funding

(a) Purpose.—Beginning with fiscal year 2010, the Secretary shall provide—

(b) Formula for Allocations.—The amount appropriated under subsection (i) for a fiscal year shall be apportioned—

(1) 80 percent of such amount to grants under subsection (a) to health professions schools that meet the conditions described in paragraph (3) or (4) of subsection (c) (including meeting the conditions under subsection (e));

(2) 20 percent of such amount to grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5).

(3) Allocation.—If amounts appropriated under subsection (i) for a fiscal year exceed $25,000,000 but are less than $30,000,000—

(4) Allocation.—If amounts appropriated under subsection (i) for a fiscal year exceed $25,000,000 but are less than $40,000,000, the Secretary shall make available—

(1) 20 percent of such excess amount shall be available for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (3) or (4) of subsection (c) (including meeting the conditions under subsection (e)); and

(2) 20 percent of such excess amount shall be available for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5).

(5) CATEGORIZATION.—If amounts appropriated under subsection (i) for a fiscal year exceed $30,000,000 but are less than $40,000,000, the Secretary shall make available—

(i) not less than $12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(2)(A); and

(2) not less than $12,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in paragraph (3) or (4) of subsection (c) (including meeting the conditions pursuant to subsection (e)); and

(3) not less than $6,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(2)(B); and

(4) not less than $6,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(2)(C) or (c)(2)(D); and

(5) not less than $18,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5).
schools that meet the conditions described in subsection (c)(5); and

“(iv) after grants are made with funds under clauses (i) through (iii), any remaining funds remaining under subsection (a) to health professions schools that meet the conditions described in paragraph (2)(A), (3), (4), or (5) of subsection (c).

“(A) not less than $10,000,000. If amounts appropriated under subsection (i) for a fiscal year are $10,000,000 or more, the Secretary shall make available—

“(I) not less than $16,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(2)(A); and

“(II) not less than $8,000,000 for grants under subsection (a) to health professions schools that meet the conditions described in subsection (c)(5); and

“(iv) after grants are made with funds under clauses (i) through (iii), any remaining funds remaining under subsection (a) to health professions schools that meet the conditions described in paragraph (2)(A), (3), (4), or (5) of subsection (c).

“(B) POINT OF SERVICE MAINTENANCE AND ENHANCEMENT .—The Secretary shall make awards to eligible entities to maintain and improve the effectiveness and capabilities of an existing area health education center program, and make other modifications to the program that are appropriate due to changes in demographics, needs of the populations served, or other similar issues affecting the area health education center program. For the purposes of this section, the term ‘Program’ refers to the area health education center program.

“SEC. 751. AREA HEALTH EDUCATION CENTERS.

“(a) ESTABLISHMENT OF AWARDS.—The Secretary shall make the following 2 types of awards in accordance with this section:

“(1) INFRASTRUCTURE DEVELOPMENT AWARD.—The Secretary shall make awards to eligible entities to enable such entities to initiate health care workforce educational programs or to continue to carry out comparable programs that are operating at the time the awards are made, developing, operating, and evaluating an area health education center program.

“(2) POINT OF SERVICE MAINTENANCE AND ENHANCEMENT AWARD.—The Secretary shall make awards to eligible entities to maintain and improve the effectiveness and capabilities of an existing area health education center program, and make other modifications to the program that are appropriate due to changes in demographics, needs of the populations served, or other similar issues affecting the area health education center program.

“(b) ELIGIBLE ENTITIES.—

“(1) ELIGIBLE ENTITIES.—(A) INFRASTRUCTURE DEVELOPMENT.—For purposes of subsection (a)(1), the term ‘eligible entity’ means a school of medicine or osteopathic medicine, an incorporated consortium of such schools, or the parent institutions of such a school. With respect to a State in which a new education center under this program is in operation, the Secretary may award a grant or contract under subsection (a)(2) to a school.

“(B) POINT OF SERVICE MAINTENANCE AND ENHANCEMENT.—For purposes of subsection (a)(2), the term ‘eligible entity’ means an entity that has received funds under this section, is operating an area health education center program, including an area health education center or centers, and has a center or centers that are no longer eligible to receive financial assistance under subsection (a)(1).

“(2) APPLICATION.—An eligible entity desiring to receive an award under this section shall submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

“(c) USE OF FUNDS.—(1) REQUIRED ACTIVITIES.—An eligible entity shall use amounts awarded under a grant under subsection (a)(1) or (a)(2) to carry out the following activities:

“(A) Develop and implement strategies in coordination with the applicable one-stop development center of the workforce investment Act of 1998, to recruit individuals from underrepresented minority populations or from disadvantaged or rural areas, or to provide training programs, the State workforce agency, or the local workforce investment boards, and in health care safety net sites.

“(B) Prepare individuals to more effectively provide health services to underserved areas and populations, in collaboration with other Federal and State health care workforce development programs, the State workforce agency, local workforce investment boards, and in health care safety net sites.

“(C) Conduct and participate in interdisciplinary training that involves physicians, physician assistants, nurse practitioners, nurse midwives, dentists, psychologists, nurses, nurse practitioners, community health workers, public and allied health professionals, or other health professionals, as practicable.

“(D) Deliver or facilitate continuing education and information dissemination programs for health care professionals, with an emphasis on individuals providing care in underserved areas and for health disparity populations.

“(E) Propose and implement effective program and outcomes measurement and evaluation strategies.

“(F) Establish a youth public health program to expose and recruit high school students into health careers, with a focus on careers in public health.

“(G) INNOVATIVE OPPORTUNITIES.—An eligible entity may use amounts awarded under a grant under subsection (a)(1) or subsection (a)(2) to carry out any of the following activities:

“(I) Develop and implement innovative curricula in collaboration with community-based participatory research with academic health centers, and facilitate rapid flow and dissemination of evidence-based health care information, research results, and best practices to improve quality, efficiency, and effectiveness of health care and health care systems within community settings.

“(J) Develop and implement other strategies to address identified workforce needs and increase and enhance the health care workforce in the area served by the area health education center program.

“(K) Coordinate community-based participatory research with academic health centers, and facilitate rapid flow and dissemination of evidence-based health care information, research results, and best practices to improve quality, efficiency, and effectiveness of health care and health care systems within community settings.

“(L) Develop and implement other strategies to address identified workforce needs and increase and enhance the health care workforce in the area served by the area health education center program.

“(M) REQUIREMENTS.—(A) HEALTH CARE EDUCATION CENTER PROGRAM.—In carrying out this section, the Secretary shall ensure the following:

“(B) An entity that receives an award under this section shall conduct at least 10 percent of clinical education required for medical students in community settings that are removed from the primary teaching facilities of the contracting institution for grantees that operate a school of medicine or osteopathic medicine. In States in which an
entity that receives an award under this section is a nursing school or its parent institution, the Secretary shall alternatively ensure that—

"(1) any nursing school conducts at least 10 percent of clinical education required for nursing students in community settings that are remote from the primary teaching facility of such school; and

"(2) any area health education center program includes at least 1 area health education center program area.

"(B) An entity receiving funds under subsection (a)(1) shall distribute such funds to a center that is eligible to receive funding under subsection (a)(1).

"(2) AREA HEALTH EDUCATION CENTER.—The Secretary shall ensure that—

"(A) a public or private organization whose structure, governance, and operation is independent from the awardee and the parent institution of the awardee;

"(B) is not a school of medicine or osteopathic medicine, the parent institution of such a school, or a branch campus or other subunit of a school of medicine or osteopathic medicine, such a parent institution, or a consortium of such entities;

"(C) designates an underserved area or population to be served by the center which is in a location provided in the local area designated for purposes of section 751 of the Public Health Service Act (42 U.S.C. 294x-1); and

"(D) fosters networking and collaboration among communities and between academic health centers and community-based centers;

"(E) serves communities with a demonstrated need of health professionals in partnership with academic medical centers;

"(F) addresses the health care workforce needs of the communities served in coordination with the public workforce investment system; and

"(G) has a community-based governing or advisory board that reflects the diversity of the communities served.

"(e) MATCHING FUNDS.—With respect to the costs of operating a program through a grant under this section, to be eligible for financial assistance under this section, an entity shall make available (directly or through contributions from State, county or municipal governments, or the private sector) recurring non-Federal contributions in cash or in kind, toward such costs in an amount that is equal to not less than 50 percent of such costs. The Federal share shall be 50 percent of the total required non-Federal contributions shall be in cash. An entity may apply to the Secretary for a waiver of not more than 75 percent of the match requirement for any fiscal year. The Secretary shall fund an entity for each of the first 3 years the entity is funded through a grant under subsection (a)(1).

"(f) LIMITATION.—Not less than 75 percent of the total amount provided to an area health education center program under subsection (a)(1) or (a)(2) shall be allocated to the area health education centers participating in the program under this section. To provide needed flexibility to newly funded area health education center programs, the Secretary may waive the requirement in the sentence for the first 2 years of a new area health education center program funded under this section.

"(g) AWARD.—An award to an entity under this section shall be not less than $250,000 annually per area health education center included in the program involved. If amounts appropriated to carry out this section are not sufficient to comply with the preceding sentence, the portion of the granteecenter amount provided for in such sentence as necessary, provided the distribution established in subsection (j)(2) is maintained.

"(h) Private Sector Participation.——

"(1) IN GENERAL.—Except as provided in paragraph (2), the period during which payments may be made under an award under subsection (a)(2) shall not exceed 6 years.

"(2) EXCEPTION.—The periods described in paragraph (1) shall not apply to programs receiving point of service maintenance and enhancement awards under subsection (a)(2) to maintain existing centers and activities.

"(i) INAPPLICABILITY OF PROVISION.—Notwithstanding any other provision of this title, section 751(h) shall not apply to an area health education center funded under this section.

"(j) AUTHORIZATION OF APPROPRIATIONS.—

"(1) In general.—The term ‘health extension agent’ means an individual who has completed an educational program and who is accountable for activities promoting health, disease prevention, and health promotion services for men, women, and children of all ages, developing a practice environment, and provide information dissemination and educational support to primary care providers about preventive medicine, health promotion, chronic disease management, mental and behavioral health services (including substance abuse and treatment services), and evidence-based and evidence-informed therapies and techniques, in order to enable providers to incorporate such resources into their daily practice, with priority for primary care.

"(B) PRIMARY CARE PROVIDER.—The term ‘primary care provider’ means a clinician with formal ties to primary care who helps patients develop and maintain appropriate access to primary care and facilitates and provides assistance to primary care practices by implementing quality improvement or system redesign, incorporating the principles of the patient-centered medical home to provide high-quality, effective, efficient, and safe primary care and to provide guidance to patients in culturally and linguistically appropriate ways, and linking practices to diverse health system resources.

"(C) DEFINITIONS.—In this section—

"(A) HEALTH EXTENSION AGENT.—The term ‘Health Extension Agent’ means any local, community-based health worker who facilitates and provides assistance to primary care practices by implementing quality improvement or system redesign, incorporating the principles of the patient-centered medical home to provide high-quality, effective, efficient, and safe primary care and to provide guidance to patients in culturally and linguistically appropriate ways, and linking practices to diverse health system resources.

"(B) PRIMARY CARE PROVIDER.—The term ‘primary care provider’ means a clinician with formal ties to primary care who helps patients develop and maintain appropriate access to primary care and facilitates and provides assistance to primary care practices by implementing quality improvement or system redesign, incorporating the principles of the patient-centered medical home to provide high-quality, effective, efficient, and safe primary care and to provide guidance to patients in culturally and linguistically appropriate ways, and linking practices to diverse health system resources.

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practicing in the context of family and community, as recognized by a State licensing or regulatory authority, unless otherwise specified in this section.

(b) Establish State Hubs and Local Primary Care Extension Agencies.—

(1) Grants.—The Secretary shall award competitive grants to States for the establishment of State- or multistate-level primary care Primary Care Extension Program State Hubs (referred to in this section as ‘‘Hubs’’).

(2) COMPOSITION OF HUBS.—A Hub established by a State pursuant to paragraph (1)—

(A) shall consist of, at a minimum, the State health department, the entity responsible for overseeing the State Medicaid program (if other than the State health department), the State-level entity administering the Medicare program, and the departments of 1 or more health professions schools in the State that train providers in primary care; and

(B) may include entities such as hospital associations, primary care practice-based research networks, health professional societies, State primary care associations, State licensing boards, organizations with a contract from the Secretary under section 1863(l) of the Social Security Act, consumer groups, and other appropriate entities.

(c) STATE AND LOCAL ACTIVITIES.—

(1) GRANTS.—Hubs established under a grant subsection (b) shall—

(A) submit to the Secretary a plan to coordinate functions with quality improvement organizations and area health education centers if such entities are members of the Hub not described in subsection (b)(2)(A);

(B) contract with a county- or local-level entity that shall serve as the Primary Care Extension Agency to administer the services described in paragraph (2);

(C) administer grant funds to county- or local-level Primary Care Extension Agencies that serve a catchment area, as determined by the State; and

(D) organize State-wide or multistate networks of local-level Primary Care Extension Agencies to share and disseminate information and practices.

(d) LOCAL PRIMARY CARE EXTENSION AGENCY ACTIVITIES.—

(1) REQUIRED ACTIVITIES.—Primary Care Extension Agencies established by a Hub under paragraph (1)—

(i) assist primary care providers to implement a patient-centered medical home to improve the accessibility, quality, and efficiency of primary care services, including health homes;

(ii) develop and support primary care learning communities to enhance the dissemination of research findings for evidence-based practice, assess implementation of practice improvement, share best practices, and involve community clinicians in the generation of evidence and the identification of important questions for research;

(iii) participate in a national network of Primary Care Extension Hubs and propose how the Primary Care Extension Agency will share and disseminate lessons learned and best practices; and

(iv) develop a plan for financial sustainability involving State, local, and private contributions, to provide for the reduction in Federal funds that is expected after an initial 6-year period of program establishment, infrastructure development, and planning;

(2) DISCRETIONARY ACTIVITIES.—Primary Care Extension Agencies established by a Hub under paragraph (1) may—

(A) assist and support primary care training and, and organizational support for community health teams established under section 3962 of the Patient Protection and Affordable Care Act;

(B) collect data and provision of primary care provider feedback from standardized measurement instruments to aid in continuous performance improvement;

(C) collaborate with local health departments, community health centers, tribes and tribal organizations, and local health agencies to identify community health priorities and local health workforce needs, and participate in community-based efforts to address those needs and to determine the scope of health, strengthen the local primary care workforce, and eliminate health disparities;

(D) develop measures to monitor the impact of the Hubs on the health of practice enrollees and of the wider community served; and

(E) participate in other activities, as determined appropriate by the Secretary.

(e) FEDERAL PROGRAM ADMINISTRATION.—

(1) GRANTS; TYPES.—Grants awarded under subsection (b) shall be—

(A) program grants, that are awarded to State or multistate entities that submit fully-developed plans for the implementation of a Hub, for a period of 6 years; or

(B) placement grants awarded to State or multistate entities with the goal of developing a plan for a Hub, for a period of 2 years.

(2) APPLICATION.—To be eligible for a grant under subsection (b), a State or multistate entity shall submit to the Secretary an application, at such time, in such manner, and containing such information as the Secretary may require.

(3) EVALUATION.—A State that receives a grant under subsection (b) shall be evaluated at the end of the grant period by a evaluation panel appointed by the Secretary.

(4) CONTINUING SUPPORT.—After the sixth year in which assistance is provided to a State under a grant awarded under subsection (b), the State may receive additional support under this section if the State program has received satisfactory evaluation with respect to program performance and the merits of the State sustainability plan, as determined by the Secretary.

(5) LIMITATION.—A State shall not use in excess of 10 percent of the amount received under a grant to carry out administrative activities under this section. Funds awarded pursuant to this subsection shall not be used for funding direct patient care.

(f) REQUIREMENTS ON THE SECRETARY.—In carrying out this section, the Secretary shall consult with the leadership of other Federal agencies with demonstrated experience and expertise in health care and preventive medicine, such as the Centers for Disease Control and Prevention, the Substance Abuse and Mental Health Administration, the Health Resources and Services Administration, the National Institutes of Health, the Office of the National Coordinator for Health Information Technology, the Indian Health Service, the Agricultural Cooperative Extension Service of the Department of Agriculture, and other entities as the Secretary determines appropriate.

(g) AUTHORIZATION OF APPROPRIATIONS.—To award grants as provided in subsection (d), there are authorized to be appropriated $120,000,000 for each of fiscal years 2011 and 2012, and such sums as may be necessary to carry out this section for each of fiscal years 2013 through 2017.

Subtitle F—Strengthening Primary Care and Other Workforce Improvements

SEC. 5501. EXPANDING ACCESS TO PRIMARY CARE SERVICES AND GENERAL SURGERY SERVICES.

(a) Incentive Payment Program for Primary Care Services.—

(1) IN GENERAL.—Section 1333 of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

(2) INCENTIVE PAYMENTS FOR PRIMARY CARE SERVICES.—

(1) IN GENERAL.—In the case of primary care services furnished on or after January 1, 2011, and before January 1, 2016, by a primary care practitioner, in addition to the amount of payment that would otherwise be made for such services under subsection (a)(1), there shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

(2) DEFINITIONS.—In this subsection:

(A) PRIMARY CARE PRACTITIONER.—The term ‘‘primary care practitioner’’ means an individual who—

(i) is a physician (as described in section 1861(r)(1)) who has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or

(ii) is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861(aa)(5)); and

(iii) for whom primary care services are acceptable at least 60 percent of the allowed charges under this part for such physician or practitioner in a prior period as determined appropriate by the Secretary.

(B) PRIMARY CARE SERVICES.—The term ‘‘primary care services’’ means services identified, as of January 1, 2009, by the following HCPCS codes and as subsequently modified by the Secretary:

(i) 99301 through 99215.

(ii) 99304 through 99340.

(ii) 99341 through 99350.

(iii) 99391 through 99393.

(3) COORDINATION WITH OTHER PAYMENTS.—The amount of the additional payment for a service under this subsection and subsection (b) shall be determined without regard to any additional payment for the service under subsection (m) and this subsection, respectively.

(4) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1978, or otherwise, respecting the identification of primary care practitioners under this subsection.

(5) INCLUSION OF GRANDFATHERED SERVICES.—Section 1833(g)(2)(B) of the Social Security Act (42 U.S.C. 1395m(g)(2)(B)) is amended by adding at the end the following new sentence: ‘‘Section 1833(g)(2)(B) shall not be used in determining the amounts that would otherwise be paid pursuant to the preceding sentence.’’

(6) INCLUSION OF GRANDFATHERED SERVICES.—In the case of major surgical procedures furnished on or after January 1, 2011, and before January 1, 2016, by a general surgeon in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area as identified by the Secretary prior to the beginning of the year involved, in addition to the amount of payment that would otherwise be made for such services under this part, there shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

(h) Incentive Payment Program for Major Surgical Procedures Furnished in Health Professional Shortage Areas.—

(1) IN GENERAL.—Section 1333 of the Social Security Act (42 U.S.C. 1395l), as amended by subsection (a)(1), is amended by adding at the end the following new subsection:

(2) INCENTIVE PAYMENTS FOR MAJOR SURGICAL PROCEDURES FURNISHED IN HEALTH PROFESSIONAL SHORTAGE AREAS.—

(1) IN GENERAL.—In the case of major surgical procedures furnished on or after January 1, 2011, and before January 1, 2016, by a general surgeon in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a health professional shortage area as identified by the Secretary prior to the beginning of the year involved, in addition to the amount of payment that would otherwise be made for such services under this part, there shall be paid (on a monthly or quarterly basis) an amount equal to 10 percent of the payment amount for the service under this part.

(i) DEFINITIONS.—In this section:

(A) GENERAL SURGEON.—In this section, the term ‘‘general surgeon’’ means a
physician (as described in section 1861(r)(1)) who has designated CMS specialty code 02—
General Surgery as their primary specialty code in the physician's enrollment under section
1848(b).

"(B) MAJOR SURGICAL PROCEDURES.—The term 'major surgical procedures' means phys-
sicians' services which are surgical procedures requiring at least a one-night or 96-hour hospital
stay.

"(C) FEDERALLY QUALIFIED HEALTH CENTERS.—

"(1) IN GENERAL.—The Secretary shall establish a process for identifying and publishing a
list of 'Federally qualified health centers' (as described in subsection (c)(5)(B) of the Social
Security Act (42 U.S.C. 1395m(g)(2)(B)), as amended by subsection (b) of section 1834(g)(2)(B)
of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)) is amended by

"(2) IMPLEMENTATION.—

"(A) IN GENERAL.—Notwithstanding section 1833(a)(3)(B), the Secretary shall provide, for
cost reporting periods beginning on or after January 1, 2011, for payments for Federally
qualified health centers that under this title that would have occurred for such services
in such year if the system had not been implemented.

SEC. 5503. DISTRIBUTION OF ADDITIONAL RESI-
DENCY POSITIONS.

(a) IN GENERAL.—(Section 1886(h) of the Social
Security Act (42 U.S.C. 1395w(h)) is amended—

"(1) in paragraphs (4)(F)(i), by striking "paragraph (7)" and inserting "paragraphs (7) and (8)";

"(2) in paragraph (4)(H)(i), by striking "paragraph (7)" and inserting "paragraphs (7) and (8)";

"(3) in paragraph (7)(E), by inserting "or paragraph (8)" before the period at the end;

(b) DISTRIBUTION OF ADDITIONAL RESIDENCY
POSITIONS.—

"(1) IN GENERAL.—(The Secretary shall establish a
system for making Federal additional residency positions available under this section in
accordance with the requirements in paragraph (a).

"(2) CONFORMING AMENDMENT.—Section 1834(g)(2)(B) of the Social Security Act (42
U.S.C. 1395w–4(c)(2)(B)) is amended by inserting at the end the following clause:

"(y) additional payments under this section under this subsection in the same manner as
such additional payments are determined under section 1822(q).

SEC. 5504. MEDICARE QUALIFIED HEALTH CENTER IMPROVEMENTS.

(a) EXTENSION OF MEDICARE-QUALIFIED
PREVENTIVE SERVICES.—At Federally Qualified Health Centers—

"(1) IN GENERAL.—(Section 1861(a)(3)(A) of the Social Security Act (42 U.S.C. 1395w
(aa)(3)(A)) is amended—

"(A) services of the type described subparagraphs (A) through (C) of paragraph (1) and
preventive services (as defined in section 1861(d)(3)(B)); and

"(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services
furnished on or after January 1, 2011.

(b) PROSPECTIVE PAYMENT SYSTEM FOR
FEDERALLY QUALIFIED HEALTH CENTERS.—

"(1) IN GENERAL.—(Section 1834 of the Social Security Act (42 U.S.C. 1395m) is amended
by adding at the end the following subsection:

"(II) the number of full-time equivalent pri-
care residents, as determined by the Secretary, that—

"(i) whether the hospital is located in a
major surgical procedures specialty;

"(ii) the demonstration likelihood of the
hospital filling the positions made available
under this paragraph.

"(2) EFFECTIVE DATE.—The amendment
made by paragraph (1) shall apply to services
furnished on or after January 1, 2011.

(c) IMPLEMENTATION.—

"(1) IN GENERAL.—The Secretary shall de-
develop a prospective payment system for pay-
ment for Federally qualified health centers
furnished by Federally qualified health centers
under this title.

"(2) EFFECTIVE DATE.—The amendment
made by paragraph (1) shall apply to services
furnished on or after January 1, 2011.

"(3) FEDERALLY QUALIFIED HEALTH CENTERS.—

"(1) IN GENERAL.—The Secretary shall de-
develop a prospective payment system for pay-
ment for Federally qualified health centers
furnished by Federally qualified health centers
under this title.

"(2) EFFECTIVE DATE.—The amendment
made by paragraph (1) shall apply to services
furnished on or after January 1, 2011.

"(4) PROSPECTIVE PAYMENT SYSTEM FOR
PREVENTIVE SERVICES.—

"(1) IN GENERAL.—The Secretary shall de-
develop a prospective payment system for pay-
ment for Federally qualified health centers
furnished by Federally qualified health centers
under this title.

"(2) EFFECTIVE DATE.—The amendment
made by paragraph (1) shall apply to services
furnished on or after January 1, 2011.
SEC. 5504. COUNTING RESIDENT TIME IN NONPROVIDER SETTINGS.

(a) GME.—Section 1886(h)(4)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(E)) is amended—

(1) by striking ‘‘(v) 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, 2010;’’; and

(2) by inserting at the end the following new paragraph:

‘‘(v)(II) Effective for discharges occurring on or after July 1, 2010, all the time spent by an intern or resident in patient care activities in a nonprovider setting shall be counted toward the determination of full-time equivalency in a nonprovider setting;’’.

(b) IME DETERMINATIONS.—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following new clause:

‘‘(x)(I) The provisions of subparagraph (K) of section 1886(d)(5)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) are amended—

(1) by striking the period at the end and inserting ‘‘; and

(2) by striking ‘‘(y)’’ and inserting ‘‘(yi)’’.

(c) APPLICATION.—The amendments made by this section shall be applied in a manner that requires reopening of any settled hospital cost reports as to which there is not a jurisdictionally proper appeal pending as of the date of the enactment of this Act on the issue of payment for indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) or for direct graduate medical education costs under section 1886(h) of such Act (42 U.S.C. 1395ww(h)).

SEC. 5505. RULES FOR COUNTING RESIDENT AND SCHOLAR ACTIVITIES AND OTHER ACTIVITIES.

(a) GME.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)), as amended by section 5504, is amended—

(1) in paragraph (4)—

(A) in subparagraph (E), by striking ‘‘Such rules’’ and inserting ‘‘Subject to subparagraphs (J) and (K), such rules’’; and

(B) by adding at the end the following new subparagraph:

‘‘(J) TREATMENT OF CERTAIN NONPROVIDER AND SCHOLAR ACTIVITIES.—The Secretary shall provide that all time spent by an intern or resident in an approved medical residency training program in a nonprovider setting that is primarily engaged in furnishing patient care as defined in paragraph (5)(K) in non-patient care activities, such as didactic conferences and seminars, but not including research not associated with the treatment or diagnosis of a particular patient, as such time and activities are defined by the Secretary, shall be counted toward the determination of full-time equivalency.’’.

(2) in paragraph (5), by adding at the end the following new subparagraph:

‘‘(K) NONPROVIDER TIME THAT IS PrimARILY ENGAGED IN FURISHING 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.’’.

(b) IME DETERMINATIONS.—Section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding at the end the following new clause:

‘‘(y)(I) The provisions of subparagraph (K) of section 1886(d)(5)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) are amended—

(1) by striking ‘‘(iv) Effective for discharges occurring on or after October 1, 1997’’ and inserting ‘‘(iv)(I) Effective for discharges occurring on or after October 1, 1997, and before July 1, 2010;’’; and

(2) by inserting at the end the following new subparagraph:

‘‘(vi) Effective for discharges occurring on or after July 1, 2010, all the time spent by an intern or resident in patient care activities in a nonprovider setting shall be counted toward the determination of full-time equivalency in a nonprovider setting;’’.

(2) Effective Dates.—
AFTER A HOSPITAL CLOSES.—Subject to the succeeding provisions of this clause, in determining for which hospitals the increase in the otherwise applicable resident limit is provided under such process, the Secretary shall distill the increase to hospitals in the following priority order (with preference given within each category to hospitals that are members of the same affiliated group as defined by the Secretary under clause (ii) as the closed hospital):

(1) First, to hospitals located in the same core-based statistical area contiguous to, the hospital that closed.
(2) Second, to hospitals located in the same region of the country as the hospital that closed.
(3) Third, to hospitals located in the same core-based statistical area as the hospital that closed.
(4) Fourth, only if the Secretary is not able to distribute the increase to hospitals described in item (cc), to qualifying hospitals in accordance with the provisions of paragraph (8).

(II) PRIORITY FOR HOSPITALS IN CERTAIN AREAS.—Subject to the succeeding provisions of this clause, in determining for which hospitals the increase in the otherwise applicable resident limit is provided under such process, the Secretary shall distill the increase to hospitals in the following priority order (with preference given within each category to hospitals that are members of the same affiliated group as defined by the Secretary under clause (ii) as the closed hospital):

(a) First, to hospitals located in the same core-based statistical area as, or a core-based statistical area contiguous to, the hospital that closed.
(b) Second, to hospitals located in the same region of the country as the hospital that closed.
(c) Third, to hospitals located in the same core-based statistical area as, or a core-based statistical area contiguous to, the hospital that closed.
(d) Fourth, only if the Secretary is not able to distribute the increase to hospitals described in item (cc), to qualifying hospitals in accordance with the provisions of paragraph (8).

(III) REQUIREMENT HOSPITAL LIKELY TO FILL POSITION WITHIN CERTAIN TIME PERIOD.—The Secretary may only increase the otherwise applicable resident limit of a hospital under such process if the Secretary determines the hospital has demonstrated a likelihood of filling the positions made available under such process within 3 years.

(IV) LIMITATION.—The aggregate number of increases in the otherwise applicable resident limits for hospitals under this clause shall not exceed the number of resident positions in the approved medical residency programs that closed on or after the date specified in subclause (I).

(V) ADMINISTRATION.—Chapter 53 of title 42, United States Code, shall not apply to the implementation of this clause.

SEC. 5506. PRESERVATION OF RESIDENT CAP POSITIONS FROM CLOSED HOSPITALS.

(a) GMF.—Section 1886(h)(4)(H) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(H)) is amended by adding at the end the following new clause:

"(V) DISTRIBUTION OF RESIDENCY SLOTS AFTER A HOSPITAL CLOSURES.—"

(1) In general.—Subject to the succeeding provisions of this clause, the Secretary shall, for purposes of establishing a process by which the Secretary may only increase the otherwise applicable resident limit under this paragraph or program (or that closed on or after October 1, 2001. Such information shall not be presented in an effect prior to such date should be interpreted.

SEC. 5507. DESIGNATION PROJECTS TO ADDRESS HEALTH PROFESSIONS WORKFORCE DEVELOPMENT AND FAMILIES TO FAMILY-FAMILY HEALTH INFORMATION CENTERS.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECTS.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.) is amended by adding at the end the following:

"SEC. 208. DEMONSTRATION PROJECTS TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS.

"(a) DEMONSTRATION PROJECTS TO PROVIDE LOW-INCOME INDIVIDUALS WITH OPPORTUNITIES FOR EDUCATION, TRAINING, AND CAREER ADVANCEMENT TO ADDRESS HEALTH PROFESSIONS WORKFORCE NEEDS.—"

(1) AUTHORITY TO AWARD GRANTS.—The Secretary, in consultation with the Secretary of Labor, shall award grants to eligible entities to conduct demonstration projects that provide eligible individuals with the opportunity to obtain education and training for occupations in the health care field that pay well and are expected to either experience labor shortages or be in high demand.

(2) REQUIREMENTS.—

(A) AID AND SUPPORTIVE SERVICES.—In carrying out a demonstration project conducted by an eligible entity awarded a grant under this section, the Secretary shall provide, if appropriate, such training programs to the eligible entity in cooperation with the appropriate agencies of the Federal, State, and local governments, including agencies responsible for providing such training programs to such eligible individuals.

(B) EVALUATION.—The Secretary shall, by regulation, require that the grantee submit reports to demonstrate the extent to which the grantee is achieving the objectives of the grant.

"(B) ELIGIBLE ENTITIES.—An eligible entity means an organization that meets the requirements of this subsection.

(C) INDIAN TRIBE; TRIBAL ORGANIZATION.—The term ‘Indian tribe’ means a tribe of Indian Indians, and includes any other tribe or tribal organization that provides services to eligible individuals participating in a demonstration project conducted by an eligible entity.

(D) INSTITUTION OF HIGHER EDUCATION.—The term ‘institute of higher education’ means an academic institution of higher education that meets the requirements of this subsection.

(E) STATE.—The term ‘State’ means each State, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam.

(F) STATE TANF PROGRAM.—The term ‘State TANF program’ means the temporary..."
assistance for needy families program funded under part A of title IV.

"(G) TRLIAL COLLEGE OR UNIVERSITY.—The term ‘Tribal College or University’ has the meaning given that term in section 316(b) of the Higher Education Act of 1965 (20 U.S.C. 1009(c)).

"(b) DEMONSTRATION PROJECT TO DEVELOP TRAINING AND CERTIFICATION PROGRAMS FOR PERSONAL OR HOME CARE AIDES.—

"(1) AUTHORITY TO AWARD GRANTS.—Not later than 18 months after the date of enactment of this section, the Secretary shall award grants to entities, including educational institutions, to conduct demonstration projects to develop core training competencies for personal or home care aides. The Secretary shall—

"(A) evaluate the efficacy of the core training competencies described in paragraph (3)(A) for newly hired personal or home care aides and the methods used by States to implement such core training competencies in accordance with the issues specified in paragraph (3)(B); and

"(B) ensure that the number of hours of training provided by States under the demonstration project with respect to such core training competencies are not less than the number of hours of training required under any applicable State or Federal law or regulation.

"(2) DURATION.—A demonstration project shall be conducted under this subsection for not less than 3 years.

"(3) CORE TRAINING COMPETENCIES FOR PERSONAL OR HOME CARE AIDES.—

"(A) IN GENERAL.—The core training competencies for personal or home care aides described in this subparagraph include the following:

"(i) The role of the personal or home care aide (including differences between a personal or home care aide employed by an agency and a personal or home care aide employed directly by the health care consumer or an independent provider).

"(ii) Consumer rights, ethics, and confidentiality (including the role of proxy decision-makers in the case where a health care consumer has impaired decision-making capacity).

"(iii) Communication, cultural and linguistic competence and sensitivity, problem solving, behavior management, and relationship skills.

"(iv) Personal care skills.

"(v) Health care support.

"(vi) Nutritional support.

"(vii) Infection control.

"(viii) Safety and emergency training.

"(ix) Training specific to an individual consumer’s needs (including older individuals, individuals with disabilities, individuals with developmental disabilities, individuals with dementia, and individuals with mental and behavioral health needs).

"(B) IMPLEMENTATION.—The implementation issues specified in this subparagraph include the following:

"(i) The length of the training.

"(ii) The appropriate trainer to student ratio.

"(iii) The amount of instruction time spent in the classroom as compared to on-site in the home or a facility.

"(iv) Trainer qualifications.

"(B) APPLICATION AND ELIGIBILITY.—A State seeking to participate in the project shall—

"(i) submit an application to the Secretary containing such information and at such time as the Secretary may specify;

"(ii) meet the training criteria established under subparagraph (C); and

"(iii) meet such additional criteria as the Secretary may specify.

"(C) SELECTION CRITERIA.—In selecting States to participate in the program, the Secretary shall establish criteria to ensure (if applicable with respect to the activities involved):

"(i) geographic and demographic diversity;

"(ii) that participating States offer medical assistance for personal care services under the State Medicaid plan;

"(iii) that the existing training standards for personal or home care aides in each participating State are different from the core training competencies described in paragraph (3)(A);

"(iv) that participating States do not reduce the number of hours of training required under applicable State law or regulation after being selected to participate in the project; and

"(v) that participating States recruit a minimum number of eligible health and long-term care providers to participate in the project.

"(D) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to States in developing written materials and protocols for such core training competencies.

"(E) EVALUATION AND REPORT.—

"(A) EVALUATION.—The Secretary shall develop an experimental or control group testing protocol in consultation with an independent evaluation contractor selected by the Secretary. Such contractor shall evaluate—

"(i) the impact of core training competencies described in paragraph (3)(A), including curricula developed to implement such core training competencies, for personal or home care aides within each participating State on job satisfaction, mastery of job skills, beneficiary and family caregiver satisfaction with services, and additional measures determined by the Secretary in consultation with the expert panel;

"(ii) the impact of providing such core training competencies on the existing training infrastructure and resources of States; and

"(iii) whether a minimum number of hours of initial training should be required for personal or home care aides and, if so, what such minimum number of hours should be required.

"(B) REPORTS.—

"(1) REPORT ON INITIAL IMPLEMENTATION.—Not later than 2 years after the date of enactment of this section, the Secretary shall submit to Congress a report on the initial implementation of activities conducted under the demonstration project, including any available results of the evaluation conducted under subparagraph (A) with respect to the above activities, together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

"(2) FINAL REPORT.—Not later than 1 year after the completion of the demonstration project, the Secretary shall submit to Congress a report containing the results of the evaluation conducted under subparagraph (A), together with such recommendations for legislation or administrative action as the Secretary determines appropriate.

"(G) DEFINITIONS.—In this subsection:

"(A) ELIGIBLE HEALTH AND LONG-TERM CARE PROVIDER.—The term ‘eligible health and long-term care provider’ means a personal or home care agency (including personal or home care public authorities), a nursing home, a home health agency (as defined in section 1861(s)), or any other health care provider which—

"(i) is licensed or authorized to provide services in a participating State; and

"(ii) receives payment for services under title XIX.

"(B) PERSONAL CARE SERVICES.—The term ‘personal care services’ has the meaning given such term for purposes of title XIX.

"(C) PERSONAL OR HOME CARE AIDE.—The term ‘personal or home care aide’ means an individual who helps individuals who are elderly, disabled, ill, or mentally disabled (including an individual with Alzheimer’s disease or other dementia) to live in their own home or a residential care facility (such as a nursing home, assisted living facility, or any other facility the Secretary determines appropriate) by providing routine personal care services and other appropriate services to the individual.

"(D) STATE.—The term ‘State’ has the meaning given that term for purposes of title XIII.

"(G) FUNDING.—

"(1) IN GENERAL.—Subject to paragraph (2), out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out subsections (a) and (b) $5,000,000 for each of fiscal years 2010 through 2014.

"(2) TRAINING AND CERTIFICATION PROGRAMS FOR PERSONAL AND HOME CARE AIDES.—With respect to the demonstration projects under subsection (b), the Secretary shall use $5,000,000 of the amount appropriated under paragraph (1) for each of fiscal years 2010 through 2012 to carry out such demonstration projects and $5,000,000 for each of fiscal years 2013 through 2014 to carry out demonstration projects under subsection (b) after fiscal year 2012.

"(4) NONAPPEAL.—

"(G) EXTENSION OF FAMILY-TO-FAMILY HEALTH INFORMATION CENTERS.—

"(A) IN GENERAL.—Except as provided in paragraph (2), the preceding sections of this title shall not apply to grant awarded under this section.

"(B) LIMITATIONS ON USE OF GRANTS.—

"(1) IN GENERAL.—Subject to paragraph (2), any funds appropriated under this section shall be used to carry out demonstration projects and training and certification programs and shall not be used to fund other activities.

"(2) REPLENISHMENT OF FUNDS.—In general, the Secretary shall use such funds, and any funds that are not used for purposes specified in this section, in accordance with such priorities as the Secretary determines.
SEC. 5508. INCREASING TEACHING CAPACITY.

(a) Teaching Health Centers Training and Enhancement.—Part C of title VII of the Public Health Service Act (42 U.S.C. 258b et seq.), as amended by section 338(a), is further amended by inserting after section 749 the following:

"SEC. 749A. Teaching Health Centers Development Grants.

"(a) Program Authorized.—The Secretary may award grants under this section to teach- ing health centers for the purpose of establishing new accredited or expanded primary care residency programs.

"(b) Duration.—Grants awarded under this section shall be for a term of not more than 3 years and the maximum award may not be more than $500,000.

"(c) Conditions.—Amounts provided under a grant under this section shall be used to cover the costs of—

"(1) establishing or expanding a primary care residency training program described in subsection (a), including costs associated with—

"(A) curriculum development;

"(B) recruitment, training and retention of residents and faculty;

"(C) accreditation by the Accreditation Council for Graduate Medical Education (ACGME), the American Dental Association (ADA), or the American Osteopathic Association (AOA); and

"(D) faculty salaries during the development phase; and

"(2) technical assistance provided by an eligible entity.

"(d) Application.—A teaching health center seeking 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.

"(e) Preference for Certain Applications.—In selecting recipients for grants under this section, the Secretary shall give preference to any application that documents an existing affiliation agreement with an area health education program as defined in sections 751 and 799B.

"(1) Definitions.—In this section:

"(A) Eligible entity.—The term 'eligible entity' means an organization capable of providing technical assistance including an area health education program, as defined in sections 751 and 799B.

"(2) Primary Care Residency Program.—The term 'primary care residency program' means an approved graduate medical residency program as defined in section 340H in family medicine, internal medicine, pediatrics, internal medicine-pediatrics, obstetrics and gynecology, psychiatry, general dentistry, pediatric dentistry, and geriatrics.

"(3) Teaching Health Center.—

"(A) In General.—The term 'teaching health center' means an entity that—

"(i) is a community-based, ambulatory patient care center; and

"(ii) operates a primary care residency program.

"(B) Inclusion of Certain Entities.—Such term includes the following:

"(i) a national medical residency center, as defined in section 1905(c)(2)(B), of the Social Security Act.

"(ii) a rural health clinic, as defined in section 1905(c)(2)(B) of the Social Security Act.

"(iv) an entity operated by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization, as defined in section 4 of the Indian Health Care Improvement Act.

"(v) an entity receiving funds under title X of the Public Health Service Act.

"(g) Authorization of Appropriations.—There is authorized to be appropriated, $25,000,000 for fiscal year 2010, $50,000,000 for fiscal year 2011, $50,000,000 for fiscal year 2012, and such sums as may be necessary for each fiscal year thereafter to carry out this section. Not to exceed $5,000,000 annually may be used for technical assistance program grants.

"(h)(1) National Health Service Corps Teaching Capacity.—Section 338A(a) of the Public Health Service Act (42 U.S.C. 258a(a)) is amended to read as follows:

"(A) Service in Full-Time Clinical Practice.—Except as provided in section 338D, the following amounts:

"(B) Inclusion of Certain Entities.—Such grant shall provide service in the full-time clinical practice of such individual's profession and be provided to the extent of obligated service provided in such contract. For the purpose of calculating time spent in full-time clinical practice under this subsection, up to 50 percent of time spent teaching by a member of the Corps may be counted toward his or her service obligation.

"(i) Payments.—Subject to subsection (h)(2), the Secretary shall make payments under this section for indirect expenses associated with the direct graduate medical residency training programs.

"(ii) Amount of Payments.—

"(I) In General.—Subject to paragraph (2), the amounts payable under this section to qualified teaching health centers for an approved graduate medical residency training program for a fiscal year are each of the following:

"(A) Direct Expense Amount.—The amount determined under subsection (c) for direct expenses associated with the new approved graduate medical residency training programs.

"(B) Indirect Expense Amount.—The amount determined under subsection (d) for indirect expenses associated with the additional costs relating to teaching residents in such programs.

"(iii) Special Payment.—

"(I) In General.—The total of the payments made to qualified teaching health centers under paragraph (1)(A) or paragraph (1)(B) in a fiscal year do not exceed the total amount of funds appropriated under subsection (g) for such payments for that fiscal year.

"(B) Limitation.—The Secretary shall limit the funding of full-time equivalent residents in order to ensure the direct and indirect payments as determined under subsection (c) do not exceed the total amount of funds appropriated in a fiscal year under subsection (g).

"(c) Amount of Payment for Direct Graduate Medical Education.—

"(1) In General.—The amount determined under this subsection for payments to qualified teaching health centers for direct graduate medical residency programs for a fiscal year is equal to the product of—

"(A) the updated national per resident amount for direct graduate medical education, as determined under paragraph (2); and

"(B) the average number of full-time equivalent residents in the teaching health center's graduate approved medical residency training programs as determined under section 1886(h)(4) of the Social Security Act (without regard to the limitation under subparagraph (F) of such section) during the fiscal year.

"(2) Updated National Per Resident Amount for Direct Graduate Medical Education.—The updated per resident amount for direct graduate medical education for a qualified teaching health center for a fiscal year is an amount determined as follows:

"(A) Determination of Qualified Teaching Health Center.—The Secretary shall compute for each individual qualified teaching health center a per resident amount—

"(i) by dividing the national average per resident amount computed under section 380E(c)(2)(D) into a wage-related portion and a non-wage related portion by applying the proportion determined under subparagraph (B); and

"(ii) by dividing the wage-related portion by the factor applied under section 1886(h)(2)(B) of the Social Security Act (but without application of section 4110 of the Balanced Budget Act of 1997 (42 U.S.C. 1395ww note)) during the preceding fiscal year for the teaching health center's area; and

"(iii) by adding the non-wage-related portion to the amount computed under clause (ii).

"(B) Updating Rate.—The Secretary shall update such per resident amount for each such qualified teaching health center as determined appropriate by the Secretary.

"(d) Amount of Payment for Indirect Medical Education.—

"(1) General.—The amount determined under this subsection for payments to qualified teaching health centers for indirect expenses associated with the additional costs of teaching residents for a fiscal year is equal to an amount determined appropriate by the Secretary.

"(2) Factors.—In determining the amount under this paragraph, the Secretary shall—

"(A) evaluate indirect training costs relative to supporting a primary care residency program in qualified teaching health centers;

"(B) based on this evaluation, assure that the aggregate of the payments for indirect expenses under this subsection and the payments for direct graduate medical education as determined under section 1886(h)(4) in a fiscal year do not exceed the amount appropriated for such expenses as determined in subsection (g);

"(3) Interim Payment.—Before the Secretary makes a payment under this subsection pursuant to a determination of indirect expenses under this section, the Secretary may provide to qualified teaching health centers a payment, in addition to any payment made under subsection (c), for expected indirect expenses associated with the additional costs of teaching residents for a fiscal year, based on an estimate by the Secretary.

"(6) Clarification Regarding Relationship to Other Payments for Graduate Medical Education.—Payments under this section—

"(1) shall be in addition to any payments—

"(A) for the indirect costs of medical education, as determined under section 1886(d)(5)(B) of the Social Security Act;

"(B) for direct graduate medical education costs under section 1886(h)(4) of such Act; and
"(C) for direct costs of medical education under section 1886(k) of such Act;  

"(2) shall not be taken into account in ap-
plying the limitation on the number of total full-time equivalent residents under paragraph (2) or under section 1886(d)(4) of such Act and clauses (v), (vi)(I), and (vi)(II) of section 1886(d)(5)(B) of such Act for the portion of time that a resident rotates to a hospital; and  

"(3) shall not include the time in which a resident is counted toward full-time equiva-

tence under paragraph (2) or under section 1886(d)(4) of such Act and clauses (v), (vi)(I), and (vi)(II) of such Act for the portion of time that a resident is counted toward full-time equivalence after the completion of training at the end of such residency aca-
demic year.

"(b) Notice and Opportunity to Provide Accurate and Missing Information.—Before imposing a reduction under subparagraph (A) with respect to the provision of qualified medical residency training, the Secretary shall provide no-

tice of such failure and the Secretary's intention to impose such reduction and shall provide the teaching health center the opportunity to provide the required information within the period of 30 days beginning on the date of such notice. If the teaching health center provides such information within such period, no reduction shall be made under subparagraph (A) on the basis of the previous failure to provide such information.

"(4) Residents.—The residents described in this paragraph are those who are in part-
time or full-time equivalent resident training positions at a qualified teaching health center during the current fiscal year.

"(g) Funding.—To carry out this section, there are appropriated such sums as may be necessary, not to exceed $200,000,000, for the period of fiscal years 2011 through 2015.

"(h) Annual Reporting Required.—

"(1) Annual Report.—The report required under this paragraph for a qualified teaching health center for a fiscal year is a report that includes (in a form and manner speci-
died by the Secretary) the following information:

"(A) Participation in which may be count-
ted toward certification in a specialty or sub-

specialty and includes formal postgraduate training programs in geriatric medicine ap-

proved by the Secretary;  

"(B) That meets criteria for accreditation (as established by the Accreditation Council for Graduate Medical Education, the Amer-

ican Osteopathic Association, or the Ameri-

can Dental Association).

"(2) Primary Care Residency Program.—

The term 'primary care residency program' has the meaning given that term in section 749A.

"(3) Qualified Teaching Health Center.—

The term 'qualified teaching health center' has the meaning given that term 'teaching health center' in section 749A.

SEC. 5508. GRADUATE NURSE EDUCATION DEMONSTRATION.

(a) In General.—

"(1) Establishment.—

The Secretary shall establish a demonstration under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) under which an eligible hospital may receive pay-

ment for clinical training for advance prac-
tice nurses.

"(2) Number.—

The demonstration shall include up to 5 eligible hospitals.

(b) Written Agreements.—Eligible hos-

pitals selected to participate in the demo-

nstration shall enter into written agree-

ments pursuant to subsection (b) in order to reimburse the eligible partners of the hos-

pital the share of the costs attributable to each partner.

(c) Costs Described.—

"(1) In General.—Subject to subparagraph (B) and subsection (d), the costs described in this paragraph include costs attributable to providing advanced practice registered nurses with qualified training.

"(B) Limitation.—With respect to a year, the amount reimbursed under subparagraph (A) may not exceed the amount of costs de-
scribed in subparagraph (A) that are attrib-
utable to providing advanced practice regis-
tered nurses enrolled in a program that provides qualified training during the year for which the hospital is being reimbursed under this demonstration, as compared to the average number of ad-

vance practice registered nurses who gradu-

ated in each year during the period begin-

ning on January 1, 2006, and ending on De-

cember 31, 2010 (as determined by the Sec-

retary) from the graduate nursing education program operated by the applicable school of nursing under the demonstration for purposes of the demonstration.

"(3) Waiver Authority.—The Secretary may wa-

ive such requirements of titles XI and XVIII of the Social Security Act as may be necessary to carry out the demonstration.

"(4) Administration.—Chapter 33 of title 44, United States Code, shall apply to the implementation of this section.

"(b) Written Agreements With Eligible Partners.—No payment shall be made under this section to an eligible hospital unless such hospital has in effect a written agree-

ment with the eligible partners of the hos-

pital. Such written agreement shall describe, at a minimum—

"(1) the obligations of the eligible partners with respect to the provision of qualified training; and

"(2) the obligation of the eligible hospital to reimburse such eligible partners applicable (in a timely manner) for the costs of such qualified training attributable to the eligible partners.

"(c) Evaluation.—No later than October 17, 2017, the Secretary shall submit to Con-

gress a report on the demonstration. Such report shall include an analysis of the fol-

lowing:

"(1) The growth in the number of advanced practice registered nurses with respect to a specific base year as a result of the demo-

nstration.

"(2) The growth for each of the specialties described in subparagraphs (A) through (D) of subsection (c).

"(3) The costs to the Medicare program under title XVIII of the Social Security Act as a result of the demonstration.

"(d) Funding.—

"(1) In General.—There is hereby appro-

priated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $50,000,000 for each of fiscal years 2012 through 2015 to carry out this section, in-
cluding the design, implementation, moni-

toring, and evaluation of the demonstration.

"(2) Proration.—If the aggregate payments to eligible hospitals under the demonstra-

tion exceed $50,000,000 for a fiscal year de-

scribed in paragraph (1), the Secretary shall prorate the payment amounts to each eligi-
ble hospital in such a manner that the ag-

gregate payments do not exceed such amount.

"(3) Without Fiscal Year Limitation.—

Amounts appropriated under this subsection shall remain available without fiscal year limita-

tion.

"(e) Definitions.—In this section:

"(A) Advanced practice registered nurse.—The term 'advanced practice registered nurse' includes the following:

"(A) A clinical nurse specialist (as defined in section 1861(v) of the Social Security Act (42 U.S.C. 1395x)).

"(B) A nurse practitioner (as defined in subsection (b)(2) of such section).
(D) A certified nurse-midwife (as defined in subsection (gg)(2) of such section).

(2) APPLICABLE NON-HOSPITAL COMMUNITY-BASED CARE SETTING.—The term “applicable non-hospital community-based care setting” means a non-hospital community-based care setting which has entered into a written agreement (as described in subsection (b)) with an eligible hospital participating in the demonstration. Such settings include Federally qualified health centers, rural health clinics, and other non-hospital community-based care settings as determined appropriate by the Secretary.

(3) APPLICABLE SCHOOL OF NURSING.—The term “applicable school of nursing” means an accredited school of nursing (as defined in section 801 of the Public Health Service Act) which has entered into a written agreement (as described in subsection (b)) with an eligible hospital participating in the demonstration.

(4) DEMONSTRATION.—The term “demonstration” means the graduate nurse education demonstration established under subsection (a).

(5) ELIGIBLE HOSPITAL.—The term “eligible hospital” means a hospital (as defined in section 1395x(r) of such title) or a critical access hospital (as defined in subsection (m)(3) of such section) that has a written agreement in place with—

(A) 1 or more applicable schools of nursing; and

(B) 2 or more applicable non-hospital community-based care settings.

(6) ELIGIBLE PARTNERS.—The term “eligible partners” includes the following:

(A) An applicable non-hospital community-based care setting.

(B) An applicable school of nursing.

(7) QUALIFIED NON-HOSPITAL PROVIDER.—The term “qualified non-hospital provider” means—

(A) In general.—The term “qualified non-hospital provider” means—

(i) a provider of primary care, preventive care, transitional care, chronic care management, and other services appropriate for individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act, or enrolled under subchapter 3 of chapter 5 of title 5, United States Code, under a negotiated rulemaking committee (as described in subsection (d)(3) of such section), or (ii) a provider of primary care, preventive care, transitional care, chronic care management, and other services appropriate for individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act, enrolled under part B of such title, or enrolled under subchapter 3 of chapter 5 of title 5, United States Code, under a negotiated rulemaking committee (as described in subsection (d)(3) of such section); or

(B) In cases in which—

(i) a provider is designated as a non-hospital community-based care setting, and (ii) the provider would be otherwise eligible to receive funds under this section through a contract with a community health center center under subparagraph (A), such clinic or hospital shall establish policies to ensure—

(1) non-discrimination based on the ability of a patient to pay; and

(2) the establishment of a sliding fee scale for low-income patients.”.

SEC. 5602. NEGOTIATED RULEMAKING FOR DESIGNATING MEDICALLY UNSERVICED POPULATIONS AND HEALTH PROFESSIONS SHORTAGE AREAS.

(a) Establishment.—

(1) In general.—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall establish, through a negotiated rulemaking process under subchapter 5 of such title 5, United States Code, a comprehensive methodology and criteria for designation of—

(A) medically underserved populations in accordance with section 330(r)(3) of the Public Health Service Act (42 U.S.C. 254(r)(3));

(B) health professions shortage areas under section 332 of the Public Health Service Act (42 U.S.C. 254a).

(2) Factors to consider.—In establishing the methodology and criteria under paragraph (1), the Secretary—

(A) shall consult with relevant stakeholders who will be significantly affected by a rule (such as national, State and regional organizations representing affected entities, State health offices, community organizations, health centers and other affected entities, and other interested parties; and

(B) shall take into account—

(i) the timely availability and appropriateness of data used to determine a designation to potential applicants for such designations; and

(ii) the degree of ease or difficulty that will face potential applicants for such designations in acquiring the necessary data and making this designation to communities of various types and on health centers and other safety net providers; and

(iii) the degree of ease or difficulty that will face potential applicants for such designations in acquiring the necessary data and making this designation to communities of various types and on health centers and other safety net providers; and

(iv) the extent to which the methodology accurately identifies and removes barriers that confront individuals and population groups in seeking health care services.

(b) Publication of Notice.—In carrying out the rulemaking process under this section, the Secretary shall publish the notice provided for under section 56(a) of title 5, United States Code, not later than 45 days after the date of the enactment of this Act.

(c) Target Date for Publication of Rule.—As part of the notice under subsection (b), and for purposes of this subsection, the “target date for publication”, as referred to in section 56(a)(5) of title 5, United States Code, shall be July 1, 2010.

(d) Appointment of Negotiated Rulemaking Committee and Facilitator.—The Secretary shall provide for—

(1) the appointment of a negotiated rulemaking committee appointed under subsection (d) shall report to the Secretary, by not later than April 1, 2010, regarding the creation and consolidation on a jurisdictional basis of such committees achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before one month after the target publication date of the rule. If the committee reports that the committee has failed to make significant progress toward such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this section through such other methods as the Secretary determines to be appropriate.

(e) Preliminary Committee Report.—If the committee is not terminated under subsection (d), the committee shall submit a report containing a proposed rule by not later than one month before the target publication date.

(f) Final Committee Report.—If the committee is not terminated under subsection (d), the committee shall provide for the publication of a rule under this section through such other methods as the Secretary determines to be appropriate.

SEC. 5603. REAUTHORIZATION OF THE WAKEFIELD EMERGENCY MEDICAL SERVICES FOR CHILDREN PROGRAM.

Section 1910 of the Public Health Service Act (42 U.S.C. 300q-9) is amended—

(1) in subsection (a), by striking “3-year period (with an optional 4th year)” and inserting “4-year period (with an optional 5th year)” and

(2) in subsection (d)—

(A) by striking “and such sums” and inserting “such sums”;

(B) by inserting before the period the following: “, $10,000,000 for fiscal year 2011,”.

SEC. 5604. CO-LOCATING PRIMARY AND SPECIALTY CARE IN COMMUNITY-BASED MENTAL HEALTH SETTINGS.

Subpart 3 of part B of title V of the Public Health Service Act (42 U.S.C. 290b–31 et
There are authorized to be appropriated to the National Academy of Sciences under which the National Academy of Sciences shall enable the establishment of a key national indicator system; (I) creating its own institutional capacity; or (II) partnering with an independent private nonprofit organization as an Institute to implement a key national indicator system.

(C) QUALIFICATIONS.—In making appointments under subparagraph (A), the National Academy of Sciences shall enable the establishment of a key national indicator system for purposes of section 501(c)(3) of the Internal Revenue Code of 1986 with an educational mission, a governance structure that emphasizes independence, and characteristics that make such entity appropriate for establishing a key national indicator system.

(3) RESPONSIBILITIES.—Either the Academy or the Institute designated under clause (i)(II) shall be responsible for the following:

(IV) Developing a quality assurance framework to ensure rigorous and independent peer review of the selection of quality data.

(VI) Developing a budget for the construction and management of a sustainable, adaptable, and evolving key national indicator system that reflects all Commission members.

(VII) Reporting annually to the Commission regarding its selection of issue areas, adaptable, and evolving key national indicators.

(VIII) Identifying and selecting the measures used for key national indicators within the issue areas under subclause (I).

(II) Identifying and selecting data to populate the key national indicators described under subclause (II).

(IV) Designing, publishing, and maintaining a public website that contains a freely accessible database allowing public access to the key national indicators.

(V) Developing a quality assurance framework to ensure rigorous and independent peer review of the selection of quality data.

(VI) Developing a budget for the construction and management of a sustainable, adaptable, and evolving key national indicator system that reflects all Commission members.

(VII) Reporting annually to the Commission regarding its selection of issue areas, adaptable, and evolving key national indicators.

(VIII) Identifying and selecting the measures used for key national indicators within the issue areas under subclause (I).

(II) Identifying and selecting data to populate the key national indicators described under subclause (II).

(IV) Designing, publishing, and maintaining a public website that contains a freely accessible database allowing public access to the key national indicators.

(V) Developing a quality assurance framework to ensure rigorous and independent peer review of the selection of quality data.

(VI) Developing a budget for the construction and management of a sustainable, adaptable, and evolving key national indicator system that reflects all Commission members.

(VII) Reporting annually to the Commission regarding its selection of issue areas, adaptable, and evolving key national indicators.

(VIII) Identifying and selecting the measures used for key national indicators within the issue areas under subclause (I).

(II) Identifying and selecting data to populate the key national indicators described under subclause (II).

(IV) Designing, publishing, and maintaining a public website that contains a freely accessible database allowing public access to the key national indicators.

(V) Developing a quality assurance framework to ensure rigorous and independent peer review of the selection of quality data.
TITLE VI—TRANSPARENCY AND PROGRAM INTEGRITY
Subtitle A—Physician Ownership and Other Transparency

SEC. 6001. LIMITATION ON MEDICARE EXEMPTION TO THE PROHIBITION ON CERTAIN PHYSICIAN REFERRALS FOR HOSPITALS.

(a) IN GENERAL.—Section 1877 of the Social Security Act (42 U.S.C. 1395m) is amended—

(1) in subsection (d)(2)—

(A) in subparagraph (A), by striking “and” at the end;

(B) in subparagraph (B), by striking the period at the end and inserting “and”;

and

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

“(C) the hospital meets the requirements of paragraph (3)(D).”;

(2) in subsection (d)(3)—

(A) in subparagraph (B), by striking “and” 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 new subparagraph:

“(D) the hospital meets the requirements described in subsection (i)(1) not later than 18 months after the date of enactment of this subparagraph.”;

and

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

“(I) REQUIREMENTS FOR HOSPITALS TO QUALIFY FOR RURAL PROVIDER AND HOSPITAL EXCEPTION TO OWNERSHIP OR INVESTMENT PROHIBITION.—

(I) REQUIREMENTS DESCRIBED.—For purposes of subsection (d)(3)(D), the requirements described in this paragraph for a hospital are as follows:

(A) PROVIDER AGREEMENT.—The hospital had—

(i) physician ownership or investment on February 1, 2010; and

(ii) a provider agreement under section 1877 of the Social Security Act in effect on such date.

(B) LIMITATION ON EXPANSION OF FACILITY CAPACITY.—Except as provided in paragraph (3), the number of operating rooms, procedure rooms, and beds for which the hospital is licensed at any time on or after the date of enactment of this subsection is no greater than the number of operating rooms, procedure rooms, and beds for which the hospital is licensed as of such date.

(C) PATIENT SAFETY.—

(i) The hospital submits to the Secretary an annual report containing a detailed description of—

(I) the identity of each physician owner or investor and any other owners or investors of the hospital; and

(II) the nature and extent of all ownership and investment in the hospital.

(ii) The hospital has procedures in place to require that any referring physician owner or investor discloses to the patient being referred, and that permits the patient to make a meaningful decision regarding the receipt of care, as determined by the Secretary.

(C) PATIENT SAFETY.—

(i) The hospital submits to the Secretary an annual report containing a detailed description of—

(I) the identity of each physician owner or investor and any other owners or investors of the hospital; and

(II) the nature and extent of all ownership and investment in the hospital.

(ii) The hospital has procedures in place to require that any referring physician owner or investor discloses to the patient being referred, and that permits the patient to make a meaningful decision regarding the receipt of care, as determined by the Secretary.

(ii) The hospital discloses such fact to a patient and

(iii) The hospital has the capacity to—

(I) provide assessment and initial treatment for patients; and

(ii) refer and transfer patients to hospitals with the capability to treat the needs of the patient involved.

(F) LIMITATION ON APPLICATION TO CERTAIN CONVERTED FACILITIES.—The hospital was not converted from an ambulatory surgical center to a hospital on or after the date of enactment of this subsection.

(G) PROHIBITION ON INFORMATION REPORTED.—The Secretary shall publish, and update on an annual basis, the information submitted by hospitals under paragraph (1)(B) and (2)(B) of the April 1, 2010, version of the public Internet website of the Centers for Medicare & Medicaid Services.

(H) EXCEPTION TO PROHIBITION ON EXPANSION OF FACILITY CAPACITY.—

(i) PROCESS.—The Secretary shall establish and implement a process under
which an applicable hospital (as defined in subparagraph (E)) may apply for an exception from the requirement under paragraph (1)(B).

(ii) OPPORTUNITY FOR COMMUNITY INPUT.—
The process under clause (i) shall provide individuals and entities in the community in which the applicable hospital applying for an exception with the opportunity to provide input with respect to the application.

(iii) TIMING FOR IMPLEMENTATION.—The Secretary shall implement the process under clause (i) on August 1, 2011.

(iv) REGULATIONS.—Not later than July 1, 2011, the Secretary shall promulgate regulations to carry out the process under clause (i).

(b) FREQUENCY.—The process described in subparagraph (A) shall apply to an applicable hospital to apply for an exception up to once every 2 years.

(c) PERMITTED INCREASE.—

(i) IN GENERAL.—Subject to clause (i) and subparagraph (D), an applicable hospital granted an exception under the process described in subparagraph (A) may increase the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed above the baseline number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed.

(ii) LICENSED ABOVE.—A licensed hospital is licensed above the baseline number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed under clause (i) to the extent such increase would result in the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed exceeding 200 percent of the baseline number of operating rooms, procedure rooms, and beds of the applicable hospital.

(iii) BASELINE NUMBER OF OPERATING ROOMS, PROCEDURE ROOMS, AND BEDS.—In this paragraph, the term ‘baseline number of operating rooms, procedure rooms, and beds’ means the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed.

(iv) LICENSED ABOVE.—For purposes of this paragraph, the term ‘applicable hospital’ means an applicable hospital that applies for an increase under clause (i) and is granted an exception under the process described in subparagraph (A) of section 1862(q).

(v) PERMITTED INCREASE.—

(A) IN GENERAL.—The Secretary shall permit an increase in the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed above the baseline number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed under clause (i) to the extent such increase would result in the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed exceeding 200 percent of the baseline number of operating rooms, procedure rooms, and beds of the applicable hospital.

(B) LIMITATION ON REVIEW.—The Secretary shall increase the number of operating rooms, procedure rooms, and beds for which the applicable hospital is licensed, under clause (i) and does not permit physicians practicing at the hospital to discriminate against such beneficiaries;
designated on behalf of a physician holding such an ownership or investment interest, including the information described in clauses (i) through (viii) of paragraph (1)(A), except that such clauses, 'physician' shall be substituted for 'covered recipient' each place it appears.

(1) Any other information regarding the ownership interest the Secretary determines appropriate.

(b) PENALTIES FOR NONCOMPLIANCE.—

(1) IN GENERAL.—Subject to subparagraph (B) except as provided in paragraph (2), any applicable manufacturer or applicable group purchasing organization that fails to submit information required under subsection (a) in a timely manner in accordance with rules or regulations promulgated to carry out such subsection, or that fails to pay 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 and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

(2) KNOWING FAILURE TO REPORT.—

(A) IN GENERAL.—Subject to subparagraph (B), any applicable manufacturer or applicable group purchasing organization that knowingly fails to submit information required under subsection (a) by an applicable manufacturer or applicable group purchasing organization shall not exceed $150,000.

(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 an applicable manufacturer or applicable group purchasing organization that knowingly fails to submit information required under subsection (a) in a timely manner in accordance with rules or regulations promulgated to carry out such 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 and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

(C) 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.

(1) PURPOSES FOR SUBMISSION OF INFORMATION AND PUBLIC AVAILABILITY.—

(A) ESTABLISHMENT.—Not later than October 1, 2013, the Secretary shall establish procedures—

(i) for applicable manufacturers and applicable group purchasing organizations to submit information to the Secretary under subsection (a) and

(ii) for the Secretary to make such information submitted available to the public.

(B) DEFINITION OF TERMS.—The procedures established under subparagraph (A) shall provide for the definition of terms other than those terms defined in subsection (e), as applicable purposes of this section.

(C) PUBLIC AVAILABILITY.—Except as provided in subparagraph (E), the procedures established under subparagraph (A)(i) shall ensure that not later than September 30, 2013, and on June 30 of each calendar year beginning thereafter, the information submitted under subsection (a) with respect to the preceding calendar year is made available through an Internet website that—

(i) is searchable and in a format that is clear and useful;

(ii) contains information that is presented by the name of the applicable manufacturer or applicable group purchasing organization and recipient, the business address of the covered recipient, the specialty of the covered recipient, the value of the payment or other transfer of value, the date on which the payment or other transfer of value was provided to the covered recipient, the form of the payment or other transfer of value (as appropriate) under subsection (a)(1)(A)(vii), the name of the payment or other transfer of value, indicated (as appropriate) under subparagraph (C)(i) of section 1128B(a) or the covered drug, device, biological, or medical supply, as applicable;

(iii) contains information that is able to be easily aggregated and downloaded;

(iv) contains a description of any enforcement actions taken to carry out this section, including any penalties imposed under subsection (b) during the preceding year;

(v) contains background information on industry-physician relationships;

(vi) in the case of information submitted with respect to other transfers of value described in subparagraph (E)(i), lists such information separately from the other information submitted under subsection (a) and is separately listed information as funding for clinical research;

(vii) contains any other information the Secretary determines would be helpful to the average consumer;

(viii) does not contain the National Provider Identifier of the covered recipient;

(ix) subject to subparagraph (D), provides the applicable manufacturer, applicable group purchasing organization, or covered recipient an opportunity to review and submit corrections to the information submitted with respect to the applicable manufacturer, applicable group purchasing organization, or covered recipient, respectively, for a period of not less than 45 days prior to such information being made available to the public;

(2) CONSULTATION.—In establishing the procedures under paragraph (1), the Secretary shall consult with the General Counsel of the Department of Health and Human Services, affected industry, consumers, consumer advocates, and other interested parties in order to ensure that the information made available to the public under such paragraph is presented in the appropriate overall context.

(2) ANNUAL REPORTS AND RELATION TO STATE LAWS.—

(A) ANNUAL REPORT TO CONGRESS.—Not later than April 1 of each year beginning with 2013, the Secretary shall submit to Congress a report that includes the following:

(T) The information submitted under subsection (a) during the preceding year, aggregated for each applicable manufacturer and applicable group purchasing organization that submitted such information during such year (except, in the case of information submitted with respect to a payment or other transfer of value described in subsection (c)(1)(E)(i), such information shall be included in the first report submitted to Congress after the date on which such information is made available to the public under such subsection).

(B) A description of any enforcement action taken to carry out this section, including any penalties imposed under subsection (b), during the preceding year.

(2) ANNUAL REPORTS TO STATES.—Not later than September 30, 2013 and on June 30 of each calendar year thereafter, the Secretary shall submit to States a report that includes a summary of the information submitted under subsection (a) during the preceding year with respect to covered recipients in the State (except, in the case of information submitted with respect to a payment or other transfer of value described in subsection (c)(1)(E)(i), such information shall be included in the first report submitted to States after the date on which such information is made available to the public under such subsection).

(3) RELATION TO STATE LAWS.—

(A) IN GENERAL.—In the case of a payment or other transfer of value provided by an applicable manufacturer that is received by a covered recipient (as defined in subsection (e)) on or after January 1, 2012, subject to subparagraph (B), the provisions of this section shall preempt any statute or regulation of a State or of a political subdivision of a State that requires an applicable manufacturer (as so defined) to disclose or report, in any format, the type of information as described in subsection (a)(i) regarding such payment or other transfer of value.

(B) PREEMPTION OF ADDITIONAL REQUIREMENTS.—Subparagraph (A) shall not preempt any statute or regulation of a State or of a political subdivision of a State that requires the disclosure or reporting of information—

(i) not of the type required to be disclosed or reported under this section; or

(ii) not of the type described in subsection (a)(iv), except in the case of information described in clause (i) of such subsection.
“(iii) by any person or entity other than an applicable manufacturer (as so defined) or a covered recipient (as defined in subsection (e)); or

(iv) to a Federal, State, or local government agency for public health surveillance, investigation, or other public health purposes or health oversight purposes.

(3) Nothing in subparagraph (A) shall be construed to limit the discovery or admissibility of information described in such subparagraph in a criminal, civil, or administrative proceeding.

(4) Consultation.—The Secretary shall consult with the Inspector General of the Department of Health and Human Services on the implementation of this section.

(5) Definitions.—In this section:

(1) Applicable group purchasing organization.—The term ‘applicable group purchasing organization’ means a group purchasing organization (as defined by the Secretary) that purchases, arranges for, or negotiates the purchase of a covered drug, device, biological, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States.

(2) Applicable manufacturer.—The term ‘applicable manufacturer’ means a manufacturer, device, biological, or medical supply which is operating in the United States, or in a territory, possession, or commonwealth of the United States.

(3) Clinical investigation.—The term ‘clinical investigation’ means any experiment involving one or more human subjects, or materials derived from human subjects, in which a drug or device is administered, dispensed, or used.

(4) Covered device.—The term ‘covered device’ means any device for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

(5) Covered drug, device, biological, or medical supply.—The term ‘covered drug, device, biological, or medical supply’ means any drug, biological product, device, or medical supply for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

(6) Covered recipient.—

(A) In general.—Except as provided in subparagraph (B), the term ‘covered recipient’ means the following:

(1) A physician.

(2) A licensed non-medical professional.

(B) Exclusion.—Such term does not include a physician who is an employee of the applicable manufacturer that is required to submit information under subsection (a).

(7) Employee.—The term ‘employee’ has the meaning given such term in section 1877(b)(2).

(8) Privately.—The term ‘privately’ has the meaning given such term in section 3729(b) of title 31, United States Code.

(9) Manufacturer of a covered drug, device, biological, or medical supply.—The term ‘manufacturer of a covered drug, device, biological, or medical supply’ means any entity which is engaged in the production, preparation, compounding, or conversion of a covered drug, device, biological, or medical supply (or any entity under common ownership with such entity which provides assistance or support to such entity with respect to the production, preparation, compounding, conversion, marketing, promotion, sale, distribution of a covered drug, device, biological, or medical supply).

(10) Payment or other transfer of value.—

(A) In general.—The term ‘payment or other transfer of value’ means a transfer of anything of value. Such term does not include a transfer of anything of value that is made indirectly to a covered recipient through a third party in connection with an activity or service in the case where the applicable manufacturer is not aware of the identity of the covered recipient.

(B) Exclusions.—An applicable manufacturer shall not be required to submit information under subsection (a) with respect to the following:

(i) A transfer of anything of value which is less than $10, unless the aggregate amount transferred to, requested by, or designated on behalf of the covered recipient by the applicable manufacturer during the calendar year exceeds $100. For calendar years after 2009, the amount identified in the preceding sentence shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) for the 12-month period ending with June of the previous year.

(ii) Product samples that are not intended to be sold and are intended for patient use.

(iii) Educational materials that directly benefit patients or are intended for patient use.

(iv) The loan of a covered device for a short-term trial period, not to exceed 90 days, to permit evaluation of the covered device by the covered recipient.

(v) Items or services provided under a contractual warranty, including the replacement of a covered device, where the terms of the warranty are set forth in the purchase or lease agreement for the covered device.

(vi) A transfer of anything of value to a covered recipient when the covered recipient is a patient and not acting in the professional capacity as a licensed non-medical professional.

(vii) Discounts (including rebates).

(viii) In-kind items used for the provision of charity care.

(ix) A dividend or other profit distribution from, or ownership or investment interest in, a publicly traded security and mutual fund (as described in section 1877(c)).

(x) In the case of an applicable manufacturer who offers a self-insured plan, payments for the provision of health care to employees under the plan.

(xi) In the case of a covered recipient who is a licensed medical professional, a transfer of anything of value to the covered recipient if the transfer is payment solely for the nonprofessional services of such licensed medical professional.

(xii) In the case of a covered recipient who is a physician, a transfer of anything of value to the covered recipient if the transfer is payment solely for the services of the covered recipient with respect to a civil or criminal action or an administrative proceeding.

(xiii) By—

(A) a self-insured plan, payment or other transfer of value to a covered recipient that is a physician with respect to certain imaging services.

(B) a waiver of such a plan.

(2) Covered drug, device, biological, or medical supply.—The term ‘covered drug, device, biological, or medical supply’ means any drug, biological product, device, or medical supply for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

(3) Manufac—

A. IN GENERAL.—Section 1877(b)(2) of the Social Security Act (42 U.S.C. 1395m(b)(2)) is amended by adding at the end the following new sentence: ‘‘Such requirements shall, with respect to magnetic resonance imaging, computed tomography, positron emission tomography, and any other designated health services specified under subsection (h)(3)(A) of such section:’’. (B) In the case of a covered recipient who is a physician, a transfer of anything of value to the covered recipient if the transfer is payment solely for the services of the covered recipient with respect to a civil or criminal action or an administrative proceeding.

(4) Physicians.—The term ‘physician’ has the meaning given such term in section 1861(r).

SEC. 6003. DISCLOSURE REQUIREMENTS FOR OFFICE ANNUAL SERVICES EXCEPTION TO TRANSPARENCY REQUIREMENTS ON PHYSICIAN SELF-REFERAL FOR CERTAIN IMAGING SERVICES.

(a) In General.—Section 1877(b)(2) of the Social Security Act (42 U.S.C. 1395m(b)(2)) is amended by adding at the end the following new sentence: ‘‘Such requirements shall, with respect to magnetic resonance imaging, computed tomography, positron emission tomography, and any other designated health services specified under subsection (h)(3)(A) of such section:’’. (b) Definitions.—In this section:

(1) Applicable drug.—The term ‘applicable drug’ means a drug—

(A) which is subject to subsection (a)(6) of such section 503; and

(B) for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

(2) Authorized distributor of record.—The term ‘authorized distributor of record’ has the meaning given such term in subsection (e)(3)(A)(ii) of such section 1395m.

(3) Manufacturer.—The term ‘manufacturer’ has the meaning given such term for purposes of subsection (d) of such section.”.

SEC. 6005. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 11263 the following new section:

SEC. 11268. REPORTING OF INFORMATION RELATING TO DRUG SAMPLES.

(a) In General.—Not later than April 1 of each year, the applicable manufacturer and authorized distributor of record of an applicable drug shall submit to the Secretary (in a form and manner specified by the Secretary) the following information with respect to the preceding year:

(1) In the case of a manufacturer or authorized distributor of record which makes distributions by mail or common carrier under subsection (d)(2) of section 503 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 335), the identity and quantity of drug samples requested and quantity of drug samples distributed under such subsection during that year, aggregated by—

(A) the name, address, professional designation, and signature of the practitioner making the request under subparagraph (A)(i) of such subsection, or of any individual who makes or signs for the request on behalf of the practitioner; and

(B) any other category of information determined appropriate by the Secretary.

(2) In the case of an applicable manufacturer or authorized distributor of record which makes distributions by means other than mail or common carrier under subsection (d)(3) of such section 503, the identity and quantity of drug samples requested and quantity of drug samples distributed under such subsection during that year, aggregated by—

(A) the name, address, professional designation, and signature of the practitioner making the request under subparagraph (A)(i) of such subsection, or of any individual who makes or signs for the request on behalf of the practitioner; and

(B) any other category of information determined appropriate by the Secretary.

(3) Definitions.—In this section:

(1) Applicable drug.—The term ‘applicable drug’ means a drug—

(A) which is subject to subsection (a)(6) of such section 503; and

(B) for which payment is available under title XVIII or a State plan under title XIX or XXI (or a waiver of such a plan).

(2) Authorized distributor of record.—The term ‘authorized distributor of record’ has the meaning given such term in subsection (e)(3)(A)(ii) of such section 1395m.

(3) Manufacturer.—The term ‘manufacturer’ has the meaning given such term for purposes of subsection (d) of such section.”.

SEC. 1150A. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

(a) Provision of information.—A pharmacy benefit manager or any entity that provides pharmacy benefit management services on behalf of a health benefits plan (in this section referred to as the ‘PBM’ or ‘PBM’) that manages drug benefits under such plan shall be required to provide the PBM’s prescription drug coverage under a contract with
"(1) A PDP sponsor of a prescription drug plan or an MA organization offering an MA-PD plan under part D of title XVIII; or "(2) A qualified health benefits plan offered through Medicare in accordance with the establishes a state under section 1311 of the Patient Protection and Affordable Care Act, shall provide the information described in subsection (b) to the Secretary and, in the case of a PBM, to the plan with which the PBM is under contract with, at such times, and in such form and manner, as the Secretary shall specify.

"(b) INFORMATION DESCRIBED.—The information described in this subsection is the following with respect to services provided by a health benefits plan or PBM for a contract year:

"(1) The percentage of all prescriptions that were provided through retail pharmacies and the percentage of prescriptions for which a generic drug was available and dispensed (generic dispensing rate), by pharmacy type (which includes an independent pharmacy, chain pharmacy, supermarket pharmacy, or mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medication to the general public), that is paid by the health benefits plan or PBM under the contract.

"(2) The aggregate amount, and the type of rebates, discounts, or price concessions (excluding bona fide service fees, which include but are not limited to distribution service fees, inventory management fees, product, and stock allowances, and fees associated with administrative services agreements and patient care programs (such as medication compliance programs and patient education programs)) that the PBM negotiates that are attributable to patient utilization under the plan, and the aggregate amount of the rebates, discounts, or price concessions that are passed through to the plan sponsor, and the total number of prescriptions that were dispensed.

"(3) The aggregate amount of the difference between the amount the health benefits plan pays the PBM and the amount that the PBM pays retail pharmacies, and mail order pharmacies, and the total number of prescriptions dispensed.

"(c) CONFIDENTIALITY.—Information disclosed by a health benefits plan or PBM under this section is confidential and shall not be disclosed by the Secretary or by a plan receiving the information, except that the Secretary may disclose the information in a form which does not disclose the identity of a specific PBM, plan, or prices charged for drugs, for the following purposes:

"(1) As the Secretary determines to be necessary to carry out this section or part D of title XVIII.

"(2) To permit the Comptroller General to review the information provided.

"(3) To the Director of the Congressional Budget Office to review the information provided.

"(4) To States to carry out section 1311 of the Patient Protection and Affordable Care Act.

"(d) PENALTIES.—The provisions of subsection (b)(3)(C) of section 1927 shall apply to a health benefits plan or PBM that fails to provide information required under subsection (a) on a timely basis or that knowingly or recklessly falsifies the information in the same manner as such provisions apply to a manufacturer with an agreement under that section.

Subtitle B—Nursing Home Transparency and Improvement

PART I—IMPROVING TRANSPARENCY OF INFORMATION

SEC. 6101. REQUIRED DISCLOSURE OF OWNER-ADDITIONAL DISCLOSABLE PARTIES INFORMATION.

(a) In General.—Section 1121 of the Social Security Act (42 U.S.C. 1320a-3) is amended by adding at the end the following new subsection:

"(c) REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.—

"(1) DISCLOSURE.—A facility shall have the information described in paragraph (2) available.

"(A) During the period beginning on the date of the enactment of this subsection and ending on the date such information is made available to the public under section 6101(b) of the Patient Protection and Affordable Care Act for submission to the Secretary, the Inspector General of the Department of Health and Human Services, the State in which the facility is located, and the State long-term care ombudsman in the case where the Secretary, the Inspector General, the State, or the State long-term care ombudsman requests such information; and

"(B) beginning on the effective date of the final regulations promulgated under paragraph (3)(A), for reporting such information in accordance with such final regulations.

"(2) Nothing in subparagraph (A) shall be construed as authorizing a facility to disclose or delete information described in such subparagraph after the effective date of the final regulations promulgated under paragraph (3)(A).

"(b) INFORMATION DESCRIBED.—

"(1) 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—

"(I) each member of 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 owner, director, manager, business manager, administrator, managing employee, or other person or entity who—

"((aa) owns a whole or part interest in any intermediate entity; and

"(bb) is directly or indirectly owned by, or controlled by, or provides financial or cash management, or clinical, consulting, or other services, or owns or controls a facility.

"(iii) The organizational structure of each such additional disclosable party to the facility, including the relationship of each such additional disclosable party to the facility and to one another.

"(B) SPECIAL HUR (WHERE INFORMATION IS ALREADY REPORTED).—To the extent that information reported by a facility to the Internal Revenue Service on Form 990, information submitted by a facility to the Securities 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 clause (A), the Secretary may provide such Form or such information submitted to meet the requirements of paragraph (1).

"(C) SPECIAL HURL.—In applying subparagraph (A)(i)

"(i) with respect to subsections (a) and (b), ownership or control interest shall include direct or indirect ownership, including such interests in intermediate entities; and

"(ii) subsection (a)(3)(A)(ii) shall include the owner of a whole or part interest in any intermediate entity.

"(ii) an individual, contact information otherwise submitted to the Secretary, the Inspector General, the State in which the facility is located, the State long-term care ombudsman in the case where the Secretary, the Inspector General, the State, or the State long-term care ombudsman requests such information; and

"(iii) an individual, contact information otherwise submitted to the Secretary, the Inspector General, the State in which the facility is located, the State long-term care ombudsman in the case where the Secretary, the Inspector General, the State, or the State long-term care ombudsman requests such information; and

"(iii) The term ‘organizational structure’ means, in the case of—

"(i) a corporation, the officers, directors, and shareholders of the corporation who have an ownership interest in the corporation which is equal to or exceeds 5 percent;

"(ii) a limited liability company, the members and managers of the limited liability company (including, as applicable, what percentage each member and manager has of the ownership interest in the limited liability company);

"(iii) a general partnership, the partners of the general partnership;

"(iv) a limited partnership, the general partner and any limited partnership who have an ownership interest in the limited partnership which is equal to or exceeds 5 percent;

"(v) the facility, the trust; and

"(vi) an individual, contact information for the individual; and

SEC. 6101. REQUIRED DISCLOSURE OF OWNER-ADDITIONAL DISCLOSABLE PARTIES INFORMATION.

(a) In General.—Section 1121 of the Social Security Act (42 U.S.C. 1320a-3) is amended by adding at the end the following new subsection:

"(c) REQUIRED DISCLOSURE OF OWNERSHIP AND ADDITIONAL DISCLOSABLE PARTIES INFORMATION.—

"(1) DISCLOSURE.—A facility shall have the information described in paragraph (2) available.

"(A) During the period beginning on the date of the enactment of this subsection and ending on the date such information is made available to the public under section 6101(b) of the Patient Protection and Affordable Care Act for submission to the Secretary, the Inspector General of the Department of Health and Human Services, the State in which the facility is located, and the State long-term care ombudsman in the case where the Secretary, the Inspector General, the State, or the State long-term care ombudsman requests such information; and

"(B) beginning on the effective date of the final regulations promulgated under paragraph (3)(A), for reporting such information in accordance with such final regulations.

"(2) Nothing in subparagraph (A) shall be construed as authorizing a facility to disclose or delete information described in such subparagraph after the effective date of the final regulations promulgated under paragraph (3)(A).

"(b) INFORMATION DESCRIBED.—

"(1) 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—

"(I) each member of 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 owner, director, manager, business manager, administrator, managing employee, or other person or entity who—

"(aa) owns a whole or part interest in any intermediate entity; and

"(bb) is directly or indirectly owned by, or controlled by, or provides financial or cash management, or clinical, consulting, or other services, or owns or controls a facility.

"(iii) The organizational structure of each such additional disclosable party to the facility, including the relationship of each such additional disclosable party to the facility and to one another.

"(B) SPECIAL HURL WHERE INFORMATION IS ALREADY REPORTED. —To the extent that information reported by a facility to the Internal Revenue Service on Form 990, information submitted by a facility to the Securities 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 clause (A), the Secretary may provide such Form or such information submitted to meet the requirements of paragraph (1).

"(C) SPECIAL HURL.—In applying subparagraph (A)(i)

"(i) with respect to subsections (a) and (b), ownership or control interest shall include direct or indirect ownership, including such interests in intermediate entities; and

"(ii) subsection (a)(3)(A)(ii) shall include the owner of a whole or part interest in any intermediate entity.
“(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 1124(c)(3)(A) of the Social Security Act (42 U.S.C. 1395i–3(j)) are published in the Federal Register, the Secretary of Health and Human Services shall make the information reported in accordance with such final regulations available to the public in accordance with procedures established by the Secretary.

(c) CONFORMING AMENDMENTS.—

(1)サポート差額.—

(A) SKILLED NURSING FACILITIES.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395f–3(d)(1)) is amended by striking subparagraph (C) and redesignating subparagraph (D) as subparagraph (C) and redesignating subparagraph (E) as subparagraph (D).

(2) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date on which the Secretary makes the information described in subsection (b)(1) available to the public under such subsection.

SEC. 6102. ACCOUNTABILITY REQUIREMENTS FOR SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.), as amended by sections 6002 and 6004, is amended by inserting after section 1123 the following new section:

“SEC. 11281. ACCOUNTABILITY REQUIREMENTS FOR SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES

“(a) DEFINITION OF FACILITY.—In this section, the term ‘facility’ means—

“(1) a skilled nursing facility as defined in section 1819(a); or

“(2) a nursing facility as defined in section 1919(a).

“(b) EFFECTIVE COMPLIANCE AND ETHICS PROGRAMS.—

“(1) REQUIREMENT.—On or after the date that is 36 months after the date of the enactment of this section, a facility shall, with respect to the facility as an operating organization (in this subparagraph referred to as the ‘operating organization’ or ‘organization’), have in operation a compliance and ethics program of an operating organization that—

“(A) has been reasonably designed, implemented, and enforced so that it generally will prevent and detect criminal, civil, and administrative violations under this Act and in promoting quality of care and

“(B) includes at least the required components specified in paragraph (4).

“(4) REQUIRED COMPONENTS OF PROGRAM.—The required components of a compliance and ethics program of an operating organization are the following:

“(A) The organization must have established compliance standards and procedures to be followed by its employees and other agents and by having in place and publishing a reporting system whereby employees and other agents could report violations by others within the organization to the federal authorities.

“(B) The organization must have taken reasonable steps to achieve compliance with its standards, such as by utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under this Act and in promoting quality of care.

“(C) The organization must periodically undertake reassessment of its compliance and ethics program to reflect changes within the organization and its facilities.

“(d) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

“(1) IN GENERAL.—Not later than December 31, 2011, the Secretary shall establish and implement a quality assurance and performance improvement program in (in this subparagraph referred to as the ‘QAPI program’) for facilities, including multi unit nursing home chains.

“(2) REGULATIONS.—The Secretary shall promulgate regulations to carry out this subsection.

SEC. 6103. NURSING HOME COMPARE MEDICARE WEBSITE.

(a) SKILLED NURSING FACILITIES.—

“(1) IN GENERAL.—Section 1819 of the Social Security Act (42 U.S.C. 1395f–3(1)) is amended—

“(A) by redesigning section 1819(b)(1)(B) and redesignating subsection (j); and

“(B) by inserting after subsection (h) the following new subsection:

“(i) NURSING HOME COMPARE WEBSITE.

“(1) INCLUSION OF ADDITIONAL INFORMATION.—

“(A) IN GENERAL.—The Secretary shall ensure that the Department of Health and Human Services includes, as part of the information provided for comparison of nursing homes on the official Internet website of the Federal Government for Medicare beneficiaries (commonly referred to as the ‘Nursing Home Compare’ Medicare website) (or a successor website), the following information in a manner that is prominent, updated on a timely basis, easily accessible, readily understandable to consumers of long-term care services, and searchable:

“(I) Staffing data for each facility (including resident census data and data on the hours of care provided per resident per day) based on data submitted under section 1819(b)(5)(D) and section 1919(b)(5)(D), and data that is clearly understandable to consumers of long-term care services and allows such consumers to compare differences in staffing between facilities and to compare conditions for the various types of staff that are available at each facility;

“(II) Differences in types of staff (such as staffing associated with different categories of staff);

“(III) the relationship between nurse staffing levels and quality of care; and

“(IV) an explanation of appropriate staffing levels vary based on patient case mix.

“(II) Links to State Internet websites with information regarding State survey and certification programs, links to Form 2567 State inspection reports (or a successor form) on such websites, information to guide consumers in how to interpret such reports, and the facility plan of correction or other response to such report. Any such links shall be posted on a timely basis.

“(III) The Secretary shall promulgate regulations to carry out this subsection.

“(d) QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT PROGRAM.—

“(1) IN GENERAL.—Not later than December 31, 2011, the Secretary shall establish and implement a quality assurance and performance improvement program (in this paragraph referred to as the ‘QAPI program’) for facilities, including multi unit nursing home chains. Not later than one year after the date on which the regulations are promulgated under paragraph (a), a facility must submit to the Secretary a plan for the facility to meet such standards and implement a quality assurance and ethics program that will be effective in preventing and detecting criminal, civil, and administrative violations under this Act and in promoting quality of care.
“(iv) Summary information on the number, type, severity, and outcome of substantiated complaints.

(v) The number of adjudicated instances of criminal activity as having taken place by a facility or the employees of a facility—

‘(i) that were committed inside the facility;

‘(ii) with respect to such instances of violations or crimes committed outside of the facility that were the violations or crimes of abuse, neglect, and exploitation, criminal sexual conduct, or other violations or crimes that resulted in serious bodily injury; and

‘(iii) the number of civil monetary penalties assessed against the facility, employees, contractors, and other agents.

(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)(i) is included on such website (or a successor website) not later than 1 year after the date of the enactment of this subsection.

‘(2) REVIEW AND MODIFICATION OF WEBSITE.—

‘(A) IN GENERAL.—The Secretary shall establish, by inserting at the end the following new paragraph:

‘(i) to review the accuracy, clarity of presentation, timeliness, and comprehensiveness of information reported on such website as of the date 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 remove such information in accordance with the review conducted under clause (i).

‘(B) CONSULTATION.—In conducting the review under subparagraph (A)(i), the Secretary shall consult with—

‘(i) State long-term care ombudsman programs;

‘(ii) consumer advocacy groups;

‘(iii) provider stakeholder groups; and

‘(iv) any other representatives of programs or groups the Secretary determines appropriate.

(2) TIMELINESS OF SUBMISSION OF SURVEY AND CERTIFICATION INFORMATION.—

(A) IN GENERAL.—Section 1919(g)(5) of the Social Security Act (42 U.S.C. 1396r-3(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 subparagraph (A) and provided on the Nursing Home Compare Medicare website under section 1919(g)(5) the Secretary shall submit information respecting any survey or certification made respecting a skilled nursing facility (including any enforcement actions taken by the State) to the Secretary not later than the date on which the State sends such information to the Secretary.

‘(F) Effective date.—The amendment made by this paragraph shall take effect 1 year after the date of the enactment of this Act.

(3) SPECIAL FOCUS FACILITY PROGRAM.—Section 1919(f) of the Social Security Act (42 U.S.C. 1396r-3(f)) is amended by adding at the end the following new subparagraph:

‘(E) SPECIAL FOCUS FACILITY PROGRAM.—

‘(1) Skilled nursing facilities.—Section 1819(d)(1) of the Social Security Act (42 U.S.C. 1395f(d)(1)) is amended by adding at the end the following new paragraph:

‘(A) IN GENERAL.—The Secretary shall conduct special surveys and inspections as necessary to determine whether a facility has failed to substantially comply with a standard or requirement of this Act.

‘(B) DEADLINE FOR PROVISION OF INFORMATION.—

‘(i) IN GENERAL.—Except as provided in clause (ii), the Secretary shall ensure that the information described in subparagraph (A) is included on the website (or a successor website) not later than 1 year after the date on which the Secretary receives such information.

‘(ii) EXCEPTION.—The Secretary shall ensure that the information described in subparagraph (A) is included on the website (or a successor website) not later than 1 year after the date on which the Secretary receives such information.
"(C) AVAILABILITY OF SURVEY, CERTIFICATION, AND COMPLAINT INVESTIGATION REPORTS.—A skilled nursing facility must—
"(i) have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years available for any individual to review upon request; and
"(ii) have 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."

"(D) DEFINITIONS.—In this subsection:

(1) IN GENERAL.—For cost reports submitted under this subsection, the term "cost report" means a cost report that is available to the public.

(2) OF THE SOCIAL SECURITY ACT, as added and amended by this subsection, shall take effect 1 year after the date of the enactment of this Act.

(g) SUBMISSION OF STAFFING INFORMATION ON A NATIONAL AND STATE-SPECIFIC BASIS.—

SEC. 6105. ENSURING STAFFING ACCOUNTABILITY.

Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

"SEC. 6106. ENSURING STAFF ACCOUNTABILITY.

Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

"SEC. 6105. ENSURING STAFF ACCOUNTABILITY.

SEC. 6106. ENSURING STAFF ACCOUNTABILITY.

Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

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Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

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Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

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Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

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SEC. 6106. ENSURING STAFF ACCOUNTABILITY.

Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

"SEC. 6105. ENSURING STAFF ACCOUNTABILITY.

SEC. 6106. ENSURING STAFF ACCOUNTABILITY.

Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

"SEC. 6105. ENSURING STAFF ACCOUNTABILITY.

SEC. 6106. ENSURING STAFF ACCOUNTABILITY.
(4) include information on employee turnover and tenure and on the hours of care provided by each category of certified employees referenced in paragraph (1) per resident per day.

Nothing in this subsection shall be construed as preventing the Secretary from requiring submission of such information with respect to specific facilities, such as nursing staff, before other categories of certified employees. Information under this subsection with respect to agency and contract staff shall be kept separate from information on employee staffing.

SEC. 6107. GAO STUDY AND REPORT ON FIVE-STAR QUALITY RATING SYSTEM.

(a) Study.—The Comptroller General of the United States (in this section referred to as the "Comptroller General") shall conduct a study on the Five-Star Quality Rating System for nursing homes of the Centers for Medicare & Medicaid Services. Such study shall include an analysis of—

(1) how such system is being implemented; (2) any problems associated with such system or its implementation; and (3) how such system could be improved.

(b) Report.—Not later than 2 years after the date of enactment of this Act, the Comptroller General 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 Comptroller General determines appropriate.

PART II—TARGETING ENFORCEMENT

SEC. 6108. CIVIL MONEY PENALTIES.

(a) Skilled Nursing Facilities.—

(1) In General.—Section 1915(i)(2)(B)(i) of the Social Security Act (42 U.S.C. 1396i–3(b)(2)(B)) is amended—

(A) by striking "PENALTIES.—The Secretary'' and inserting "PENALTIES.—''

(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 under this clause, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

(III) PENALTIES FOR REPEATED VIOLATIONS.—

(aa) Repeat Violations.—The Secretary may not reduce the amount of a penalty under subclause (II) if the facility is imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

(bb) Certain Other Penalties.—The Secretary shall not reduce the amount of a penalty under subclause (II) if the facility is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

(bb) Collection of Civil Money Penalties.—In the case of a civil money penalty imposed under this clause, the Secretary shall issue regulations that—

(aa) subject to item (cc), not later than 30 days after the date of such imposition, the Secretary may require.

(bb) in the case where the penalty is imposed 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 an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

(ee) in the case where the penalty is imposed 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.

(ff) 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

(ff) in the case where all such appeals are unsuccessful, 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 implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).

(2) Conforming Amendment.—The second sentence of subsection (b) of section 1819(h)(5) of the Social Security Act (42 U.S.C. 1395i–3(b)(5)) is amended by inserting "(ii)(IV)," after "(i),".

(b) Nursing Facilities.—

(1) In General.—Section 1919(h)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1396k(h)(3)(C)) is amended—

(A) by striking "PENALTIES.—The Secretary'' and inserting "PENALTIES.—''

(I) In General.—Subject to subclause (II), the Secretary''; and

(B) by adding at the end the following new subclauses:

(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 under this clause, the Secretary may reduce the amount of the penalty imposed by not more than 50 percent.

(III) PENALTIES FOR REPEATED VIOLATIONS.—

(aa) Repeat Violations.—The Secretary may not reduce the amount of a penalty under subclause (II) if the facility is imposed on the facility in the preceding year under such subclause with respect to a repeat deficiency.

(bb) Certain Other Penalties.—The Secretary shall not reduce the amount of a penalty under subclause (II) if the facility is imposed on the facility for a deficiency that is found to result in a pattern of harm or widespread harm, immediately jeopardizes the health or safety of a resident or residents of the facility, or results in the death of a resident of the facility.

(bb) Collection of Civil Money Penalties.—In the case of a civil money penalty imposed under this clause, the Secretary shall issue regulations that—

(aa) subject to item (cc), not later than 30 days after the date of such imposition, the Secretary may require.

(bb) in the case where the penalty is imposed 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 an independent informal dispute resolution process which generates a written record prior to the collection of such penalty;

(ee) in the case where the penalty is imposed 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.

(ff) 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

(ff) in the case where all such appeals are unsuccessful, 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 implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).

(2) Conforming Amendment.—Section 1919(h)(5)(B) of the Social Security Act (42 U.S.C. 1396k(h)(5)(B)) is amended by inserting "(iii)(IV)," after "(ii),".

(c) Skilled Nursing Facilities and Nursing Facilities.—

(1) General.—Notwithstanding any provision of this Act, any amount collected as a penalty shall be kept in such account pending the resolution of any subsequent appeals.

(2) Dispute Resolution Process Which Generates a Written Record.—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

(3) Amounts Collected for the Return of Such Amounts Collected.—Nothing in this subsection shall be construed to prevent the Secretary from requiring the Secretary to reduce the amount of a penalty if the Secretary determines appropriate.

(d) Requirements.—The Secretary shall evaluate chains selected to participate in the demonstration project in each state on the basis of criteria selected by the Secretary, including where evidence suggests that a
number of the facilities of the chain are experiencing serious safety and quality of care problems. Such criteria may include the evaluation of a chain that includes a number of facilities in the 'Special Focus Facility' program (or a successor program) or multiple facilities with a record of repeated serious safety and quality of care deficiencies.

(c) RESPONSIBILITIES.—An independent monitor that enters into a contract with the Secretary to participate in the conduct of the demonstration project under this section shall—

(1) conduct periodic reviews and prepare root-cause 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) conduct sustained oversight of the efforts of the chain, whether publicly or privately held, to achieve compliance by facilities of the chain with State and Federal laws and regulations applicable to the facilities;

(3) analyze the management structure, distribution of expenditures, 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, the facilities of the chain, the Secretary, and to relevant States; and

(5) publish the results of such reviews, analyses, and oversight.

(d) IMPLEMENTATION OF RECOMMENDATIONS.—

(1) RECEIPT OF FINDING BY CHAIN.—Not later than 10 days after receipt of a finding of an independent monitor under subsection (c)(4), a chain participating in the demonstration project 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 such recommendations, and why it will not do so.

(2) RECEIPT OF REPORT BY INDEPENDENT MONITOR.—Not later than 10 days after receipt 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, the Secretary, and the State or States, including such final recommendations.

(e) COST OF APPOINTMENT.—A chain shall be responsible for the costs associated with the appointment of independent monitors under the demonstration project under this section. The chain shall pay such portion to the Secretary (in an amount and in accordance with procedures established by the Secretary).

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XVIII and XIX of the Social Security Act (42 U.S.C. 1386 et seq.; 1396 et seq.) as may be necessary for the Secretary to carry out the demonstration project under this section.

(g) 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) WAIVERABLE PARTY.—The term ‘additional discardable party’ has the meaning given such term in section 1124(c)(3)(A) of the Social Security Act, as added and amended by this Act.

(2) FACILITY.—The term ‘facility’ means a skilled nursing facility or a nursing facility.

(3) 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(a)).

(4) SECRETARY.—The term ‘Secretary’ means the Secretary of Health and Human Services, acting through the Assistant Secretary for Planning and Evaluation.

(5) 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. 1395f-3(h)(4)).

(i) EVALUATION AND REPORT.—

(1) EVALUATION.—In consultation with the Inspector General of the Department of Health and Human Services, the Secretary shall evaluate the demonstration project conducted under this section.

(2) REPORT.—Not later than 180 days after the completion of the demonstration project under this section, the Secretary shall submit to Congress a report containing the results of the evaluation conducted under paragraph (1), together with recommendations:

(A) as to whether the independent monitor program should be established on a permanent basis;

(B) if the Secretary recommends that such program be so established, on appropriate procedures and mechanisms for such establishment; and

(C) for such legislation and administrative action as the Secretary determines appropriate.

SEC. 6115. NOTIFICATION OF FACILITY CLOSURE.

(a) IN GENERAL.—Section 1128I of the Social Security Act, as added and amended by this Act, is amended by adding at the end the following new subsection:

(‘‘(B) Notification of Facility Closure.—

‘‘(1) IN GENERAL.—Any individual who is the administrator of a facility must—

(A) 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 clause (ii), not later than the date that is 60 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;

(B) ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

(C) provide in the notice a plan for the transfer and adequate relocation of the residents of the facility by a specified date prior to closure that has been approved by the Secretary, including that the residents will be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.

(2) RELOCATION.—

(A) 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.

(B) CONTINUATION OF PAYMENTS UNTIL RESIDENTS RELOCATED.—The Secretary may, as the Secretary determines appropriate, continue to make payments under this title with respect to residents of a facility that has submitted a notification under paragraph (1) during the period beginning on the date such notification is submitted and ending on the date on which the resident is successfully relocated.

(3) SANCTIONS.—Any individual who is the administrator of a facility that fails to comply with the provisions of subsection (1)—

(A) shall be subject to a civil monetary penalty of up to $100,000;

(B) may be subject to exclusion from participation in any Federal health care program (as defined in section 1128B(f)); and

(C) shall be subject to any other penalties that may be prescribed therein.

(4) PROCEDURE.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply with respect to civil money penalty or exclusion under paragraph (3) in the same manner as such provisions apply to a penalty or proceeding under section 1128B(a).

(b) CONFORMING AMENDMENTS.—Section 1128B(h) of the Social Security Act (42 U.S.C. 1395f-3(h)(4)) is amended—

(1) in the first sentence, by striking the Secretary shall terminate and inserting the Secretary shall terminate such facility and relating to the Secretary, and shall, as the case may be, terminate such facility;

(2) in the second sentence, by striking subsection (c)(2) and inserting subsection (c)(2) and section 1128B(h).

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

SEC. 6114. NATIONAL DEMONSTRATION PROJECTS ON CULTURE CHANGE AND USE OF INFORMATION TECHNOLOGY IN NURSING HOMES.

(a) IN GENERAL.—The Secretary shall conduct 2 demonstration projects, 1 for the development of best practices in skilled nursing facilities and nursing facilities that are involved in the culture change movement (including the development of resources for facility staff to find and adopt best practices in order to undertake culture change) and 1 for the development of best practices in skilled nursing facilities and nursing facilities for the use of information technology to improve resident care.

(b) CONDUCT OF DEMONSTRATION PROJECTS.—

(1) AUTOMATION AWARD.—Under each demonstration project conducted under this section, the Secretary shall award 1 or more grants to facility-based settings for the development of best practices described in subsection (a) with respect to the demonstration project involved. Such award shall be made on a competitive basis and may be allocated in 1 lump sum payment or in multiple payments.

(2) CONSIDERATION OF SPECIAL NEEDS OF RESIDENTS.—Each demonstration project conducted under this section shall take into consideration the special needs of residents of skilled nursing facilities and nursing facilities who have cognitive impairment, including dementia.

(3) DURATION AND IMPLEMENTATION.—The demonstration projects shall each be conducted for a period not to exceed 3 years.

(4) IMPROVEMENTS.—The demonstration projects shall each be implemented not later than 1 year after the date of the enactment of this Act.

(d) DEFINITIONS.—In this section:

(1) 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. 1396n(a)).

(2) SECRETARY.—The term ‘Secretary’ means the Secretary of Health and Human Services.

(3) 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. 1396r(a)).

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

(f) REPORT.—Not later than 9 months after the completion of the demonstration project,
the Secretary shall submit to Congress a report on such project, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

PART III—IMPROVING STAFF TRAINING

SEC. 621. DEMENTIA AND ABUSE PREVENTION TRAINING

(a) SKILLING long-term FACILITIES.—

(1) IN GENERAL.—Section 1919(b)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1396r(b)(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 patient abuse prevention training’’ before ‘‘(II)’’.

(2) CLARIFICATION OF DEFINITION OF NURSE AIDE.—Section 1919(b)(5)(F) of the Social Security Act (42 U.S.C. 1396r(b)(5)(F)) is amended by adding at the end the following flush sentence:

‘‘Such term includes an individual who provides such services through an agency or under a contract with the facility.’’.

(b) NURSING FACILITIES.—

(1) IN GENERAL.—Section 1919(b)(2)(A)(i)(I) of the Social Security Act (42 U.S.C. 1396r(b)(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 patient abuse prevention training’’ before ‘‘(II)’’.

(2) CLARIFICATION OF DEFINITION OF NURSE AIDE.—Section 1919(b)(5)(F) of the Social Security Act (42 U.S.C. 1396r(b)(5)(F)) is amended by adding at the end the following flush sentence:

‘‘Such term includes an individual who provides such services through an agency or under a contract with the facility.’’.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 1 year after the date of the enactment of this Act.

Subtitle C—Nationwide Program for National and State Background Checks on Direct Patient Access Employees of Long-term Care Facilities and Providers

SEC. 6201. NATIONWIDE PROGRAM FOR NATIONAL AND STATE 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 identify efficient, effective, and economic processes and procedures for long-term care facilities or providers 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’’). Except for the following modifications, the Secretary shall carry out the nationwide program under similar terms and conditions as the pilot program under section 307 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 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 subsection (b)(3)(A) and (b)(6), respectively, of such section 307:

(1) AGREEMENTS.—

(A) NEWLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has entered into an agreement with subsection (c)(1) of such section 307 on a Statewide basis; and

(ii) that agrees to conduct background checks under the nationwide program on a Statewide basis;

(B) CERTAIN PREVIOUSLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has entered into an agreement with subsection (c)(1) of such section 307, but only in the case where such agreement did not require the State to conduct background checks under the program established under subsection (a) of such section 307 on a Statewide basis;

(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.

(B) CERTAIN PREVIOUSLY PARTICIPATING STATES.—The Secretary shall enter into agreements with each State—

(i) that the Secretary has entered into an agreement with subsection (c)(1) of such section 307, but only in the case where such agreement did not require the State to conduct background checks under the program established under subsection (a) of such section 307 on a Statewide basis;

(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.

(2) NONAPPEAL OF SELECTION CRITERIA.—The selection criteria required under subsection (c)(3)(B) of such section 307 shall not apply.

(3) REQUIRED FINGERPRINT CHECK AS PART OF CRIMINAL HISTORY BACKGROUND CHECK.—The procedures established under subsection (b)(1) of such section 307 shall—

(A) require that the long-term care facility or provider (or the designated agent of the long-term care facility or provider) obtain an initial criminal history background check on the prospective employee through such means as the Secretary determines appropriate, efficient, and effective that utilize state-based abuse and neglect registries and databases, including the abuse and neglect registries of another State in the case where a prospective employee is employed by a provider in another State;

(B) require that the 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 that such records;

(C) determine which individuals are direct patient access employees to determine whether the employee has any conviction for a relevant crime;

(D) immediately report to the long-term care facility or provider that requested the criminal history background check the results of such review; and

(E) in the case of an employee with a conviction for a relevant crime that is subject to reporting under section 11206 of the Social Security Act (42 U.S.C. 1320a-7e), reporting the existence of such conviction to the database established under that section.

(v) define appropriate and include nonapplication of selection criteria.

(2) NONAPPLICATION OF SELECTION CRITERIA.—The selection criteria required under subsection (c)(3)(B) of such section 307 shall not apply.

(3) REQUIRED FINGERPRINT CHECK AS PART OF CRIMINAL HISTORY BACKGROUND CHECK.—The procedures established under subsection (b)(1) of such section 307 shall—

(A) require that the long-term care facility or provider (or the designated agent of the long-term care facility or provider) obtain an initial criminal history background check on the prospective employee through such means as the Secretary determines appropriate, efficient, and effective that utilize state-based abuse and neglect registries and databases, including the abuse and neglect registries of another State in the case where a prospective employee is employed by a provider in another State;

(B) require that the 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 that such records;

(C) determine which individuals are direct patient access employees to determine whether the employee has any conviction for a relevant crime;

(D) immediately report to the long-term care facility or provider that requested the criminal history background check the results of such review; and

(E) in the case of an employee with a conviction for a relevant crime that is subject to reporting under section 11206 of the Social Security Act (42 U.S.C. 1320a-7e), reporting the existence of such conviction to the database established under that section.

(v) define appropriate and include nonapplication of selection criteria.

(3) REQUIRED FINGERPRINT CHECK AS PART OF CRIMINAL HISTORY BACKGROUND CHECK.—The procedures established under subsection (b)(1) of such section 307 shall—

(A) require that the long-term care facility or provider (or the designated agent of the long-term care facility or provider) obtain an initial criminal history background check on the prospective employee through such means as the Secretary determines appropriate, efficient, and effective that utilize state-based abuse and neglect registries and databases, including the abuse and neglect registries of another State in the case where a prospective employee is employed by a provider in another State;

(B) require that the 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 that such records;

(C) determine which individuals are direct patient access employees to determine whether the employee has any conviction for a relevant crime;

(D) immediately report to the long-term care facility or provider that requested the criminal history background check the results of such review; and

(E) in the case of an employee with a conviction for a relevant crime that is subject to reporting under section 11206 of the Social Security Act (42 U.S.C. 1320a-7e), reporting the existence of such conviction to the database established under that section.

(v) define appropriate and include nonapplication of selection criteria.

(3) REQUIRED FINGERPRINT CHECK AS PART OF CRIMINAL HISTORY BACKGROUND CHECK.—The procedures established under subsection (b)(1) of such section 307 shall—

(A) require that the long-term care facility or provider (or the designated agent of the long-term care facility or provider) obtain an initial criminal history background check on the prospective employee through such means as the Secretary determines appropriate, efficient, and effective that utilize state-based abuse and neglect registries and databases, including the abuse and neglect registries of another State in the case where a prospective employee is employed by a provider in another State;

(B) require that the 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 that such records;

(C) determine which individuals are direct patient access employees to determine whether the employee has any conviction for a relevant crime;

(D) immediately report to the long-term care facility or provider that requested the criminal history background check the results of such review; and

(E) in the case of an employee with a conviction for a relevant crime that is subject to reporting under section 11206 of the Social Security Act (42 U.S.C. 1320a-7e), reporting the existence of such conviction to the database established under that section.

(v) define appropriate and include nonapplication of selection criteria.
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 3 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed $3,000,000.

(b) Previously Participating States.—(i) Federal Law.—Any part of the application submitted by a State under paragraph (1)(B)(iii), the State shall guarantee, with respect to costs incurred by the State, 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)(B) shall be 3 times the amount that the State guarantees to make available under clause (i), except that in no case may the payment amount exceed $3,000,000.

(c) Definitions.—Under the nationwide program:

(A) Conviction for a Relevant Crime.—The term ‘conviction for a relevant crime’ means any Federal or State criminal conviction found after

(i) any offense described in section 1128(a) of the Social Security Act (42 U.S.C. 1395f–3(a)); or

(ii) such other types of offenses as a participating State may specify for purposes of conducting the program in such State.

(B) Disqualifying Information.—The term ‘disqualifying information’ means any substantiated finding of patient or resident abuse.

(C) Finding of Patient or Resident Abuse.—The term ‘finding of patient or resident abuse’ means any substantiated finding of the most appropriate, efficient, and effective procedures for conducting such background checks.

(D) Direct Patient Access Employee.—The term ‘direct patient access employee’ means any employee 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 Secretary for purposes of the nationwide program.

(E) 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:

(a) A skilled nursing facility (as defined in section 1819(a) of the Social Security Act (42 U.S.C. 1395l(a)));

(b) A home health agency (as defined in section 1919(a) of such Act (42 U.S.C. 1396l(a)));

(c) A skilled nursing facility (as defined in section 1919(a) of such Act (42 U.S.C. 1396l(a))); or

(d) A provider of hospice care (as defined in section 1861(dd)(1) of such Act (42 U.S.C. 1395xv(1)(1)));

(e) A long-term care hospital (as described in section 1915(c)(2)(A)(ix) of such Act (42 U.S.C. 1395ww(d)(1)(A)(iv))); or

(f) A provider of personal care services.

(vi) A provider of adult day care.

(vii) A resident care provider that arranges for, or otherwise provides, long-term care services, including an assisted living facility that provides a level of care established by the Secretary.

(viii) An intermediate care facility for the mentally retarded (as defined in section 1905(d) of such Act (42 U.S.C. 1396d(d))).

(ix) Any other facility or provider of long-term care services under such titles as the pregnant, perinatal, and postpartum pregnancy care program established under section (a)(7)(A).

(E) Federal Match.—The payment amount to be provided for the conduct of the evaluation under subsection (a)(7)(A) shall be 3 times the amount that the Secretary enters into an agreement with under paragraph (1).

(f) Report to Congress.—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).

(g) Evaluation and Report.—(A) Evaluation.—(i) In general.—The Inspector General of the Department of Health and Human Services shall conduct an evaluation of the nationwide program.

(ii) Inclusion of Specific Topics.—The evaluation conducted under clause (i) shall include the following:

(I) A review of the various procedures implemented by participating States for long-term care facilities or providers, including staffing, background checks, and verification of direct patient access employees

(II) An assessment of the extent to which conducting such background checks leads to any unintended consequences, including a reduction in the available workforce for long-term care facilities or providers.

(III) An assessment of the impact of the nationwide program on reducing the number of incidents of neglect, abuse, and misappropriation of patient property to the extent practicable.

(V) An evaluation of other aspects of the nationwide 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).

(H) Funding.—(A) Notification.—The Secretary of Health and Human Services shall notify the Appropriations Committees of Congress containing the results of the evaluation conducted under subsection (a)(7)(A).
(A) RESEARCH.—The Institute shall carry out the research project agenda established under paragraph (2) in accordance with the methodological standards adopted under paragraph (9) using methods, including the following:

(i) primary research, such as randomized clinical trials, molecularly informed trials, and observational studies;

(ii) systematic reviews and assessments of existing and future research and evidence including original research conducted subsequent to the date of the enactment of this section.

(B) MANAGEMENT OF FUNDING AND CONDUCT OF RESEARCH.—

(1) CONTRACTS.—In general.—In accordance with the methodology committee established under paragraph (1)(B), the Institute shall enter into contracts for the management of funding and conduct of research in accordance with this section.

(2) TAKING INTO ACCOUNT POTENTIAL DIFFERENCES.—Research shall be designed, as appropriate, to take into account the potential for differences in the effectiveness of health care or medical technology that is included under such contract.

(3) DATA COLLECTION.—

(A) IN GENERAL.—The Secretary shall, with appropriate safeguards for privacy, make available to the Institute such data collected by the Centers for Medicare & Medicaid Services under the programs under titles XVIII, XIX, and XXI, as well as provide access to the data collected by such Agency or Institutes.

(B) USE OF DATA.—The Institute shall only use data provided under subparagraph (A) in accordance with laws and regulations governing the release and use of such data, including applicable conflict of interest rules.

(4) APPOINTING EXPERT ADVISORY PANELS.—

(A) APPOINTMENT.—In general.—The Institute may appoint permanent or ad hoc expert advisory panels as determined appropriate to assist in identifying research priorities and establishing the research project agenda under paragraph (1) and for other purposes.

(B) EXPERT ADVISORY PANELS FOR CLINICAL TRIALS.—The Institute shall appoint expert advisory panels in carrying out randomized clinical trials under the research project agenda under paragraph (2)(A). Such expert advisory panels shall advise the Institute and the agency, instrumentality, or entity which enters into another contract with the Institute for making the information available to the public under paragraph (8) and that have other appropriate measures, to the extent that such coverage or other measures are necessary to preserve the quality of a research project to such as in the case where the research project shall be blinded.

(C) REVIEW AND UPDATE OF EVIDENCE.—The Institute shall review and update evidence on a periodic basis as appropriate.

(D) TAKING INTO ACCOUNT POTENTIAL DIFFERENCES.—Research shall be designed, as appropriate, to take into account the potential for differences in the effectiveness of health care or medical technology that is included under such contract.
field, such as health services research, clinical research, comparative clinical effectiveness research, biostatistics, genomics, and research methodologies. Stakeholders with such expertise or experience shall be appointed to be members of the methodology committee. In addition to the members appointed under the first sentence, the Directors of the National Institutes of Health, the Agency for Healthcare Research and Quality (or their designees) shall each be included as members of the methodology committee.

(C) Board of Governors.—Subject to subparagraph (D), the methodology committee shall work to develop and improve the science and methods of comparative clinical effectiveness research, and periodically update the following:

(i) Methodological standards for research. Such methodological standards shall provide specific criteria for internal validity, generalizability, feasibility, and timeliness of research and for health outcomes measures, risk adjustment, and other relevant aspects of research and assessment with respect to the design of research. Any methodological standards developed and updated under this subsection shall be scientifically based and include methods by which new information, data, or advances in technology are considered. Such standards shall be developed in consultation with relevant stakeholders and shall be periodically updated by the methodology committee. In the case where the Institute does not adopt such processes in accordance with the preceding sentence, the processes shall be reviewed by the methodology committee. In the case where the Institute does not adopt such processes in accordance with the preceding sentence, the processes shall be reviewed by the methodology committee.

(7) PROVIDING FOR A PEER-REVIEW PROCESS FOR PRIMARY RESEARCH.—

(A) IN GENERAL.—The Institute shall ensure that a peer-review process for primary research described in subparagraph (A)(ii) of paragraph (2) that is conducted under such paragraph. Under such process—

(1) the research described in paragraph (2) (A)(ii) shall be reviewed to assess scientific integrity and adherence to methodological standards adopted under paragraph (9); and

(2) the reviews of individuals contributing to any peer-review process during the preceding year or years shall be made public and included in annual reports in accordance with paragraph (10)(D).

(B) COMPOSITION.—Such peer-review process shall be designed in a manner so as to ensure that the selection of the members of the Institute, the peer-reviewed project, or the part of the reviewers and shall be composed of experts in the scientific field relevant to the research under review.

(C) PROCESSES.—

(i) PROCESSES OF ANOTHER ENTITY.—In the case where the Institute enters into a contract or other agreement with another entity for the development of research under this section, the Institute may utilize the peer-review process of such entity if such process meets the requirements under subparagraphs (A) and (B).

(ii) PROCESSES OF APPROPRIATE MEDICAL JOURNALS.—The Institute may utilize the peer-review process of appropriate medical journals if such process meets the requirements under subparagraphs (A) and (B).

(8) RELEASE OF RESEARCH FINDINGS.—

(A) IN GENERAL.—The Institute shall, not later than 90 days after the receipt of research findings under this part, make such research findings available to clinicians, patients, and the general public. The Institute shall ensure that the research findings—

(i) convey the findings of research in a manner that is comprehensible and useful to patients and providers in making health care decisions;

(ii) fully convey findings and discuss considerations specific to certain subpopulations, risk factors, and comorbidities, as appropriate;

(iii) include limitations of the research and what further research may be needed as appropriate;

(iv) not be construed as mandates for practice guidelines, coverage recommendations, payment, or policy recommendations; and

(v) not include any data which would violate the privacy of research participants or any confidentiality agreements made with respect to the use of data under this section.

(B) DEFINITION OF RESEARCH FINDINGS.—In this paragraph, the term ‘research findings’ means the results of a study or assessment.

(9) SUBCLASP E (H), (I), (J), AND (K) OF SUBSECTION (G) MISSES THE MEANING OF THE FOLLOWING MEMBERS:

(A) Evidence from such primary research.

(B) Methodological standards for research.

(C) Risk adjustment, and other relevant aspects of research.

(D) Provision of the research project agenda established by the methodology committee.

(E) ADMINISTRATION.—

(1) IN GENERAL.—Subject to paragraph (2), the Board shall carry out the duties of the Institute.

(2) NONDELEGABLE DUTIES.—The activities described in subsections (d)(1) and (d)(2) are nondelegable.

(3) BOARD OF GOVERNORS.—

(A) The Director of the National Institutes of Health (or the Director’s designee).

(B) The Director of the National Institutes of Health (or the Director’s designee).

(C) Seventeen members appointed, not later than 6 months after the date of enactment of this section, by the Comptroller General of the United States, with the following members:

(i) 3 members representing patients and health care consumers.

(ii) 3 members representing physicians and providers, including at least 1 surgeon, nurse, State-licensed integrative health care practitioner, and representative of a hospital.

(iii) 3 members representing private payers, of whom at least 1 member shall represent health insurance issuers and at least 1 member shall represent employers who self-insure employee benefits.

(iv) 3 members representing pharmaceutical, device, and diagnostic manufacturer or developer.

(v) 1 member representing quality improvement or independent health service researchers.

(vi) 2 members representing the Federal Government or the States, including at least 1 member representing a Federal health program or agency.

(4) CHAIRPERSON AND VICE-CHAIRPERSON.—The Board shall represent a broad range of perspectives and collectively have scientific expertise in clinical health sciences research, including epidemiology, biostatistics, genomics, and statistics. In appointing the Board, the Comptroller General of the United States shall consider and disclose any conflicts of interest directly related to the research project or the matter that could affect or be affected by such participation.

(5) COMPENSATION.—Each member of the Board shall be appointed for a term of 6 years, except with respect to the members first appointed, whose terms of appointment shall be staggered by over 2-year increments. No individual shall be appointed to the Board for more than 2 terms. Vacancies shall be filled in the same manner as the original appointment was made. A member of the Board who is not an officer or employee of the Federal Government shall be entitled to
compensation (equivalent to the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code) and expenses incurred while performing duties of the Board, or an officer or employee of the Federal government who is a member of the Board shall be exempt from compensation.

(6) HIRE AND STAFF; EXPERTS AND CONSULTANTS.—The Board may employ and fix the compensation of an Executive Director and such other personnel as may be necessary to carry out the duties of the Institute and may seek such assistance and support of, or contract with, experts and consultants that may be necessary for the performance of the duties of the Institute.

(7) MEETINGS AND HEARINGS.—The Board shall meet and hold hearings at the call of the Chairperson or a majority of its members. Meetings not solely concerning matters of personnel shall be advertised at least 7 days in advance and open to the public. A majority of the Board members shall constitute a quorum, but a lesser number of members may meet and hold hearings.

(8) FINANCIAL AND GOVERNMENTAL OVERSIGHT.—

(1) CONTRACT FOR AUDIT.—The Institute shall provide for the conduct of financial audits of the Institute on an annual basis by a private entity with expertise in conducting financial audits.

(2) REVIEW AND ANNUAL REPORTS.—

(A) REVIEW.—The Comptroller General of the United States shall review the following:

(i) Not less frequently than every 5 years, the financial audits conducted under paragraph (1).

(ii) Not less frequently than every 5 years, the activities conducted under section 937 of the Public Health Service Act, including a determination of the dissemination, the types of training conducted and supported, and the conduct of research projects, in order to determine whether information produced by such projects is objective and credible, is produced in a manner consistent with the requirements under this section, and is developed through a transparent process.

(iii) Not less frequently than every 5 years, the dissemination and training activities and data networks established under section 937 of the Public Health Service Act, including the research priorities and the conduct of research projects, in order to determine whether information contained in research findings, and other duties, activities conducted under section (d)(10), except that, in the case of individuals contributing to any such research projects is objective and credible, and access are met:

(A) include a description of the peer review process, such description shall be posted on the Internet website of the Institute; and

(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 in the case where such individual is participating in a clinical trial and such costs would otherwise be covered under such title with respect to the beneficiary.

(2) ADDITIONAL FORUMS.—The Institute shall submit public research findings to the Government Accountability Office. The Office, in consultation with relevant agencies, instrumentalities, and individuals who are stakeholders, shall develop a publicly available resource database that collects and contains government-funded evidence and research from public, private, not-for-profit, and academic sources.

(3) PUBLIC AVAILABILITY.—The Institute shall make available the public and disclose through the official public Internet website of the Institute the following:

(A) Information contained in research findings as specified in subsection (d)(9).

(B) The process and methods for the conduct of research, including the identity of the entity and the investigators conducting such research, and any conflicts of interests of such parties, any direct or indirect links the entity has to industry, and research priorities and data networks established under section (d)(1)(A), the research project agenda established under subsection (d)(1)(B), the methodological standards developed, the activities conducted under section (d)(9), in selecting individuals to conduct research, including the identity of such individuals and their qualifications, and data are produced in a manner consistent with the requirements under this section.

(C) Notice of public comment periods under paragraph (1), including deadlines for public comments.

(D) Notice of public comments received during each of the public comment periods.

(E) In accordance with applicable laws and procedures and as the Institute determines appropriate, proceedings of the Institute.

(4) DISCLOSURE OF CONFLICTS OF INTEREST.—

(A) IN GENERAL.—A conflict of interest shall be disclosed in the following manner:

(i) By the Institute in appointing members to an expert advisory panel under subsection (b) of this section or any working group established under section (d)(7), and for employment as executive staff of the Institute.

(ii) By the Comptroller General in appointing members of the methodology committee under subsection (d)(6);

(iii) By the Institute in the annual report under subsection (d)(7) to the extent that, in the case of individuals contributing to any such peer review process, such description shall be in a manner such that those individuals cannot be identified with a particular research project.

(5) DISCLOSED INFORMATION.—Information disclosed under the preceding sentence shall include the type, nature, and magnitude of the interests of the individual involved, except to the extent that the individual involved, in the case of individuals contributing to any such peer review process, such description shall be in a manner such that those individuals cannot be identified with a particular research project.

(6) MANNER OF DISCLOSURE.—Conflicts of interest shall be disclosed as described in subsection (b). Public information shall be disseminated by the Internet web site of the Institute and of the Government Accountability Office. The information disclosed under the preceding sentence shall include the type, nature, and magnitude of the interests of the individual involved, except to the extent that the individual involved, in the case of individuals contributing to any such peer review process, such description shall be in a manner such that those individuals cannot be identified with a particular research project.

(7) RULES OF CONSTRUCTION.—

(A) IN GENERAL.—The Institute shall broadly disseminate the research findings that are published by the Patient-Centered Outcomes Research Institute established under section 1181(b) of the Social Security Act (referred to in this section as the ‘Institute’) and other government-funded research relevant to comparative clinical effectiveness research. The Office shall create information tools that organize and disseminate research findings for physicians, health care providers, health plans, patients, payers, and policy makers. The Office shall also develop a publicly available resource database that collects and contains government-funded evidence and research from public, private, not-for-profit, and academic sources.

(8) REQUIREMENTS.—The Office shall provide for the dissemination of the Institute’s research findings and government-funded research relevant to comparative clinical effectiveness research to physicians, health care providers, payers, and policy makers. The Institute, the Office, and the Board shall assist users of health information technology focused on clinical decision support

(9) PUBLIC AVAILABILITY.—The Institute shall submit public research findings to the Government Accountability Office. The Office, in consultation with relevant agencies, instrumentalities, and individuals who are stakeholders, shall develop a publicly available resource database that collects and contains government-funded evidence and research from public, private, not-for-profit, and academic sources.

(10) DISCLOSURE OF CONFLICTS OF INTEREST.—

(A) IN GENERAL.—A conflict of interest shall be disclosed in the following manner:

(i) By the Institute in appointing members to an expert advisory panel under subsection (b) of this section or any working group established under section (d)(7), and for employment as executive staff of the Institute.

(ii) By the Comptroller General in appointing members of the methodology committee under subsection (d)(6);

(iii) By the Institute in the annual report under subsection (d)(7) to the extent that, in the case of individuals contributing to any such peer review process, such description shall be in a manner such that those individuals cannot be identified with a particular research project.

(iv) By the Institute in the annual report under subsection (d)(7) to the extent that, in the case of individuals contributing to any such peer review process, such description shall be in a manner such that those individuals cannot be identified with a particular research project.

(v) Not later than 8 years after the date of enactment of this section, the adequacy and use of the funding for the Institute and the activities conducted under section 937 of the Public Health Service Act, including a determination as to whether, based on the utilization of the findings by public and private payers, funding sources for the Patient-Centered Outcomes Research Trust Fund under section 9511 of the Internal Revenue Code, and the Institute’s activities, such findings are useful and will lead to provision of care.
to promote the timely incorporation of research findings disseminated under subsection (a) into clinical practices and to promote the ease of use of such incorporation.

(c) The Office shall establish a process to receive feedback from physicians, health care providers, patients, and vendors on the implementation of technology focused on clinical decision support, patient and professional associations, and Federal and private health plans about the value of the use of the disapproved and the assistance provided under this section.

(d) RULE OF CONSTRUCTION.—Nothing in this section shall preclude the Institute from extending the life of an elderly, disabled, or not terminally ill.

XVIII in a manner that treats extending an individual’s life due to the individual’s age, disability, or terminal illness.

(d)(1) The Secretary shall not use evidence or findings from comparative clinical effectiveness research under section 1181 in determining coverage, reimbursement, or incentive programs under title XVIII in a manner that precludes, or with the intent to preclude an individual from choosing a health care treatment based on how the individual values the tradeoffs between extending the length of their life and the risk of disability.

(d)(2)(A) Paragraph (1) shall not be construed to—

(i) limit the application of differential co-payments under title XVIII based on factors such as cost or type of service; or

(ii) prevent the Secretary from using evidence or findings from such comparative clinical effectiveness research.

(b) Adjustments for increases in health care spending.—In the case of any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a) for such fiscal year shall be equal to the sum of such dollar amount for the previous fiscal year (determined after the application of this subsection), plus an amount equal to—

(1) such dollar amount for the previous fiscal year, multiplied by

(2) the percentage increase in the projected per capta amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year.

9. PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND; FINANCING FOR TRUST FUND.—

(1) ESTABLISHMENT OF TRUST FUND.—

(A) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to establishment of trust funds) is amended by adding at the end the following new section:

SEC. 9801. PATIENT-CENTERED OUTCOMES RESEARCH TRUST FUND.

(a) Creation of trust fund.—There is established in the Treasury of the United States a trust fund to be known as the ‘‘Patient-Centered Outcomes Research Trust Fund’’ (hereafter in this section referred to as the ‘‘PCORTF’’), consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this section and section 9602(b).

(b) Transfers to fund.—

(1) Appropriation.—There are hereby appropriated to the Trust Fund the following:

(A) For fiscal year 2010, $10,000,000.

(B) For fiscal year 2011, $50,000,000.

(C) For fiscal year 2012, $150,000,000.

(D) For fiscal year 2013—

(i) an amount equivalent to the net revenues received in the Treasury from the fees imposed under subsection (f) of section 3401 in relation to fees on health insurance and self-insured plans for such fiscal year; and

(ii) $150,000,000.

(E) For each of fiscal years 2014, 2015, 2016, 2017, 2018, and 2019—

(i) an amount equivalent to the net revenues received in the Treasury from the fees imposed under subsection (f) of section 3401 in relation to fees on health insurance and self-insured plans for such fiscal year; and

(ii) $150,000,000.

The amounts appropriated under subparagraphs (A), (B), (C), (D)(ii), and (E)(ii) shall be transferred from the general fund of the Treasury, from funds not otherwise appropriated.

(2) Trust fund transfers.—In addition to the amounts appropriated under paragraph (1), there shall be credited to the PCORTF the amounts transferred under section 1183 of the Social Security Act.

(3) Limitation on transfers to PCORTF.—No amount may be appropriated or transferred to the PCORTF for any fiscal year beyond the date of any expenditure permitted under this section. The determination of whether an expenditure is so permitted shall be made without regard to—

(A) any provision of law which is not contained or referenced in this chapter or in a revenue Act, and

(B) whether such provision of law is a subsequently enacted provision or directly or indirectly seeks to waive the application of the provision.

(c) Trustee.—The Secretary of the Treasury shall be the trustee of the PCORTF.

(d) Expenditures from fund.—

(1) COUNTS AVAILABLE TO THE PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE.—Subject to paragraph (2), amounts in the
PCORTF are available, without further appropriation, to the Patient-Centered Outcomes Research Institute established under section 1181(b) of the Social Security Act for carrying out that title of the Social Security Act (as in effect on the date of enactment of such Act).

"(2) TRANSFER OF FUNDS.—(A) In general.—The trustee of the PCORTF shall provide for the transfer from the PCORTF of 20 percent of the amounts appropriated or credited to the PCORTF for each such fiscal year through 2016 to the Secretary of Health and Human Services to carry out section 937 of the Public Health Service Act.

"(B) AVAILABILITY.—Amounts transferred under subparagraph (A) shall remain available until expended.

"(C) Consequences.—Of the amounts transferred under subparagraph (A) with respect to a fiscal year, the Secretary of Health and Human Services shall distribute—

"(1) 80 percent to the Office of Communication and Knowledge Transfer of the Agency for Healthcare Research and Quality (or any other appropriate office designated by Agency for Healthcare Research and Quality) to carry out the activities described in section 937 of the Public Health Service Act; and

"(ii) 20 percent to the Secretary to carry out the activities described in such section 937.

"(D) Net revenues.—For purposes of this section, the term ‘net revenues’ means the amount estimated by the Secretary of the Treasury based on the excess of—

"(1) the fees received in the Treasury under subchapter B of chapter 34, over

"(2) the decrease in the tax imposed by chapter 1 resulting from the fees imposed by such chapter.

"(E) TERMINATION.—No amounts shall be available for expenditure from the PCORTF after September 30, 2019, and any amounts in such Trust Fund after such date shall be transferred to the general fund of the Treasury.

"(F) CLERICAL AMENDMENT.—The table of sections for subchapter A of chapter 98 of such Code is amended by adding at the end the following new item:

“Sec. 9811. Patient-centered outcomes research purpose fund.”

"(2) FINANCING FOR FUND FROM FEES ON INSURED AND SELF-INSURED HEALTH PLANS.—(A) GENERAL RULE.—Chapter 34 of the Internal Revenue Code of 1986 is amended by adding at the end the following new 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. Federal health insurance.

"(a) IMPOSITION OF FEE.—There is hereby imposed on each specified health insurance policy for each policy year ending after September 30, 2012, a fee equal to the product of—

"(i) such dollar amount for plan years ending in the previous fiscal year, multiplied by—

"(1) such dollar amount for policy years ending in the previous fiscal year, multiplied by—

"(2) the percentage increase in the projected per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year.

"(o) TERMINATION.—This section shall not apply to policy years ending after September 30, 2019.

"SEC. 4376. SELF-INSURED HEALTH PLANS.

"(a) IMPOSITION OF FEE.—In the case of any applicable self-insured health plan for any plan year ending after September 30, 2012, there is hereby imposed a fee equal to $2 ($1 in the case of plan years ending during fiscal year 2013) 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 SPONSORS.—In the case of—

"(i) the term ‘plan sponsor’ means—

"(A) the employer in the case of a plan established by an employer organization;

"(B) the employee organization in the case of a plan established by an employee organization;

"(C) in the case of—

"(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations; or

"(ii) a multiple employer welfare arrangement, or

"(ii) a voluntary employees’ beneficiary association described 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;

"(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such 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) any portion of such coverage is provided other than through an insurance policy, and

"(2) such plan is established or maintained—

"(A) by 1 or more employers for the benefit of their employees or former employees,

"(B) by 1 or more employer organizations for the benefit of their members or former members,

"(C) jointly by 1 or more employers and 1 or more employer organizations for the benefit of employees or former employees, or

"(D) by any organization described in section 501(c)(9), or

"(E) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement (as defined in section 3(40) of the Employee Retirement Income Security Act of 1974), a rural electric cooperative (as defined in section 3(40)(B)(iv) of such Act), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

"(d) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any plan year ending in any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a) for such plan year shall be equal to the sum of such dollar amount for policy years ending in the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

"(1) such dollar amount for policy years ending in the previous fiscal year, multiplied by—

"(2) the percentage increase in the projected per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year.

"(ii) the term ‘exempt governmental program’ means any program which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4375(c)).

"(ii) the term ‘insurance policy’ means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended to individuals included in section 3(40) of such Act, or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

"(d) ADJUSTMENTS FOR INCREASES IN HEALTH CARE SPENDING.—In the case of any plan year ending in any fiscal year beginning after September 30, 2014, the dollar amount in effect under subsection (a) for such plan year shall be equal to the sum of such dollar amount for policy years ending in the previous fiscal year (determined after the application of this subsection), plus an amount equal to the product of—

"(i) such dollar amount for plan years ending in the previous fiscal year, multiplied by—

"(2) the percentage increase in the projected per capita amount of National Health Expenditures, as most recently published by the Secretary before the beginning of the fiscal year.

"(ii) the term ‘exempt governmental program’ means any program which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4375(c)).

"(ii) the term ‘insurance policy’ means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended to individuals included in section 3(40) of such Act.

"(ii) the term ‘exempt governmental program’ means any program which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4375(c)).

"(ii) the term ‘insurance policy’ means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended to individuals included in section 3(40) of such Act.

"(ii) the term ‘exempt governmental program’ means any program which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4375(c)).

"(ii) the term ‘insurance policy’ means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended to individuals included in section 3(40) of such Act.

"(ii) the term ‘exempt governmental program’ means any program which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4375(c)).

"(ii) the term ‘insurance policy’ means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended to individuals included in section 3(40) of such Act.

"(ii) the term ‘exempt governmental program’ means any program which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4375(c)).

"(ii) the term ‘insurance policy’ means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended to individuals included in section 3(40) of such Act.
be covered over to any possession of the United States.

(B) CLERICAL AMENDMENTS.—

(i) Chapter 34 of such Code is amended by striking the chapter heading and inserting the following:

"CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES".

(ii) Section 804 of Division A of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. 299b–8), including the requirement under section 804 of Division A of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. 299b–8), including the requirement under such section of the Internal Revenue Code of 1986 is amended by striking the item relating to chapter 34 and inserting the following:

"(I) for 2010, $200; and

(II) for 2011 and each subsequent year, the amount determined under this clause for the preceding year, adjusted by the percentage change in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with June of the previous year.

(III) LEVEL OF SCREENING.—The Secretary shall impose a fee on each individual provider of medical or other items or services or supplier (such as a hospital or skilled nursing facility) with respect to which screening is conducted under this paragraph in an amount equal to—

(1) for 2010, $200; and

(2) for 2011 and each subsequent year, the amount determined under this clause for the preceding year, adjusted by the percentage change in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with June of the previous year.

(IV) INSTUTIONAL PROVIDERS.—Except as provided in clause (iii), the Secretary shall impose a fee on each institutional provider of medical or other items or services or supplier (such as a hospital or skilled nursing facility) with respect to which screening is conducted under this paragraph in an amount equal to—

(1) for 2010, $500; and

(2) for 2011 and each subsequent year, the amount determined under this clause for the preceding year, adjusted by the percentage change in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with June of the previous year.

(V) EXEMPT STATUS OF THE PATIENT-INSURED.—The Secretary may make any necessary adjustments to payments to the applicable provider of services or supplier under the program under this title, on or after the date that is 1 year after such date of enactment.

(IV) LIMITATION ON ENROLLMENT AND REVALIDATION OF ENROLLMENT.—In no case may a provider of medical or other items or services or supplier who has been screened under this paragraph be initially enrolled or reenrolled in the program under this title, title XIX, or title XXI on or after the date that is 3 years after such date of enactment.

(E) EXPEDITED RULEMAKING.—The Secretary may promulgate an interim final rule to carry out this paragraph.

PROVISIONAL AUTHORITY TO ADJUST PAYMENTS TO PROVIDERS OF SERVICES AND SUPPLIERS.—

The Secretary shall establish procedures to provide for a transitional period not less than 30 days and not more than 1 year during which new providers of medical or other items or services and suppliers, as the Secretary determines appropriate, including categories of providers or suppliers, would be subject to enhanced oversight, such as procurement, enrollment, reenrollment, or suspension, under the program under this title, the Medicaid program under title XIX, and the CHIP program under title XXI.

SEC. 6011. IMPLEMENTATION.—The Secretary may establish by program instruction or otherwise the procedures under this paragraph.

"(4) INCREASED DISCLOSURE REQUIREMENTS.—

(A) DISCLOSURE.—A provider of medical or other items or services or supplier who submits an application for enrollment or reenrollment of enrollees under the program under this title, title XIX, or title XXI on or after the date that is 1 year after the date of enactment of this paragraph shall disclose (in a form and manner as determined by the Secretary) any current or previous affiliation, directly or indirectly, with a provider of medical or other items or services or supplier that has not been screened or that has a past-due obligation, that has been excluded from participation under the program under this title, the Medicaid program under title XIX, or the CHIP program under title XXI, or has had its billing privileges revoked, or that has been subject to a payment suspension under a Federal health care program.

(B) AUTHORITY TO DENY ENROLLMENT.—If the Secretary determines that such previous affiliation poses an undue risk of fraud, waste, and abuse, the Secretary may deny such application. Such a denial shall be subject to appeal in accordance with paragraph (7).

(C) AUTHORITY TO ADJUST PAYMENTS OF PROVIDERS OF SERVICES AND SUPPLIERS WITH THE SAME TAX IDENTIFICATION NUMBER FOR PAST-DUE OBLIGATIONS.—

(1) IN GENERAL.—Notwithstanding any other provision of this title, in the case of an applicable provider of services or supplier, the Secretary may make any necessary adjustment to payments to the applicable provider of services or supplier under the program under this title in order to satisfy any
past-due obligations described in subparagraph (B)(ii) of an obligated provider of services or supplier.

(B) DEFINITIONS.—In this paragraph:

(1) the term ‘obligated provider of services or supplier’ means a provider of services or supplier that has the same taxpayer identification number as assigned by the Internal Revenue Code of 1986 as is assigned to the obligated provider of services or supplier under such section, regardless of whether the applicable services or supplier is assigned a different billing number or national provider identification number under the program and shall be treated as if such number is assigned to the obligated provider of services or supplier.

(2) ‘OBLIGATED PROVIDER OF SERVICES OR SUPPLIER.—The term ‘obligated provider of services or supplier’ means a provider of services or supplier that owes a past-due obligation under the program under this title as determined by the Secretary.

(3) TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS.—

(4) TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS.—

(5) COMPLIANCE PROGRAMS.—

(6) ESTABLISHMENT OF CORE ELEMENTS.—

(7) ESTABLISHMENT OF CORE ELEMENTS.—

(A) IN GENERAL.—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 subparagraph (B) with respect to that provider or supplier and industry or category.

(B) ESTABLISHMENT OF CORE ELEMENTS.—

(C) ESTABLISHMENT OF CORE ELEMENTS.—

(D) ESTABLISHMENT OF CORE ELEMENTS.—

(E) ESTABLISHMENT OF CORE ELEMENTS.—

(F) ESTABLISHMENT OF CORE ELEMENTS.—

(G) ESTABLISHMENT OF CORE ELEMENTS.—

(H) ESTABLISHMENT OF CORE ELEMENTS.—

(I) ESTABLISHMENT OF CORE ELEMENTS.—

(J) ESTABLISHMENT OF CORE ELEMENTS.—

(K) ESTABLISHMENT OF CORE ELEMENTS.—

(L) ESTABLISHMENT OF CORE ELEMENTS.—

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(O) ESTABLISHMENT OF CORE ELEMENTS.—

(P) ESTABLISHMENT OF CORE ELEMENTS.—

(Q) ESTABLISHMENT OF CORE ELEMENTS.—

(R) ESTABLISHMENT OF CORE ELEMENTS.—

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(T) ESTABLISHMENT OF CORE ELEMENTS.—

(U) ESTABLISHMENT OF CORE ELEMENTS.—

(V) ESTABLISHMENT OF CORE ELEMENTS.—

(W) ESTABLISHMENT OF CORE ELEMENTS.—

(X) ESTABLISHMENT OF CORE ELEMENTS.—

(Y) ESTABLISHMENT OF CORE ELEMENTS.—

(Z) ESTABLISHMENT OF CORE ELEMENTS.—

(a) DATA MATCHING.—

(b) DATA MATCHING.—

(c) DATA MATCHING.—

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Human Services for the purpose of identifying potential fraud, waste, and abuse under the programs under titles XVIII and XIX.

"(ii) INDIVIDUALS DESCRIBED.—The following individuals are described in this clause: (I) The Commissioner of Social Security, (II) The Secretary of Veterans Affairs, (III) The Secretary of Defense, (IV) The Director of the Indian Health Service, (V) the Inspector General for the Department of Health and Human Services for the purpose of identifying potential fraud, waste, and abuse including matches of a system of records with non-Federal records:

"(3) MATCHING AGREEMENTS WITH THE COMMISSIONER OF SOCIAL SECURITY.—Section 205(r) of the Social Security Act (42 U.S.C. 405(r)) is amended by adding at the end the following new paragraph:

"(9)(A) The Commissioner of Social Security shall enter into an agreement with the Secretary or such Inspector General for the purpose of matching data in the system of records of the Social Security Administration with the programs under titles XVII, XIX, and XXI.

"(b) OIG AUTHORITY TO OBTAIN INFORMATION.—

"(1) IN GENERAL.—Notwithstanding and in addition to any other provision of law, the Inspector General of the Department of Health and Human Services may, for purposes of enforcing the integrity of programs under titles XVIII and XIX, obtain information from any individual (including a beneficiary) provided all applicable privacy protections are followed) or entity that—

"(A) is a provider of medical or other items or services, supplier, grant recipient, contractor, or subcontractor; or

"(B) directly or indirectly provides, orders, manufactures, distributes, arranges for, pre-scribes, supplies, or receives medical or other items or services payable by any Federal Health Care program or plan under part D of title XVIII, a covered part D drug (as defined in section 1860D–2(e)) for which payment is made under such program or plan under part D of such title, and any records necessary for evaluation of the economy, efficiency, and effectiveness of the programs under titles XVIII and XIX.

"(c) ADMINISTRATIVE REMEDY FOR KNOWING PARTICIPATION BY BENEFICIARY IN HEALTH CARE FRAUD SCHEME.—

"(1) IN GENERAL.—In addition to any other applicable remedies, if an applicable individual has knowingly participated in a Federal health care fraud offense or a conspiracy to commit a Federal health care fraud offense, the Secretary shall impose an appropriate administrative penalty commensurate with the offense or conspiracy.

"(2) INDIVIDUAL.—For purposes of paragraph (1), the term 'applicable individual' means an individual—

"(A) entitled to, or enrolled for, benefits under part A of title XVIII or enrolled under part B of such title;

"(B) eligible for medical assistance under a State plan under title XIX or under a waiver of such plan; or

"(C) eligible for child health assistance under a child health plan under title XXI.

"(d) REPORTING AND RETURNING OF OVERPAYMENTS.—

"(1) IN GENERAL.—If a person has received an overpayment, the person shall—

"(A) report and return the overpayment to the Secretary, the State, an intermediary, a carrier, or a contractor, as appropriate, at the correct address; and

"(B) the date any corresponding cost report is due is extended by 60 days;

"(2) ENFORCEMENT.—Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (1) is an obligation (as defined in section 3729(b)(3) of title 31, United States Code) for purposes of section 3729 of such title.

"(e) DISCLOSURES.—In this subsection:

"(A) KNOWING AND KNOWINGLY.—The terms ‘knowing’ and ‘knowingly’ have the meaning given those terms in section 3729(b)(2) of title 31, United States Code.

"(B) OVERPAYMENT.—The term ‘overpayment’ means any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title.

"(c) PERSON.—

"(1) IN GENERAL.—The term ‘person’ means a provider of services, supplier, Medicaid managed care organization (as defined in section 1315(m)(1)(A)), Medicare Advantage organization (as defined in section 1320(c)(1)), or PDP sponsor (as defined in section 1860D– 4(a)(13)).

"(ii) EXCLUSION.—Such term does not include a beneficiary.

"(d) INCLUSION OF CERTAIN INFORMATION.—Information which the Inspector General may obtain under paragraph (1) includes any supporting documentation necessary to validate claims for payment or payments under title XVIII or XIX, including Medicaid encounter data (as defined by the Secretary) for whom the State does not report enrollee identification data to the Medicaid Statistical Information System (MSIS) in a timely manner (as determined by the Secretary).

"(d) PERMISSIVE EXCLUSIONS AND CIVIL MONETARY PENALTIES.—

"(1) PERMISSIVE EXCLUSIONS.—Section 1128(b) of the Social Security Act (42 U.S.C. 1320a–7(b)) is amended by adding at the end the following new paragraph:

"(16)(i) MAKING FALSE STATEMENTS OR MISREPRESENTATION OF MATERIAL FACTS.—Any individual or entity that knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider of services or supplier under a Federal health care program (as defined in section 1128(b)) in any program under part B of title XVIII, or Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, Medicaid managed care organizations under title XIX, or other entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans:

"(A) in clause (vi), by adding '; entity that knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, bid, or contract to participate or enroll as a provider of services or supplier under a Federal health care program (as defined in section 1128(b)) in any program under part B of title XVIII, or Medicare Advantage organizations under part C of title XVIII, prescription drug plan sponsors under part D of title XVIII, Medicaid managed care organizations under title XIX, or any other entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans:‘.

"(2) CIVIL MONETARY PENALTIES.—

"(A) IN GENERAL.—Section 1128(a)(1) of the Social Security Act (42 U.S.C. 1320a–7(a)) is amended—

"(B) by striking ‘or’ at the end;

"(C) by inserting ‘or’ before the semicolon; and

"(D) by adding at the end the following new paragraph:

"(9)(A) The Commissioner of Social Security shall, upon the request of the Secretary or the Inspector General of the Department of Health and Human Services—

"(I) enter into an agreement with the Secretary or such Inspector General for the purpose of matching data in the system of records of the Social Security Administrations with the programs under titles XVII, XIX, and XXI; or

"(II) include in such agreement safeguards to assure the maintenance of the confidentiality of any information disclosed.

"(B) For purposes of this paragraph, the term ‘system of records’ has the meaning given such term in section 552(a)(5) of title 5, United States Code.
from the Federal health care program (as defined in section 1122B(f)) under which the claim was made pursuant to Federal law.

(ii) in paragraph (6), by striking "or" at the end;

(iii) by inserting after paragraph (7), the following new paragraphs:

"(8) orders or prescribes a medical or other item or service during a period in which the person is excluded or suspended under such a program;

"(9) knowingly makes or causes to be made any false statement, omission, or misrepresentation of a material fact in any application, payment, or renewal of participation in such a program as a provider of services or a supplier under a Federal health care program (as so defined), including Medicare Advantage organizations, prescription drug plan sponsors under part D of title XVIII, Medicaid managed care organizations under title XIX, and entities that apply to participate as providers of services or suppliers in such managed care organizations and such plans;

"(10) knows of an overpayment (as defined in paragraph (4) of section 1128J(d)) and does not report and return the overpayment in accordance with such section;"

(iv) in the first sentence—

"(I) by striking "or" after "prohibited relationships;" and

"(II) by striking "and" and inserting "or"; and

(v) in the second sentence, by striking "purpose)" and inserting "purpose; or" in cases under paragraph (9), $50,000 for each false statement or misrepresentation of a material fact;"

(B) CLARIFICATION OF TREATMENT OF CERTAIN CHARITABLE AND OTHER INNOCUOUS PROGRAMS.—Section 1122A(i)(6) of the Social Security Act (42 U.S.C. 1320a–7a(i)(6)) is amended—

(1) in subparagraph (C), by striking "or" at the end;

(2) in subparagraph (D), as redesignated by section 4331(e) of the Balanced Budget Act of 1997 (Public Law 105–33), by striking the period at the end and inserting a semicolon;

(3) in subparagraph (E), as added by section 4523(c) of such Act, as substituted with respect to fiscal year 2011, the waiver by a PDP sponsor of a prescription drug plan under part D of title XVIII or an MA organization offering an MA–PD plan under part C of such title of any copayment for the first fill of a covered part D drug (as defined in section 1860D–2(e)) that is a generic drug for individuals enrolled in the prescription drug plan or MA–PD plan, respectively.

"(e) TESTIMONIAL SUBPOENA AUTHORITY IN EXCLUSION-ONLY CASES.—Section 1128(b) of the Social Security Act (42 U.S.C. 1320a–7b) is amended by adding at the end the following new subsection:

"(1) KICKBACKS.—Section 1128B of the Social Security Act (42 U.S.C. 1320a–7b) is amended by adding at the end the following new subsection:

"(g) In addition to the penalties provided for in this section or section 1128A, a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of subchapter III of chapter 37 of title 31, United States Code.

(2) REVISING THE INTENT REQUIREMENT.—Section 1122B of the Social Security Act (42 U.S.C. 1320a–7b), as amended by paragraph (1), is amended by adding at the end the following new subsection:

"(h) With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section.

(g) SURETY BOND REQUIREMENTS.—

(1) DURABLE MEDICAL EQUIPMENT.—Section 1862(o)(16)(B) of the Social Security Act (42 U.S.C. 1395m(a)(16)(B)) is amended by inserting "that the Secretary is responsible for the cost of the following services rendered by the provider of services or supplier:

"(i) the services or items are not excluded from Federal health care programs by virtue of section 1122B(f) or section 1128A(i)(6);"


(2) Indexing of Amounts Appropriated.—
(A) Departments of Health and Human Services and Justice.—Section 1817(k)(3)(A)(i) of the Social Security Act (42 U.S.C. 1395ddd(a)) is amended by—
(i) in subclause (III), by inserting “and” at the end;
(ii) in subclause (IV)—
(I) by striking “for each of fiscal years 2007, 2008, 2009, and 2010” and inserting “for each fiscal year after fiscal year 2006”;
(II) by striking “; and” and inserting a period; and
(iii) by striking subclause (V).
(B) Office of the Inspector General of the Department of Health and Human Services.—Section 1817(k)(3)(A)(ii) of such Act (42 U.S.C. 1395ddd(a)(ii)) is amended—
(i) in subclause (I), by inserting “and” at the end;
(ii) in subclause (IX)—
(I) by striking “for each of fiscal years 2008, 2009, and 2010” and inserting “for each fiscal year after fiscal year 2007”; and
(II) by striking “; and” and inserting a period;
and
(iii) by striking subclause (X).
(C) Medicare Integrity Program.—Section 1817(k)(4)(C) of the Social Security Act (42 U.S.C. 1395ddd(c)(3)(B)) is amended—
(i) in clause (VII), by inserting “and” at the end;
(ii) in clause (VIII)—
(I) by striking “for each of fiscal years 2007, 2008, 2009, and 2010” and inserting “for each fiscal year after fiscal year 2007”; and
(II) by striking “; and” and inserting a period; and
(iii) by striking clause (IX).
(D) Medicaid Integrity Program.—Section 1817(k)(4)(C) of the Social Security Act (42 U.S.C. 1395ddd(c)(3)(B)) is amended—
(i) in paragraph (3), by striking “and” at the end;
(ii) in paragraph (4) (as so redesignated)—
(I) by inserting after paragraph (3) the following new paragraph:
“(4) Evaluations.—The Secretary shall conduct evaluations of eligible entities which the Secretary contracts with under this section for the reporting of certain final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (d), and shall furnish the information collected under this section to the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.).

SEC. 6403. ELIMINATION OF DUPLICATION BETWEEN THE HEALTHCARE INTEGRITY AND PROTECTION SYSTEM AND THE NATIONAL PRACTITIONER DATA BANK.
(a) Information Reported by Federal Agencies and Health Plans.—Section 1128B(e) of the Social Security Act (42 U.S.C. 1320a-7e) is amended—
(1) by striking subsection (a) and inserting the following:
“(a) In General.—The Secretary shall maintain a national health care fraud and abuse data collection program under this section for the reporting of certain final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (d), and shall furnish the information collected under this section to the National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.).

(2) by striking subsection (d) and inserting the following:
“(d) Access to Reported Information.—
“(1) Availability.—The information collected under this section shall be available from the National Practitioner Data Bank to the agencies, authorities, and officials which are provided under section 1921(b)(1) information reported under section 1921(a).

“(2) Fees for Disclosure.—The Secretary may charge or approve reasonable fees for the disclosure of information under this section. The amount of such a fee may not exceed the costs of processing the requests for disclosure in any fiscal year. Such fees shall be available to the Secretary to cover such costs.”;

(b) in each of paragraphs (4) and (6), by inserting “or the Secretary” before the comma at the end;
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(C) by striking paragraph (5) and inserting the following:

“(5) to State law or fraud enforcement agencies;

(D) by redesigning paragraphs (7) and (8) as paragraphs (8) and (9), respectively; and

(E) by inserting after paragraph (6) the following new paragraph:

“(7) to health plans (as defined in section 1128C(c));”;

(b) by redesigning subsection (d) as subsection (b), and by inserting after subsection (c) the following new subsections:

“(d) DISCLOSURE AND CORRECTION OF INFORMATION.—

(1) DISCLOSURE. With respect to information reported pursuant to subsection (a)(1), the Secretary shall—

(A) provide for disclosure of the information, upon request, to the health care practitioner who, or the entity that, is the subject of the information reported; and

(B) establish procedures for the case where the health care practitioner or entity disputes the accuracy of the information reported.

(2) CORRECTIONS. Each State licensing or certification agency and State law or fraud enforcement agency shall report corrections of information already reported about any health care practitioner or entity.

(3) DISCLOSURE.—With respect to information as required under this section, with the same accuracy of the information reported. The amount of such a fee may not exceed the costs of processing the requests for disclosure and of providing such information. Such fees shall be available to the Secretary to cover such costs.

(4) PROTECTION FROM LIABILITY FOR REPORTING. No person or entity, including any State licensing or certification agency, shall be held liable in any civil or criminal case for any disclosure of information permitted under this section.

(5) FUNDING.—Such fees shall be available to the Secretary to carry out the amendment made by subsections (a) and (b).

(f) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity, including any State licensing or certification agency or entity, shall be held liable in any civil or criminal case for any disclosure of information permitted under this section.

(g) REFERENCES.—For purposes of this section:

(1) STATE LICENSING OR CERTIFICATION AGENCY.—The term ‘State licensing or certification agency’ includes any authority of a State (or of a political subdivision thereof) responsible for the licensing or certification of health care practitioners or any peer review organization or private accreditation entity reviewing the services provided by health care practitioners.

(2) STATE LAW OR FRAUD ENFORCEMENT AGENCY.—The term ‘State law or fraud enforcement agency’ includes—

(A) a State law enforcement agency; and

(B) a State Medicaid fraud control unit (as defined in section 1933(q)).

(3) FINAL ADVERSE ACTION.—The term ‘final adverse action’ includes—

(i) civil judgments against a health care provider, supplier, or practitioner in State court related to the delivery of a health care item or service;

(ii) State criminal convictions related to the delivery of a health care item or service;

(iii) exclusion from participation in State health care programs (as defined in section 1128b));

(iv) any licensing or certification action described in subsection (a)(1)(A) taken against a supplier by a State licensing or certification agency; and

(v) any licensing or certification action described in subparagraph (A) taken against a supplier by a State licensing or certification agency and

(6) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (c) shall take effect on the first day after the final day of the transition period.

SEC. 6404. MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS REDUCED TO NOT MORE THAN 12 MONTHS.

(a) REDUCING MAXIMUM PERIOD FOR SUBMISSION OF MEDICARE CLAIMS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, during the 1-year period that begins on the date of enactment of this Act, the Secretary shall reduce the maximum period for submission of Medicare claims to not more than 12 months.

(2) LIMITATION.—Nothing in this section shall be construed to prevent the Secretary from extending the period for submission of Medicare claims in the case of certain claims or services, or in any other manner necessary to ensure that claims are submitted in a timely manner.

(b) EDITION OF HII—The term ‘Healthcare Integrity and Protection Data Bank’ includes—

(i) the database described in this section; and

(ii) any other database established by the Secretary under this Act.

(c) SOURCES.—The Healthcare Integrity and Protection Data Bank shall be accessible to the Secretary, the National Practitioner Data Bank, and the applicable Federal agencies.

(d) FEES.—The term ‘fees’ shall include—

(i) all fees paid by participants in the Healthcare Integrity and Protection Data Bank;

(ii) all fees paid by participants in the National Practitioner Data Bank; and

(iii) all fees paid by participants in other data banks established by the Secretary.

(e) FEES.—The Secretary may establish and publish regulations to carry out the amendments made by subsections (a) and (b).

(f) PROTECTION FROM LIABILITY FOR RECEIVING INFORMATION.—The National Practitioner Data Bank shall be protected from liability for receiving information as required under this Act.

(g) REFERENCES.—For purposes of this section:

(1) STATE LICENSING OR CERTIFICATION AGENCY.—The term ‘State licensing or certification agency’ includes any authority of a State (or of a political subdivision thereof) responsible for the licensing or certification of health care practitioners or any peer review organization or private accreditation entity reviewing the services provided by health care practitioners.

(2) STATE LAW OR FRAUD ENFORCEMENT AGENCY.—The term ‘State law or fraud enforcement agency’ includes—

(A) a State law enforcement agency; and

(B) a State Medicaid fraud control unit (as defined in section 1933(q)).

(3) FINAL ADVERSE ACTION.—The term ‘final adverse action’ includes—

(i) civil judgments against a health care provider, supplier, or practitioner in State court related to the delivery of a health care item or service;

(ii) State criminal convictions related to the delivery of a health care item or service;

(iii) exclusion from participation in State health care programs (as defined in section 1128b));

(iv) any licensing or certification action described in subsection (a)(1)(A) taken against a supplier by a State licensing or certification agency; and

(v) any licensing or certification action described in subparagraph (A) taken against a supplier by a State licensing or certification agency and

SEC. 4005. PHYSICIANS WHO ORDER ITEMS OR SERVICES REQUIRED TO BE MEDICARE ENROLLED PHYSICIANS OR ELIGIBLE PROFESSIONALS.

(a) DME.—Section 1833(a)(11) of the Social Security Act (42 U.S.C. 1395l(a)(11)) is amended by striking “physician” and inserting “physician enrolled under section
1866(j) or an eligible professional under section 1848(k)(3)(B) that is enrolled under section 1866(j).

(1) HOME HEALTH SERVICES.—

(a) In general.—Section 1315(a)(2) of such Act (42 U.S.C. 1395a(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 an eligible professional under section 1848(k)(3)(B)," before "or, in the case of services described in subparagraph (C), a physician enrolled under section 1866(j), or an eligible professional under section 1848(k)(3)(B))."

(b) In paragraph (2), by striking "an eligible professional under section 1848(k)(3)(B))."

SEC. 6407. FACE TO FACE ENCOUNTER WITH PATIENT REQUIRED BEFORE PHYSICIANS MAY CERTIFY ELIGIBILITY FOR HOME HEALTH SERVICES OR DURABLE MEDICAL EQUIPMENT UNDER MEDICARE.

(a) CONDITION OF PAYMENT FOR HOME HEALTH SERVICES.—

(1) In paragraph (6), by striking "or" at the end; and

(2) by inserting after paragraph (7) the following new paragraphs:

"(7) Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program; or

"(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, or other statutory functions of the Inspector General of the Department of Health and Human Services;" and

(3) in the first sentence, by striking "(7)" and inserting "(7) and (9)"; and

(b) In paragraph (7), by striking "act" and inserting "acts, in cases under paragraph (8), $50,000 for each false record or statement, or in cases under paragraph (9), $15,000 for each day of the failure described in such paragraph)."

SEC. 6408. REQUIREMENT FOR PHYSICIANS TO PROVIDE DOCUMENTATION ON REFERRALS TO PROGRAMS AT HIGH RISK OF WASTE AND ABUSE.

(a) PHYSICIANS AND OTHER SUPPLIERS.—

Section 1821(b) of the Social Security Act (42 U.S.C. 1395m(b)(1)) is amended by adding at the end the following new paragraph:

"(9) by providing that any employee or agent of such organization, or any provider or supplier who contracts with such organization, or any individual or entity who engages in the conduct described in subparagraphs (A) through (J) of such a paragraph, is subject to any other remedies authorized by law, for any conduct described in paragraphs (A) through (J) of such paragraph); and

(b) PROVIDERS OF SERVICES.—Section 1821(a) of such Act (42 U.S.C. 1395m(a)) is further amended—

(1) in paragraph (6), by striking "or" at the end; and

(2) in paragraph (7), by striking "and" and inserting "and".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to written orders and certifications made on or after July 1, 2010.

SEC. 6409. RISK OF WASTE AND ABUSE.

(a) IN GENERAL.—The Secretary may require that an order be written pursuant to the physician documenting that a physician, a physician assistant, a nurse practitioner, or a clinical nurse specialist (as those terms are defined in section 1861(aa)(2)) has had a face-to-face encounter (including through use of telehealth, subject to the requirements in section 183(m), and other than with respect to encounters that are incident to services involved with the individual within a reasonable timeframe as determined by the Secretary).

(b) CONDITION OF PAYMENT FOR DURABLE MEDICAL EQUIPMENT.—Section 1834(a)(11)(B) of the Social Security Act (42 U.S.C. 1395w–24(k)(3)(B)) is amended—

(1) in paragraph (6), by striking "or" at the end; and

(2) by inserting after paragraph (7) the following new paragraphs:

"(7) Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim for payment for items and services furnished under a Federal health care program; or

"(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, or other statutory functions of the Inspector General of the Department of Health and Human Services;" and

(3) in the first sentence, by striking "(7)" and inserting "(7) and (9)"; and

(b) MEDICARE ADVANTAGE AND PART D PLANS.—

(1) ENSURING TIMELY INSPECTIONS RELATING TO CONTRACTS WITH MA ORGANIZATIONS.—Section 1850(d)(2) of such Act (42 U.S.C. 1395w–27(d)(2)) is amended—

(A) in subparagraph (A), by inserting "timely" before "inspections"; and

(B) in subparagraph (B), by inserting "timely" before "audit and inspect".

(2) MARKETING VIOLATIONS.—Section 1867(c)(1) of the Social Security Act (42 U.S.C. 1395w–27(c)(1)) is amended—

(A) in subparagraph (F), by striking "or" at the end; and

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

"(H) except as provided under subparagraph (C) or (D) of section 1866–1(b)(1), enrolls an individual in any plan under this part without the prior consent of the individual or the designee of the individual;"

(3) PROVISION OF FALSE INFORMATION.—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 the amount claimed or the amount for which the plan or plan sponsor based upon the misrepresentation or falsified information involved," after "for each such determination.".

(4) OBSTRUCTION OF PROGRAM AUDITS.—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 the amount claimed or the amount for which the plan or plan sponsor based upon the misrepresentation or falsified information involved," after "for each such determination.

SEC. 6408. ENHANCED PENALTIES.

(a) CIVIL MONETARY PENALTIES FOR FALSE STATEMENTS OR DELAYING INSPECTIONS.—Section 1128(b)(2) of the Social Security Act (42 U.S.C. 1320a–7a(b)(2)) is amended by inserting before paragraph (3) the following new paragraph:

"(2) the Secretary determines that any employee or agent of such organization, or any provider or supplier who contracts with such organization, has engaged in conduct described in subparagraphs (A) through (K) of this paragraph;" and

(b) CIVIL MONETARY PENALTIES FOR FALSE STATEMENTS OR DELAYING INSPECTIONS.—Section 1128(b)(2) of the Social Security Act (42 U.S.C. 1320a–7a(b)(2)) is amended by inserting before paragraph (3) the following new paragraph:

"(2) the Secretary determines that any employee or agent of such organization, or any provider or supplier who contracts with such organization, has engaged in conduct described in subparagraphs (A) through (K) of this paragraph;" and
(2) by striking “investigation into” and all that follows through the period and inserting “investigation or audit related to—”

“(I) any offense described in paragraph (1) or in subsection (a); or

“(II) the use of funds received, directly or indirectly, from any Federal health care program (as defined in section 1128B(b)).”

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to acts committed on or after January 1, 2010.

(2) EXCEPTION.—The amendments made by subsection (b)(1) take effect on the date of enactment of this Act.

SEC. 6409. MEDICARE 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. 1395l) 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 to—

(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 of Health and Human Services shall publish 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 of Health and Human Services is authorized to reduce the amount due and owing for all violations under section 1877 of the Social Security Act (42 U.S.C. 1395l) by an amount less than that specified in subsection (g) of such section. In establishing such amount for a violation, the Secretary may consider the following factors:

(1) The nature and extent of the improper or illegal practice.

(2) The timeliness of such self-disclosure.

(3) The cooperation in providing additional information in the disclosure.

(4) Such other 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)(1), 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 the SRDP;

(2) the amounts collected pursuant to the SRDP;

(3) the types of violations reported under the SRDP; and

(4) such other information as may be necessary to evaluate the impact of this section.

SEC. 6410. ADJUSTMENTS TO THE MEDICARE DU-RABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUP-PLES. COMPETITIVE ACQUISITION PROGRAM.

(a) EXPANSION OF ROUND 2 OF THE DME COMPETITIVE ACQUISITION PROGRAM.—Section 1847(a)(1) of the Social Security Act (42 U.S.C. 1395f-k(a)(1)) is amended—

(1) in subparagraph (B)(i), by striking “70” and inserting “70 and”;

(2) in subparagraph (D)(ii)—

(A) in clause (I), by striking “and” at the end; and

(B) by redesignating clause (II) as clause (III); and

(c) By inserting after clause (I) the following new clause:

“(II) the Secretary shall include the next 21 largest metropolitan statistical areas by population (after those selected under clause (I) for such round);”.

(b) EXPANSION TO MEDICARE PARTS C AND D.—Section 1834(a)(1)(F) of the Social Security Act (42 U.S.C. 1395f-k(a)(1)(F)) is amended—

(1) in clause (i), by striking “and” at the end; and

(2) in clause (ii)—

(A) by inserting “(and, in the case of covered items furnished on or after January 1, 2016, subject to clause (iii),)” after “no part”;

(B) by striking the period at the end and inserting “;”;

(3) R EPORT.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the impact of this section.

(4) R ELATION TO ADVISORY OPINIONS.—The Secretary may be made the amounts collected pursuant to the program.

(b) EXPANSION OF THE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM.

(a) EXPANSION TO MEDICAID.—

(1) STATE PLAN AMENDMENT.—Section 1902(a)(42) of the Social Security Act (42 U.S.C. 1396a(a)(42)) is amended—

(2) in paragraph (2), by striking “parts A or B” and inserting “this title”;

(c) ANNUAL REPORT.—The Secretary of Health and Human Services, acting through the Inspector General of the Department of Health and Human Services, shall promote regulations to carry out this subsection and the amendments made by this section, including with respect to conditions of Federal financial participation, as specified by the Secretary.

(b) EXPANSION TO MEDICARE PARTS C AND D.—Section 1893(h) of the Social Security Act (42 U.S.C. 1395dd(h)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking “part A or B” and inserting “this title”;

(2) in paragraph (2), by striking “parts A and B” and inserting “this title”;

(3) in paragraph (4), by striking “(not later than December 31, 2010, in the case of contracts relating to payments made under part C or D)” after “2010”, and inserting “(not later than December 31, 2010, in the case of contracts relating to payments made under part C or D)”;

(4) in paragraph (4), in the matter preceding subparagraph (A), by striking “part A or B” and inserting “this title”;

(5) by adding at the end the following:

“(D) ensures that each MA plan under this title has an anti-fraud plan in effect and to review the effectiveness of such anti-fraud plan;

“(E) ensures that each prescription drug plan under part D has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan;

“(F) ensures that each prescription drug plan submits claims incurred in excess of the allowable reinsurance costs permitted under paragraph (2) of that section; and

“(G) review estimates submitted by such anti-fraud plans submitted claims incurred in excess of the allowable reinsurance costs permitted under paragraph (2) of that section; and

“(D) review estimates submitted by prescription drug plans by private plans with respect to the enrollment of high cost beneficiaries (as defined by the Secretary) and to compare such estimates with the numbers of such beneficiaries actually enrolled by such plans.”

(c) ANNUAL REPORT.—The Secretary of Health and Human Services, acting through...
the Administrator of the Centers for Medicare & Medicaid Services, shall submit an annual report to Congress concerning the effectiveness of the Recovery Audit Contractor program and Medicare and shall include such reports recommendations for expanding or improving the program.

**Subtitle F—Additional Medicaid Program Integrity Provisions**

SEC. 6501. TERMINATION OF PROVIDER PARTICIPATION UNDER MEDICAID IF TERMINATED UNDER MEDICARE OR OTHER STATE PLAN.

Section 1902(a)(39) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by inserting after paragraph (78) the following:

“(b) MANAGED CARE ORGANIZATIONS.—

(1) IN GENERAL.—Section 1903(r) of the Social Security Act (42 U.S.C. 1396b(r)(1)(F)) is amended by inserting after paragraph (79) the following new paragraph:

“(b) provide that the State shall not pro-

vide any payments for items or services pro-

vided under the State plan or under a waiver to any financial institution or entity located outside of the United States;”.

SEC. 6502. MEDICAID EXCLUSION FROM PARTICIPATION RELATING TO CERTAIN OWNERSHIP, CONTROL, AND MANAGEMENT AFFILIATIONS.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by inserting after paragraph (77) the following:

“(b) provide that the State agency de-

scribed in paragraph (1) shall apply with re-

spect to any individual or entity that has been suspended or excluded from participation under title XVIII or any other State plan under this title during such period;”.

SEC. 6503. BILLING AGENTS, CLEARINGHOUSES, OR OTHER ENTITY REQUIRED TO REGISTER UNDER MEDICAID.

(a) In General.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by inserting after paragraph (78) the following:

“(b) provide that any agent, clear-

inghouse, or other entity that submits claims on behalf of a health care provider must register with the State and the Secretary in a form and manner specified by the Secretary;”.

SEC. 6504. REQUIREMENT TO REPORT EXPANDED SET OF DATA ELEMENTS UNDER MMIS TO DETECT FRAUD AND ABUSE.

(a) In General.—Section 1903(r)(1)(F) of the Social Security Act (42 U.S.C. 1396b(r)(1)(F)) is amended by inserting after “necessary” the following: “and including, for data submitted to the Secretary after January 1, 2010, data elements from the automated data system that the Secretary determines (that is, from such programs integrity, program oversight, and administration, at such frequency as the Secretary shall determine)”.

(b) MANDATORY MEASURES FOR MEDICAID ORGANIZATIONS.—

(1) In General.—Section 1903(m)(2)(A)(xi) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)(xi)) is amended by inserting “and identifying such data in a form at a state at a frequency and level of detail to be specified by the Secretary” after “patients”.

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

SEC. 6505. PREVENTION ON PAYMENTS TO INSTITUTIONS OR ENTITIES LOCATED OUTSIDE OF THE UNITED STATES.

Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by section 6503, is amended by inserting after paragraph (79) the following new paragraph:

“(b) provide that the State shall not pro-

vide any payments for items or services pro-

vided under the State plan or under a waiver to any financial institution or entity located outside of the United States;”.

SEC. 6506. OVERSIGHT AND REPRESENTATIONS.

(a) EXTENSION OF PERIOD FOR COLLECTION OF OVERPAYMENTS DUE TO FRAUD.—

(1) IN GENERAL.—Section 1903(d)(2) of the Social Security Act (42 U.S.C. 1396b(d)(2)) is amended—

(A) in subparagraph (C)—

(i) by deleting in the first sentence, by striking “60 days” and inserting “1-year period”; and

(ii) by deleting in the second sentence, by striking “60 days” and inserting “1-year period”; and

(B) in subparagraph (D)—

(i) by deleting in the first sentence, by striking “60 days” and inserting “1 year”;

(ii) in the second sentence, by striking “60 days” and inserting “1 year”;

(iii) by substituting “under an administrative or judicial process” for “under an administrative or judicial determination” in the fourth sentence; and

(iv) by inserting after “the amount of the overpay-

ment under an administrative or judicial process” the following: “determination”;

(b) EFFECTIVE DATE.—The amendments made by this subsection take effect on January 1, 2011, and apply to overpayments discovered on or after that date.

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on January 1, 2011, and apply to overpayments discovered on or after that date.

(3) E F F E C T I V E D A T E .—The amendments made by the amendments made by this subtitle take effect on January 1, 2011, without regard to such amendments and such amendments and subtitle have been promulgated by that date.

(b) DELAY IF STATE LEGISLATION REQUIRED.—In the case of a State plan for medical assistance under title XIX of the Social Security Act or a child health plan under title XXI of such Act which the Secretary of Health and Human Services determines requires State legislation (other than legisla-

tion appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by this sub-

title, the State plan or child health plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this addi-

tional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

**Subtitle G—Additional Program Integrity Provisions**

SEC. 6601. PROHIBITION ON FALSE STATEMENTS AND REPRESENTATIONS.

(a) PROHIBITION.—Part 5 of subpart B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.) is amended by adding at the end the following:

“SEC. 519. PROHIBITION ON FALSE STATEMENTS AND REPRESENTATIONS.

“No person, in connection with a plan or other arrangement that is multiple employer welfare arrangement described in section 3(40), shall make a false statement or false representation of fact, knowing it to be false, in connection with the marketing or sale of such plan or arrangement, to any employer, any member of an employee organization, any beneficiary of any employer, any em-

ployee organization, the Secretary, or any other person, State, or the representative or agent of any such person, State, or the Secretary, con-

cerning—

“(1) the financial condition or solvency of such plan or arrangement;

“(2) the benefits provided by such plan or arrangement;

“(3) the regulatory status of such plan or other arrangement under any Federal or
State law governing collective bargaining, labor management relations, or intern union affairs; or

(4) the regulatory status of such plan or other arrangement regarding exemption from state regulatory authority under this Act.

This section shall not apply to any plan or arrangement that does not fall within the meaning of the term ‘multiple employer welfare arrangement’ under section 3(40)(A).”.

(b) CONFORMING AMENDMENT.—Section 501 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131) is amended—

(1) by inserting “(a)” before “Any person”; and

(2) by adding at the end the following:

“(b) Any person that violates section 519 shall upon conviction be imprisoned not more than 1 year, or fined under title 18, United States Code, or both.”.

(c) CONFORMING AMENDMENT.—The table of sections for part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding at the end the following:

“Sec. 519. Prohibition on false statements and representations.”.

SEC. 6602. CLARIFYING DEFINITION.

Section 24(a)(2) of title 18, United States Code, is amended by inserting “or section 411, 518, or 511 of the Employee Retirement Income Security Act of 1974,” after “1954 of this title”.

SEC. 6603. DEVELOPMENT OF MODEL UNIFORM REPORT FORM.

Part C of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-91 et seq.) is amended by adding at the end the following:

“SEC. 2794. UNIFORM FRAUD AND ABUSE REFERRAL FORMAT.

“The Secretary shall request the National Association of Insurance Commissioners to develop a model uniform report form for private health insurance issuer seeking to refer suspected fraud and abuse to State insurance departments or other responsible State agencies for investigation. The Secretary shall request that the National Association of Insurance Commissioners develop recommendations for uniform reporting standards for such referrals.”.

SEC. 6604. APPLICABILITY OF STATE LAW TO CREDIT AND ABUSE.

(a) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.), as amended by section 6601, is further amended by adding at the end the following:

“SEC. 520. APPLICABILITY OF STATE LAW TO CREDIT FRAUD AND ABUSE.

“The Secretary, for the purpose of identifying, preventing, or prosecuting fraud and abuse, adopt regulatory standards establishing, or issue an order relating to a specific person establishing, that a person engaged in the business of providing insurance through a multiple employer welfare arrangement described in section 3(40) is subject to the laws of the States in which such person operates which regulate insurance in such State, notwithstanding section 514(b)(6) of this Act or the Liability Risk Retention Act of 1992 (section 1339 of title 15, United States Code), or whether the law of the State is otherwise preempted under any of such provisions. This section shall not apply to any plan or arrangement that does not fall within the meaning of the term ‘multiple employer welfare arrangement’ under section 3(40)(A).”.

(b) CONFORMING AMENDMENT.—The table of sections for part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, as amended by section 6601, is further amended by adding at the end the following:

“Sec. 520. Applicability of State law to combat fraud and abuse.”.

SEC. 6605. ENABLING THE DEPARTMENT OF LABOR TO ISSUE ADMINISTRATIVE SUMMARY CEASE AND DESIST OR SUMMARY SEIZURE ORDERS AGAINST PLANS THAT ARE IN FINANCIALLY HAZARDOUS CONDITION.

(a) IN GENERAL.—Part 5 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 et seq.) is further amended by adding at the end the following:

“SEC. 521. ADMINISTRATIVE SUMMARY CEASE AND DESIST ORDERS AND SUMMARY SEIZURE ORDERS AGAINST MULTIPLE EMPLOYER WELFARE ARRANGEMENTS IN FINANCIALLY HAZARDOUS CONDITION.

“(a) IN GENERAL.—The Secretary may issue a cease and desist (ex parte) order under this title if it appears to the Secretary that the alleged conduct of a multiple employer welfare arrangement described in section 3(40), other than a plan or arrangement described in subsection (g), is fraudulent, or creates an immediate danger to the public safety or welfare, or is causing or can reasonably be expected to cause significant, imminent, and irreparable public injury.

“(b) HEARING.—A person that is adversely affected by the issuance of a cease and desist order under this section (b) shall be on the party requesting the hearing to show cause why the cease and desist order should be set aside.

“(c) BURDEN OF PROOF.—The burden of proof in any hearing conducted under section (b) shall be on the party requesting the hearing to show cause why the cease and desist order should be set aside.

“(d) DETERMINATION.—Based upon the evidence presented at a hearing under subsection (b), the cease and desist order may be modified, or set aside by the Secretary in whole or in part.

“(e) SEIZURE.—The Secretary may issue a summary seizure order under this title if it appears that a multiple employer welfare arrangement is in a financially hazardous condition.

“(f) REGULATIONS.—The Secretary may promulgate such regulations or other guidance as may be necessary or appropriate to carry out this section.

“(g) EXCEPTIONS.—This section shall not apply to any plan or arrangement that does not fall within the meaning of the term ‘multiple employer welfare arrangement’ under section 3(40)(A).”.

SEC. 6606. New chapter 25—Registration with the Department of Labor

Section 101(g) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1012(g)) is amended—

(1) by striking “Secretary may” and inserting “Secretary shall”; and

(2) by inserting “register with the Secretary prior to the operation in a State and may, by regulation, require such multiple employer welfare arrangements” after “not group health plans.”.

SEC. 6607. PREVENTING EVIDENTIARY PRIVILEGE AND CONFIDENTIAL COMMUNICATIONS.

Section 6606 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1134) is amended by adding at the end the following:

“(d) The Secretary may promulgate a regulation that provides an evidentiary privilege for, and provides for the confidentiality of communications between or among, any of the following entities or their agents, consultants, or employees:

(1) A State insurance department.

(2) A State attorney general.

(3) The National Association of Insurance Commissioners.

(4) The Department of Labor.

(5) The Department of the Treasury.

(6) The Department of Health and Human Services.

(8) Any other Federal or State authority that the Secretary determines is appropriate for the purposes of enforcing the provisions of this title.

“(e) The privilege established under subsection (d) shall apply to communications related to any investigation, audit, examination, or inquiry conducted or coordinated by any of the agencies. A communication that is privileged under subsection (d) shall not waive any privilege otherwise available to the communicating agency or to any person who provided the information that is communicated.”.

Subtitle H—Elder Justice Act

SEC. 6701. SHORT TITLE OF SUBTITLE.

This subtitle may be cited as the “Elder Justice Act of 2009”.

SEC. 6702. DEFINITIONS.

Except as otherwise specifically provided, any term that is defined in section 2011 of the Social Security Act (as added by section 6703(a)) and is used in this subtitle has the meaning given such term by such section.

SEC. 6703. ELDER JUSTICE.

(a) ELDER JUSTICE.

(1) IN GENERAL.—Title XX of the Social Security Act (42 U.S.C. 1397 et seq.) is amended—

(A) in the heading, by inserting “AND ELDER JUSTICE” after “S fallback- Services”;

(B) by inserting before section 2001 the following:

“Subtitle A—Block Grants to States for Social Services;” and

(C) by adding at the end the following:

“Subtitle B—Elder Justice”.

SEC. 6711. DEFINITIONS.

“In this subtitle:

(1) ABUSE.—The term ‘abuse’ means the knowing infliction of physical or psychological harm or the knowing deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm.

(2) ADULT PROTECTIVE SERVICES.—The term ‘adult protective services’ means services provided to adults as the Secretary may specify and includes services such as—

(A) receiving reports of adult abuse, neglect, or exploitation;

(B) investigating the reports described in subparagraph (A);

(C) case planning, monitoring, evaluation, and other case work and services; and

(D) providing, arranging for, or facilitating the provision of medical, social services, economic, legal, housing, law enforcement, or other protective, emergency, or support services.

(3) CAREGIVER.—The term ‘caregiver’ means an individual who has the responsibility of the care of an elder, either voluntarily, by contract, by receipt of payment for care, or as a result of the operation of law,

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and makes a family member or other individual who provides (on behalf of such individual or of a public or private agency, organization, or institution) compensated or uncompensated care to an elder who needs supportive services in any setting.

(4) DIRECT CARE.—The term ‘direct care’ means care by an employee or contractor who provides supportive or long-term care services to a recipient.

(5) ELDER.—The term ‘elder’ means an individual age 60 or older.

(6) ELDER JUSTICE.—The term ‘elder justice’ means—

(A) from a societal perspective, efforts to prevent, detect, treat, intervene in, and prosecute elder abuse, neglect, and exploitation; and

(B) from an individual perspective, the recognition of an elder’s rights, including the right to be free of abuse, neglect, and exploitation.

(7) ELIGIBLE ENTITY.—The term ‘eligible entity’ means a State or local government agency, Tribal organization, or any other public or private entity that is engaged in and has expertise in relation to elder justice or in a field necessary to maintain physical health, mental health, or general safety; or

(8) EXPLOITATION.—The term ‘exploitation’ means the fraudulent or otherwise illegal, unauthorized, or improper access of means care by an employee or contractor that uses the resources of an elder for monetary or personal benefit, profit, or gain, or that results in depriving an elder of rightful access to, or use of, benefits, resources, belongings, or assets.

(9) FIDUCIARY.—The term ‘fiduciary’ means—

(A) a corporation or entity with the legal responsibility—

(i) to make decisions on behalf of and for the benefit of another person; and

(ii) to act in good faith and with fairness; and

(B) a trustee, a guardian, a conservator, an executor, an attorney under a power of attorney or health care power of attorney, or a representative payee.

(10) GRANT.—The term ‘grant’ includes a written promise to provide the goods or services that are necessary to maintain physical health, mental health, or general safety.

(11) GUARDIANSHIP.—The term ‘guardianship’ means—

(A) the court process under which the court determines that an individual adult lacks capacity to make decisions about self-care or property, and appoints another individual or entity known as a guardian, as a conservator, or by a similar term, as a surrogate decisionmaker.

(B) in a manner in which the court-appointed surrogate decisionmaker carries out duties to the individual and the court; or

(C) in a manner in which the court exercises oversight of the surrogate decisionmaker.

(12) INDIAN TRIBE.—

(A) IN GENERAL.—The term ‘Indian tribe’ has the meaning given such term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

(B) INCLUSION OF PUEBLO AND RANCHERIA.—The term ‘Indian tribe’ includes any Pueblo or Rancheria.

(13) LAW ENFORCEMENT.—The term ‘law enforcement’ means the full range of potential responses to elder abuse, neglect, and exploitation including—

(A) police, sheriffs, detectives, public safety officers, and corrections personnel;

(B) fire departments; and

(C) medical examiners;

(D) investigators; and

(E) coroners.

(14) LONG-TERM CARE.—

(A) IN GENERAL.—The term ‘long-term care’ means supportive and health services specified by the individual’s needs and the Secretary for an individual who need assistance because the individuals have a loss of capacity for self-care due to illness, disability, or vulnerability.

(B) LOSS OF CAPACITY FOR SELF-CARE.—For purposes of subparagraph (A), the term ‘loss of capacity for self-care’ means an inability to engage in 1 or more activities of daily living, including eating, dressing, bathing, toileting, management of one’s financial affairs, and other activities the Secretary determines appropriate.

(15) LONG-TERM CARE FACILITY.—The term ‘long-term care facility’ means a residential care provider that arranges for, or provides, long-term care.

(16) NEGLIGENT.—The term ‘negligent’ means—

(A) the failure of a caregiver or fiduciary to provide the goods or services that are necessary to maintain the health or safety of an elder; or

(B) self-neglect.

(17) NURSING FACILITY.—

(A) IN GENERAL.—The term ‘nursing facility’ has the meaning given such term under section 1915(a).

(B) INCLUSION OF SKILLED NURSING FACILITY.—The term ‘nursing facility’ includes a skilled nursing facility (as defined in section 1915(a)).

(18) SELF-NEGLECT.—The term ‘self-neglect’ means an adult’s inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks including—

(A) obtaining essential food, clothing, shelter, and medical care;

(B) obtaining goods and services necessary to maintain physical health, mental health, or general safety; or

(C) managing one’s own financial affairs.

(19) SERIOUS BODILY INJURY.—

(A) IN GENERAL.—The term ‘serious bodily injury’ means an injury—

(i) involving extreme physical pain;

(ii) involving substantial risk of death;

(iii) involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; or

(iv) requiring medical intervention such as surgery, hospitalization, or physical rehabilitation.

(B) CRIMINAL SEXUAL ABUSE.—Serious bodily injury shall be considered to have occurred if the conduct causing the injury is conduct described in section 2241 (relating to sexual abuse) of title 18, United States Code, or any similar offense under State law.

(20) SOCIAL.—The term ‘social’, when used with respect to a service, includes adult protective services.

(21) STATE LEGAL ASSISTANCE DEVELOPER.—The term ‘State legal assistance developer’ means an individual described in section 721 of the Older Americans Act of 1965.

(22) STATE LONG-TERM CARE OMBUDSMAN.—The term ‘State long-term care ombudsman’ means an ombudsman described in section 721(a)(2) of the Older Americans Act of 1965.

[SRC. 2012. GENERAL PROVISIONS.]

(a) PROTECTION.—In pursuing activities under this subtitle, the Secretary shall ensure the protection of individual health privacy consistent with the regulations promulgated under section 1175 of the Health Insurance Portability and Accountability Act of 1996 and applicable State and local privacy laws.

(b) RULE OF CONSTRUCTION.—Nothing in this subtitle shall be construed to interfere with or abridge an elder’s right to practice his or her religion through reliance on prayer or other acts that the Secretary may prescribe for the purpose of maintaining the health and safety of the individual.

(1) is contemporaneously expressed, either orally or in writing, with respect to a service, includes adult protective services.

(2) is previous or contemporaneous, with respect to a specific illness or injury which the elder has at the time of the decision by an elder who is competent at the time of the decision; and

(3) is subsequently executed or is otherwise valid and enforceable within the elder’s life history.

[PART I—NATIONAL COORDINATION OF ELDER JUSTICE ACTIVITIES AND RESEARCH]

Subpart A—Elder Justice Coordinating Council and Advisory Board on Elder Abuse, Neglect, and Exploitation

SEC. 2011. ELDER JUSTICE COORDINATING COUNCIL

(1) ESTABLISHMENT.—There is established within the Office of the Secretary an Elder Justice Coordinating Council (in this section referred to as the ‘Council’).

(2) MEMBERSHIP.—

(A) The Secretary (or the Secretary’s designee).

(B) The Attorney General (or the Attorney General’s designee).

(C) The head of each Federal department or agency or other governmental entity identified by the Chair referred to in subsection (d) as having responsibilities, or administering programs, relating to elder abuse, neglect, and exploitation.

(3) REQUIREMENT.—Each member of the Council shall be an officer or employee of the Federal Government.

(4) VACANCIES.—Any vacancy in the Council shall not affect its powers, but shall be filled in the same manner as the original appointment was made.

(5) CHAIR.—The member described in subsection (b)(1)(A) shall be Chair of the Council.

(6) MEETINGS.—The Council shall meet at least 2 times per year, as determined by the Chair.

(7) DUTIES.—

(A) IN GENERAL.—The Council shall make recommendations to the Secretary for the coordination of activities of the Department of Health and Human Services, the Department of Justice, and other relevant Federal, State, local, and private agencies and entities, relating to elder abuse, neglect, and exploitation and other crimes against elders.

(B) REPORT.—Not later than the date that is 2 years after the date of enactment of the Elder Justice Act of 2009 and every 2 years thereafter, the Council shall submit to the Committee on Finance of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report that—

(1) describes the activities and accomplishments of, and challenges faced by—

(i) the Council; and

(ii) the entities represented on the Council; and

(B) makes such recommendations for legislation, model laws, or other action as the Council determines to be appropriate.

(c) POWERS OF THE COUNCIL.—

(1) INFORMATION FROM FEDERAL AGENCIES.—Subject to the requirements of section 501(c) of the Claims Act of 1862 and any other Federal law, the Council may secure directly from any Federal department or agency such information as the Council considers necessary to carry out this section. Upon request of the Chair, the head of each Federal department or agency shall furnish such information to the Council.
‘(2) POSTAL SERVICES.—The Advisory Board may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

‘(b) TRAVEL EXPENSES.—The members of the Advisory Board shall not receive compensation for the performance of services for the Council. The Advisory Board shall be allowed necessary and extraordinary travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Council. Notwithstanding section 1342 of title 5, United States Code, the Secretary may accept the voluntary and uncompensated services of the members of the Advisory Board.

‘(c) EXPENSES OF ANY MEMBER.—Any Federal Government employee may be detailed to the Council without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

‘(d) STATUS AS PERMANENT COUNCIL.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Council.

‘(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

‘SEC. 2022. ADVISORY BOARD ON ELDER ABUSE, NEGLECT, AND EXPLOITATION.

‘(a) ESTABLISHMENT.—There is established a board to be known as the ‘Advisory Board on Elder Abuse, Neglect, and Exploitation’ (in this section referred to as the ‘Advisory Board’). The Advisory Board shall elect a Chair and Vice Chair from among its members.

‘(b) COMPOSITION.—The Advisory Board shall be composed of 27 members appointed by the Secretary from among members of the general public who are individuals with experience and expertise in elder abuse, neglect, and exploitation prevention, detection, treatment, intervention, or prosecution.

‘(c) SOLICITATION OF NOMINATIONS.—The Secretary shall publish a notice in the Federal Register soliciting nominations for the appointment of members of the Advisory Board under subsection (b). The nominations received from the public shall be reviewed by the Advisory Board selected members.

‘(1) IN GENERAL.—Each member of the Advisory Board shall be appointed for a term of 3 years, except that, of the members first appointed—

  ‘(A) 9 shall be appointed for a term of 3 years;
  ‘(B) 9 shall be appointed for a term of 2 years; and
  ‘(C) 9 shall be appointed for a term of 1 year.

‘(2) VACANCIES.—

  ‘(A) IN GENERAL.—Any vacancy on the Advisory Board shall not affect its powers, but shall be filled in the same manner as the original appointment was made.
  ‘(B) FILLING UNEXPIRED TERM.—An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

‘(3) EXPIRATION OF TERMS.—The term of any member shall not expire before the date on which the member’s successor takes office.

‘(e) ELECTION OF OFFICERS.—The Advisory Board shall elect a Chair and Vice Chair from among its members. The Advisory Board shall select its initial Chair and Vice Chair at its initial meeting.

‘(f) DUTIES.—

‘(1) ENHANCE COMMUNICATION ON PROMOTING QUALITY OF, AND PREVENTING ABUSE, NEGLECT, AND EXPLOITATION IN, LONG-TERM CARE.—The Advisory Board shall develop collaborative strategies and recommendations to improve the quality of, including preventing abuse, neglect, and exploitation in, long-term care.

‘(2) COLLABORATIVE EFFORTS TO DEVELOP UNIFIED STRATEGIES TO ADDRESS THE MANAGEMENT OF CERTAIN QUALITY-RELATED FACTORS.—

  ‘(A) IN GENERAL.—The Advisory Board shall establish multidisciplinary panels to address subjects relating to improving the quality of long-term care.

  ‘(B) ACTIVITIES CONDUCTED.—The multidisciplinary panels established under subparagraph (A) shall examine relevant research and data, identify best practices with respect to the subject of the panel, determine the best way to carry out those best practices in a practical and feasible manner, and determine an effective manner of distributing information on such subject.

‘(g) POWERS OF THE ADVISORY BOARD.—The Advisory Board may request from any entity and submit to the Elder Justice Coordinating Council any information on such subject.

‘(h) TRAVEL EXPENSES.—The members of the Advisory Board may request travel expenses for up to 4 meetings per year, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Advisory Board. The Advisory Board shall be allowed travel expenses for up to 4 meetings per year, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Advisory Board. The Advisory Board may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

‘(i) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Advisory Board without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

‘SEC. 2023. RESEARCH PROTECTIONS.

‘(a) GUIDELINES.—The Secretary shall promulgate guidelines to assist researchers working in the area of elder abuse, neglect, and exploitation, with issues relating to human subject protection.

‘(b) DEFINITION OF LEGALLY AUTHORIZED REPRESENTATIVE FOR APPLICATION OF REGULATIONS.—For purposes of the application of subsection (a), ‘legally authorized representative’ means, unless otherwise provided by law, the individual or judicial or other body authorized under the applicable law to consent to medical treatment on behalf of another person.

‘SEC. 2024. AUTHORIZATION OF APPROPRIATIONS.

‘There are authorized to be appropriated such sums as are necessary to carry out this section.

‘SEC. 2025. ESTABLISHMENT AND SUPPORT OF ELDER ABUSE, NEGLECT, AND EXPLOITATION FORENSIC CENTERS.

‘(a) IN GENERAL.—The Secretary, in consultation with the Attorney General, shall make grants to eligible entities to establish and operate stationary and mobile forensic centers to develop forensic regard- ing, and provide services relating to, elder abuse, neglect, and exploitation.

‘(b) STATIONARY FORENSIC CENTERS.—The Secretary shall make grants as described in subsection (a) to institutions of higher education with demonstrated expertise in forensic or commitment to prevention or treating elder abuse, neglect, or exploitation, to establish and operate stationary forensic centers.

‘(c) MOBILE CENTERS.—The Secretary shall make grants as described in subsection (a) to appropriate entities to establish and operate mobile forensic centers.

‘(d) AUTHORIZED ACTIVITIES.—The Secretary shall make grants as described in subsection (a) to appropriate entities to establish and operate mobile forensic centers.

‘(e) DETERMINATION OF ELIGIBILITY.—The Secretary shall make grants as described in subsection (a) to appropriate entities to establish and operate mobile forensic centers.

‘SEC. 2026. CONSENSUS AROUND THE MANAGEMENT OF QUALITY-RELATED FACTORS OF ELDER ABUSE, NEGLECT, AND EXPLOITATION.

‘(1) ENHANCE COMMUNICATION ON PROMOTING QUALITY OF, AND PREVENTING ABUSE, NEGLECT, AND EXPLOITATION IN, LONG-TERM CARE.—The Advisory Board shall develop collaborative strategies and recommendations to improve the quality of, including preventing abuse, neglect, and exploitation in, long-term care.

‘(2) COLLABORATIVE EFFORTS TO DEVELOP UNIFIED STRATEGIES TO ADDRESS THE MANAGEMENT OF CERTAIN QUALITY-RELATED FACTORS.—

  ‘(A) IN GENERAL.—The Advisory Board shall establish multidisciplinary panels to address subjects relating to improving the quality of long-term care. At least 1 such panel shall address, and develop consensus on, methods for addressing resident-to-resident abuse in long-term care.

  ‘(B) ACTIVITIES CONDUCTED.—The multidisciplinary panels established under subparagraph (A) shall examine relevant research and data, identify best practices with respect to the subject of the panel, determine the best way to carry out those best practices in a practical and feasible manner, and determine an effective manner of distributing information on such subject.

  ‘(i) elder justice programs, research, training, services, practice, enforcement, and coordination;

  ‘(ii) coordination between entities pursuing elder justice efforts and those involved in related areas that may inform or overlap with elder justice efforts, such as activities to combat violence against women and child abuse and neglect; and

  ‘(iii) activities relating to adult fiduciary systems, including guardianship and other fiduciary arrangements;

  ‘(C) recommendations for specific modifications needed in Federal and State laws (including regulations) or for programs, research, and training to enhance prevention, detection, intervention (including diagnosis) of, intervention in (including investigation of), and prosecution of elder abuse, neglect, and exploitation;

  ‘(D) recommendations on methods for the most effective coordinated national data collection with respect to elder justice, elder abuse, neglect, and exploitation; and

  ‘(E) recommendations for a multidisciplinary strategic plan to guide the effective and efficient development of the field of elder justice.

‘(g) POWERS OF THE ADVISORY BOARD.—

  ‘(1) INFORMATION FROM FEDERAL AGENCIES.—Subject to the requirements of section 182 of the Social Security Act (42 U.S.C. 1320d), the Advisory Board may secure directly from any Federal department or agency such information as the Advisory Board considers necessary to carry out this section. Upon request of the Chair of the Advisory Board, the head of such department or agency shall furnish such information to the Advisory Board.

‘(2) SHARING OF DATA AND REPORTS.—The Advisory Board may request from any entity pursuing elder justice activities under the Elder Justice Act of 2009 or an amendment made by this subparagraph, or by the Secretary, recommendations generated in connection with such activities.
funds made available through the grant to assist in determining whether abuse, neglect, or exploitation occurred and whether a crime was committed and to conduct research to describe and disseminate information on—

(‘‘A’’ forensic markers that indicate a case in which elder abuse, neglect, or exploitation may have occurred; and

(‘‘B’’) Purchasing, installing, and maintaining computer software and hardware, including handheld computer technologies.

(‘‘C’’) Making improvements to existing computer software and hardware to enable the entities to provide training and technical assistance.

(‘‘D’’) Providing education and training to eligible long-term care facility staff on the use of such technology to implement the electronic transmission of prescription and patient information.

(3) APPLICATION.—(A) IN GENERAL.—To be eligible to receive a grant under this subsection, an entity shall—

(i) certify to the Secretary at such time, in such manner, and containing such information as the Secretary may require,

(ii) make available to the Secretary such information as the Secretary may require (which may include evidence of consultation with the State in which the long-term care facility is located with respect to carrying out activities funded under the grant).

(B) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this subparagraph shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subsection.

(C) AUTHORITY TO LIMIT NUMBER OF APPLICANTS.—Nothing in this subsection shall be construed as prohibiting the Secretary from limiting the number of applicants for a grant under this subsection.

(D) PARTICIPATION IN STATE HEALTH EXCHANGES.—A long-term care facility that receives a grant under this subsection shall be eligible to participate in a State health exchange under sections 3013(f) of the Public Health Service Act under a grant under section 3013 of the Public Health Service Act to coordinate care and for other purposes determined appropriate by the Secretary.

(E) ACCOUNTABILITY MEASURES.—The Secretary shall develop accountability measures for the exchange of clinical data by long-term care facilities, including, where available, standards for messaging and nomenclature standards. Standards adopted by the Secretary under the preceding sentence shall be consistent with standards established under part C of title XI, standards established under subsection (b)(2)(B)(i) and (e)(4) of section 1860D-4, standards adopted under section 3001 of the Public Health Service Act, and general health information technology standards.

(F) ELECTRONIC SUBMISSION OF DATA TO THE SECRETARY.—(A) IN GENERAL.—Not later than 10 years after the date of enactment of the Elder Justice Act of 2009, the Secretary shall have procedures in place to accept the optional electronic submission of clinical data by long-term care facilities pursuant to the standards adopted under paragraph (1).

(B) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to require a long-term care facility to submit clinical data electronically to the Secretary.

(C) REGULATIONS.—The Secretary shall promulgate regulations to carry out this subsection. Such regulations shall require a
State, as a condition of the receipt of funds under this part, to conduct such data collection and reporting as the Secretary determines necessary to satisfy the requirements of subsection (B).

(d) Authorization of Appropriations.—There are authorized to be appropriated to carry out this section—

(1) for fiscal year 2011, $20,000,000;

(2) for fiscal year 2012, $17,500,000; and

(3) for each of fiscal years 2013 and 2014, $15,000,000.

SEC. 2042. ADULT PROTECTIVE SERVICES FUNCTIONS AND GRANT PROGRAMS.

(a) Secretarial Responsibilities.—

(1) In general.—The Secretary shall ensure that the Department of Health and Human Services—

(A) provides funding authorized by this part to State and local adult protective services offices that investigate reports of the abuse, neglect, and exploitation of elders;

(B) collects and disseminates data annually relating to the abuse, exploitation, and neglect of elders in coordination with the Department of Justice;

(C) develops and disseminates information on best practices regarding, and provides assistance on, carrying out adult protective services;

(D) conducts research related to the provision of adult protective services; and

(E) establishes and facilitates technical assistance to States and other entities that provide or fund the provision of adult protective services, including through grants made under subsection (B) and (C).

(b) Authorization of Appropriations.—There are authorized to be appropriated to carry out this subsection, $3,000,000 for each of fiscal years 2012 through 2014.

(c) State Demonstration Programs.—

(1) Establishment.—The Secretary shall award grants to States for the purposes of conducting demonstration programs in accordance with paragraph (2).

(2) Demonstration Programs.—Funds made available pursuant to this subsection shall be used by States to provide such funds to the agency or unit of government to conduct demonstration programs that test—

(A) training modules developed for the purpose of detecting or preventing elder abuse;

(B) methods to detect or prevent financial exploitation of elders;

(C) methods to detect elder abuse;

(D) whether training on elder abuse programs enhances the detection of elder abuse by employees of the State or local unit of government;

(E) other matters relating to the detection or prevention of elder abuse.

(3) Application.—To be eligible to receive a grant under this subsection, a State shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(4) State Reports.—Each State that receives funds under this subsection shall submit to the Secretary a report at such time, in such a form, and containing such information as the Secretary may require.

(5) Authorization of Appropriations.—There are authorized to be appropriated to carry out this subsection, $100,000,000 for each of fiscal years 2011 through 2014.

SEC. 2043. LONG-TERM CARE OMBUDSMAN PROGRAM GRANTS AND TRAINING.

(a) Grants to Support the Long-Term Care Ombudsman Program.—

(1) In general.—The Secretary shall make grants to eligible entities for the purpose of—

(A) improving the capacity of State long-term care ombudsman programs and responsibilities, for the purpose of—

(i) improving the capacity of State long-term care ombudsman programs to respond to and resolve complaints about abuse and neglect;

(ii) conducting pilot programs with State long-term care ombudsman offices or local ombudsman entities; and

(iii) providing support for such State long-term care ombudsman programs and such pilot programs to the extent such programs are necessary to comply with the requirements of subsection (B).

(B) Authorized activities.—

(i) Adult Protective Services.—Funds made available pursuant to this subsection may only be used by States and local units of government to provide adult protective services and may not be used for any other purpose.

(ii) Use by Agency.—Each State receiving funds pursuant to this subsection shall provide such funds to the agency or unit of State government having legal responsibility for providing adult protective services within the State.

(iii) PAYMENT NOT SUPPLANT.—Each State or local unit of government shall use funds made available pursuant to this subsection to supplement and not supplant other Federal, State, and local public funds expended to provide adult protective services in the State.

(iv) State Reports.—Each State receiving funds pursuant to this subsection shall submit to the Secretary, at such time and in such manner as the Secretary may require, a report on the number of elders served by the grants awarded under this subsection.

(b) Authorization of Appropriations.—There are authorized to be appropriated to carry out this subsection—

(A) for fiscal year 2011, $5,000,000;

(B) for fiscal year 2012, $7,500,000; and

(C) for each of fiscal years 2013 and 2014, $10,000,000.

(c) Ombudsman Training Programs.—

(1) General.—The Secretary shall establish programs to provide and improve ombudsman training with respect to elder abuse, neglect, and exploitation for national organizations and State long-term care ombudsman programs.

(2) Authorization of Appropriations.—There are authorized to be appropriated to carry out this subsection—

(A) for fiscal year 2011, $2,000,000;

(B) for fiscal year 2012, $2,500,000; and

(C) for each of fiscal years 2013 and 2014, $3,000,000.

SEC. 2044. PROVISION OF INFORMATION REGARDING, AND EVALUATIONS OF, ELDER JUSTICE PROGRAMS.

(a) Provision of Information.—To be eligible to receive a grant under this part, an applicant shall agree—

(1) except as provided in paragraph (2), to provide the eligible entity conducting an evaluation under subsection (b) of the activities funded through the grant with such information as the Secretary may require in order to conduct such evaluation; or

(2) in the case of an applicant for a grant under section 2041(b), to provide the Secretary with such information as the Secretary may require to conduct an evaluation or audit under subsection (c).

(b) Use of Eligible Entities To Conduct Evaluations.—

(1) Evaluations required.—Except as provided in paragraph (2), the Secretary shall—

(A) reserve a portion (not less than 2 percent) of the funds appropriated with respect to each program carried out under this part; and

(B) use the funds reserved under subparagraph (A) to provide assistance to eligible entities to conduct evaluations of the activities funded under each program carried out under this part.

(2) Applications.—To be eligible to receive assistance under paragraph (1)(B), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(3) Awards.—The Secretary shall make grants to eligible entities for the purpose of conducting such evaluations in accordance with paragraph (2).

(4) Evaluations.—To be eligible to receive an award under this subsection, an entity shall submit to the Secretary, at such time, in such manner, and containing such information as the Secretary may require.

(5) Authorization of Appropriations.—There are authorized to be appropriated to carry out this subsection, $5,000,000 for each of fiscal years 2011 through 2014.

SEC. 2045. ELDER JUSTICE PROGRAM NOT INCLUDED.—The provisions of this subsection shall not apply to the certified EHR technology grant program under section 2041(b).

(a) Authorized activities.—A recipient of assistance described in paragraph (1)(B) shall use the funds made available in such assistance to conduct a validated evaluation of the effectiveness of the activities funded under a program carried out under this part.

(b) Applications.—To be eligible to receive assistance under paragraph (1)(B), an entity shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require, including a proposal for the evaluation.

(c) Reports.—Not later than a date specified by the Secretary, an eligible entity receiving assistance under paragraph (1)(B) shall submit to the Secretary, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report containing the results of the evaluation conducted using such assistance together with such recommendations as the entity determines to be appropriate.

(d) Audits.—The Secretary shall conduct an evaluation of the activities funded under this subsection together with such recommendations as the entity may require, including an evaluation of whether...
the funding provided under the grant is expended only for the purposes for which it is made.

(2) AUDITS.—The Secretary shall conduct appropriate audits of grants made under section 2491(b).

SEC. 2045. REPORT.

Not later than October 1, 2014, the Secretary of the Executive Coordinating Council established under section 2021, the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report—

(1) compiling, summarizing, and analyzing the information contained in the State plans submitted under subsections (b)(4) and (c)(4) of section 2042; and

(2) containing such recommendations for legislative or administrative action as the Secretary determines to be appropriate.

SEC. 2046. RULE OF CONSTRUCTION.

‘‘Nothing in this subtitle shall be construed—

(1) limiting any cause of action or other relief related to obligations under this subtitle that is available under the law of any State, or political subdivision thereof; or

(2) creating a private cause of action for a violation of this subtitle.’’.

(2) OPTION FOR STATE PLAN UNDER PROGRAM FOR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES.—

(A) In general.—Section 402(a)(1)(B) of the Social Security Act (42 U.S.C. 602(a)(1)(B)) is amended by adding at the end the following new clause:

‘‘(v) The document shall indicate whether the State intends to assist individuals to train for, seek, and maintain employment—

(1) by placing them in long-term care facilities (as such terms are defined under section 2011); or

(2) in other occupations related to elder care determined appropriate by the State for which the State identifies an unmet need for service personnel, and, if so, shall include an overview of such assistance.’’.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect on January 1, 2011.

(c) IN GENERAL.—The Secretary of Health and Human Services shall enter into a contract with an entity for the purpose of establishing and operating a National Training Institute for State agencies on the evaluations conducted.

(d) ACTIVITIES CARRIED OUT BY THE INSTITUTE.—The contract entered into under subparagraph (A) shall require the Institute to carry out the following activities:

(1) Provide such technical assistance to the State agencies that perform surveys of long-term care facilities that receive payments under title XVIII or XIX of the Social Security Act, and long-term care facilities that receive payments under title XVIII or XIX of the Social Security Act.

(2) AUDITS.—The contract entered into under subparagraph (A) shall require the Institute to establish and operate under such contract to carry out the following activities:

(1) Assess the performance of State complaint intake systems, in order to ensure that the intake of complaints occurs 24 hours per day, 7 days a week (including holidays).

(2) To the extent approved by the Secretary of Health and Human Services, provide a national 24 hours per day, 7 days a week (including holidays), back-up system to State complaint intake systems in order to ensure that the investigation of complaints of such abuse, neglect, and misappropriation of property.

(3) Provide an annual report to the Committee on Finance of the Senate a report—

(I) The total number and sources of complaints of such abuse, neglect, and misappropriation of property.

(II) The extent to which such complaints are referred to law enforcement agencies.

(III) General results of Federal and State investigations of such complaints.

(iv) Analyze and report annually on the following:

(A) result in serious bodily injury, the individual shall report the suspicion immediately, but not later than 2 hours after forming the suspicion;

(B) do not result in serious bodily injury, the individual shall report the suspicion not later than 24 hours after forming the suspicion.

(e) PENALTIES.—

(1) IN GENERAL.—If a covered individual violates subsection (b) and the violation exacerbates the harm to the victim of such crime or results in harm to another individual—

(A) the covered individual shall be subject to a civil money penalty of not more than $200,000; and

(B) the Secretary may make a determination in the same proceeding to exclude the covered individual from participation in any Federal health care program (as defined in section 1128B(f)).

(f) INCREASED HARM.—If a covered individual violates subsection (b) and the violation exacerbates the harm to the victim of such crime or results in harm to another individual—

(A) the covered individual shall be subject to a civil money penalty of not more than $300,000; and

(B) the Secretary may make a determination in the same proceeding to exclude the covered individual from participation in any Federal health care program (as defined in section 1128B(f)).

(g) EXCLUDED INDIVIDUAL.—During any period for which a covered individual is classified as an excluded individual under paragraph (1)(B) or (2)(B), a long-term care facility that employs such individual shall be ineligible to receive Federal funds under this Act.

(h) EXTERRITORIAL CIRCUMSTANCES.—

(A) IN GENERAL.—The Secretary may take into account the financial burden on providers with underserved populations in determining any penalty to be imposed under this subsection.

(B) UNDERSERVED POPULATION DEFINED.—In this paragraph, the term ‘‘underserved population’’ means the population of an area designated by the Secretary as an area with a shortage of elder justice programs or a population group designated by the Secretary as having a shortage of such programs. Such areas or groups designated by the Secretary may include—

(1) areas or groups that are geographically isolated (such as isolated in a rural area);
“(ii) racial and ethnic minority populations; and

“(iii) populations underserved because of special needs (such as language barriers, disabilities or age)."
are sufficient to demonstrate safety, purity, and potency in 1 or more appropriate conditions of use for which the reference product is licensed and intended to be used and for which a remuneration is sought for the biological product;

'(II) the biological product and reference product utilize the same mechanism or mechanism of action for the condition or conditions of use prescribed, recommended, or suggested in the labeling proposed for the biological product have been previously approved 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

'(IV) the facility in which the biological product is manufactured, processed, packaged, or held meets standards designed to assure that the biological product continues to be safe, pure, and potent; and

'(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 in an application submitted under this subsection.

'(III) ADDITIONAL INFORMATION.—An application submitted under this subsection—

'(A) may include any other information that the Secretary determines, in the Secretary's discretion, is necessary to determine the interchangeability of the biological product for which a prior biological product has received a determination of interchangeability for any condition of use, the Secretary shall license the biological product under this subsection if—

'(1) the Secretary determines that the reference product is safe, pure, and potent; and

'(2) the Secretary shall license the biological product if the Secretary determines that the biological product is interchangeable with the reference product;

'(B) INTERCHANGEABILITY.—An application (or a supplement to an application) submitted under this subsection—

'(i) shall be submitted after the date on which the reference product is licensed and intended to be used and for which a remuneration is sought for the biological product;

'(ii) shall be submitted not later than 1 year after the first commercial marketing of the reference product;

'(c) INTERCHANGEABILITY.— An application under this subsection may be approved if the Secretary determines that the biological product is interchangeable with the reference product; and

'(d) EXCLUSIVITY.—An application under this subsection—

'(I) may be submitted only if the application is submitted by the same sponsor or manufacturer of the biological product that is the reference product (or a successor, assignee, or other entity that holds an interest in the reference product) and

'(II) is biosimilar to the reference product; and

'(III) meets the standards described in paragraph (4), and therefore is interchangeable with the reference product; and

'(e) 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 submitted in the application (or the supplement to such application) is sufficient to show that the biological product—

'(i) is biosimilar 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 any other appropriate person—

'(i) the applicant and the inspection of the facility that is the subject of the application, in accordance with subsection (c).

'(f) SAFETY STANDARDS FOR DETERMINING INTERCHANGEABILITY.—Upon review of an application submitted under this subsection or any supplement to such application, the Secretary shall license 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 the biological product—

'(A) the biological product—

'(i) is biosimilar 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) for a biological product that is administered by individual subcutaneous or intravenous delivery, that results in a new indication, route of administration, dosage form, delivery system, delivery device, or strength;

'(g) GUIDANCE DOCUMENTS.—

'(A) IN GENERAL.—The Secretary shall, at the Secretary’s discretion, issue guidance in accordance, except as provided in paragraph (b), with section 701(h) of the Federal Food, Drug, and Cosmetic Act with respect to the licensure of a biological product under this subsection. Any such guidance may be general or specific.

'(B) PUBLIC COMMENT.—

'(I) IN GENERAL.—The Secretary shall provide the public an opportunity to comment on any proposed guidance issued under subparagraph (A) before issuing final guidance, after reviewing any relevant public comment.

'(II) NO REQUIREMENT FOR DEPARTMENTAL GUIDANCE.—The Secretary may establish a process through which the Secretary may provide the public an opportunity to comment on any proposed guidance issued under subparagraph (A) before issuing final guidance, after reviewing any relevant public comment.

'(h) Certain product classes—

'(A) INTERCHANGEABILITY.—The authority of the Secretary to determine whether a biological product is highly similar to a reference product in such product class; and

'(B) 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 indicated a guidance document that the scientific and experience, as described in clause (i), does not allow approval of such an application.

'(i) PATENTS.—

'(I) CONFIDENTIAL ACCESS TO SUBSECTION (K) APPLICATION.—No person, other than the Secretary, shall have access to any information described in this subsection.

'(II) A subsequent application filed by the same sponsor or manufacturer of the biological product that is the reference product (or a successor, assignee, or other entity that holds an interest in the reference product) for a biological product that is highly similar to the reference product shall be treated as a new application for purposes of this subsection.

'(j) MODIFICATION OR REVERSAL.—The Secretary may issue a subsequent guidance document under paragraph (a) to modify or reverse a guidance document under clause (i).

'(k) APPLICATION.—The Secretary shall provide the public an opportunity to comment on any proposed guidance issued under subparagraph (A) before issuing final guidance, after reviewing any relevant public comment.
‘‘(i) Provision of Confidential Information.—When a subsection (k) applicant submits an application under subsection (k), such applicant shall provide to the persons described in paragraph (3) the confidential information referred to in paragraph (6). Not later than 60 days after the subsection (k) applicant receives such information, the reference product sponsor shall return or destroy all confidential information received under this paragraph, provided that if the reference product sponsor opts to destroy such information, it will confirm destruction in writing to the subsection (k) applicant.

‘‘(ii) In-House Counsel.—One attorney that receives confidential information in violation of this paragraph shall be construed—

‘‘(I) as an admission by the subsection (k) applicant that the subsection (k) applicant will not provide the confidential information to any other person or entity, including the reference product sponsor employees, outside scientific consultants, or other outside counsel retained by the reference product sponsor, without the written consent of the subsection (k) applicant, which shall not be unreasonably withheld.

‘‘(ii) Number of Patents Listed by Reference Product Sponsor.—Not later than 60 days after the subsection (k) applicant receives such information, the reference product sponsor shall provide to the subsection (k) applicant a list of patents to which the subsection (k) applicant believes should be the subject of an action for patent infringement under paragraph (6). The list shall simultaneously exchange—

‘‘(A) by the subsection (k) applicant to the Secretary under subsection (k), and

‘‘(B) by the subsection (k) applicant to the Secretary under subsection (k), and

‘‘(C) by the subsection (k) applicant to the Secretary under subsection (k), and

‘‘(D) by the subsection (k) applicant to the Secretary under subsection (k), and

‘‘(E) Ownership of Confidential Information.—The confidential information disclosed in paragraph (i) is, and remain, the property of the subsection (k) applicant. By providing the confidential information pursuant to this paragraph, the subsection (k) applicant does not provide the reference product sponsor or the outside counsel any interest in or license to use the confidential information, for purposes other than those specified in subparagraph (D).

‘‘(F) Effect of Infringement Action.—In the event that the reference product sponsor files a patent infringement suit, the use of conditions shall continue to be governed by the terms of this paragraph until such time as a court enters a protective order regarding the information. Upon entry of the protective order, the subsection (k) applicant may redesignate confidential information in accordance with the terms of that paragraph (A) or listed by the subsection (k) applicant under clause (i)—

‘‘(1) a detailed statement that describes, on a claim by claim basis, the factual and legal basis of the opinion of the subsection (k) applicant that such patent is invalid, unenforceable, or will not be infringed by the commercial marketing of the biological product that is the subject of the subsection (k) application; or

‘‘(2) a statement that the subsection (k) applicant does not intend to begin commercial marketing of the biological product that is the subject of the subsection (k) application.

‘‘(2) Subsection (k) Application Information.—Not later than 60 days after the Secretary notifies the subsection (k) applicant that the application has been accepted for review, the subsection (k) applicant shall—

‘‘(A) provide to the reference product sponsor a copy of the application submitted to the Secretary under subsection (k), and such other information that describes the process or processes used to manufacture the biological product that is the subject of such application;

‘‘(B) may provide to the reference product sponsor additional information requested by or on behalf of the reference product sponsor;

‘‘(C) List and Description of Patents.—(A) List by Reference Product Sponsor.—Not later than 60 days after the receipt of the application and information under paragraph (2), the reference product sponsor shall provide to the subsection (k) applicant—

‘‘(i) a list of patents for which the reference product sponsor believes a claim of patent infringement could reasonably be asserted by the reference product sponsor, or

‘‘(ii) an identification of the patents on which the reference product sponsor believes a claim of patent infringement could reasonably be asserted by the reference product sponsor, or

‘‘(iii) a statement concerning validity and enforceability provided under subparagraph (A) or listed by the subsection (k) applicant.

‘‘(2) Failure to Reach Agreement.—If, within 15 days of beginning negotiations under subparagraph (A), the subsection (k) applicant and the reference product sponsor fail to agree on a final and complete list of which, if any, patents listed under paragraph (3) by the subsection (k) applicant or the reference product sponsor shall be the subject of an action for patent infringement under paragraph (6), the paragraphs of paragraph (5) shall apply to the parties.

‘‘(5) Patent Resolution if No Agreement.—(A) Number of Patents.—The subsection (k) applicant shall notify the reference product sponsor of the number of patents that subsection (k) applicant will pursue against the reference product sponsor under subparagraph (B)(i)(I).

‘‘(B) Exchange of Patent Lists.—(i) In General.—On a date agreed to by the subsection (k) applicant and the reference product sponsor, the number of patents listed by the subsection (k) applicant shall simultaneously exchange—

‘‘(1) the list of patents that the subsection (k) applicant believes should be the subject of an action for patent infringement under paragraph (6); and

‘‘(2) the list of patents, in accordance with clause (i), that the reference product sponsor believes should be the subject of an action for patent infringement under paragraph (6).
(2) The term ‘biosimilar’ or ‘biosimilarity’, in reference to a biological product that is the subject of an application under paragraph (k), means—

(A) that the biological product is highly similar to the reference product notwithstanding minor differences in clinically inactive components; and

(B) there are no clinically meaningful differences between the biological product and the reference product in terms of safety, purity, and potency of the product.

(3) The term ‘interchangeability’, in reference to a biological product that is shown to meet the standards for safe use and effectiveness as required under section 351(k)(7) of such Act, an application seeking approval of a biological product for a patent that could be identified pursuant to section 351(k)(3)(A)(i) of such Act; and

(iv) in the matter following subparagraph (C) (as added by clause (iii)), by striking ‘or biological product’ and inserting ‘, veterinary biological product, or biological product’; and

(II) striking ‘and’ at the end of subparagraph (C), by—

(I) striking ‘or veterinary biological product’ and inserting ‘, veterinary biological product, or biological product’; and

(II) striking the period and inserting ‘; and’;

and—

(4) in the matter following subparagraph (D), by—

(I) striking ‘or biological product’ and inserting ‘, veterinary biological product, or biological product’; and

(II) striking the period and inserting ‘; and’.

(8) NEWLY ISSUED OR LICENSED PATENTS.—In the case of a patent that—

(i) is brought after the expiration of the patent (2)(B) provided of the subsection (k) applicant under subparagraph (C), by—

(I) was brought after the expiration of the patent at the end of the period described in subparagraph (A), by—

(ii) inserting ‘or biological product’ and inserting ‘, veterinary biological product, or biological product’; and

(III) was brought after the expiration of the patent at the end of the period described in subparagraph (A), by—

(i) striking ‘or biological product’ and inserting ‘, veterinary biological product, or biological product’; and

(ii) inserting the period and inserting ‘; and’.

(9) LIMITATION ON DECLARATORY JUDGMENT ACTION.—

(1) Section 271(e) of title 35, United States Code, for a declaration of infringement, validity, or enforceability of any patent that is described in clauses (1) and (11) of paragraph (8). (B) In an action for infringement of a patent—

(iii) the term ‘biological product’, ‘veterinary biological product’, or ‘biological product’; and

(ii) in subparagraph (C), by—

(i) inserting ‘, veterinary biological product, or biological product’; and

(ii) striking ‘and’ at the end of subparagraph (C).
using, offering to sell, selling, or importation into the United States of the biological product that is the subject of the action infringed the patent, shall be a reasonable royalty.

"(C) The owner of a patent that should have been included in the list described in section 355(b)(3)(A) of the Public Health Service Act as a result of a submission provided under section 351(i)(7) of such Act for a biological product, but was not timely included in such list, may not bring an action under this section for infringement of the patent with respect to the biological product."

(2) CONFORMING AMENDMENT UNDER TITLE 28.—Section 2201(b) of title 28, United States Code, is amended by inserting before the period the following: "‘or section 351 of the Public Health Service Act’.

(3) CONFORMING AMENDMENTS UNDER THE FEDERAL FOOD, DRUG, AND COSMETIC ACT.—

(1) CONTENT AND REVIEW OF APPLICATIONS.—Section 505(b)(5)(B) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)(5)(B)) is amended by inserting before the period the following:

"(n) NEW ACTIVE INGREDIENT.—A biological product that shall be considered to have a new active ingredient under this section." (2) NEW ACTIVE INGREDIENT.—Section 505B of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355c) is amended by adding at the end the following:

"(v) representatives of patient and consumer advocacy groups; and

(vi) the regulated industry.

(B) PUBLIC REVIEW OF RECOMMENDATIONS.—After negotiations with the regulated industry, the Secretary shall—

(1) present the recommendations developed under subparagraph (A) to the recommendations under subparagraph (B), a report shall be transmitted to Congress the revised recommendations under subparagraph (B), a summary of the views and comments received under such subparagraph, and any changes made in the recommendations in response to such views and comments.

(2) ESTABLISHMENT OF USER FEE PROGRAM.—It is the sense of the Senate that, based on the recommendations transmitted to Congress by the Secretary pursuant to paragraph (1)(C), Congress should authorize a program, effective on October 1, 2012, for the collection of user fees relating to the submission of biosimilar biological product applications under section 351(k) of the Public Health Service Act (as added by this Act) for each of fiscal years 2013 through 2018.

(3) TRANSITIONAL PROVISIONS FOR USER FEES FOR BIOSIMILAR BIOLOGICAL PRODUCTS.—

(A) APPLICATION OF THE PRESCRIPTION DRUG USER FEE PROVISIONS.—Section 731(c)(B) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 377g(c)(1)(B)) is amended by striking "section 31" and inserting "section (k) or (k) of section 3511".

(B) EVALUATION OF COSTS OF REVIEWING BIO SIMILAR BIOLOGICAL PRODUCT APPLICATIONS.—During the period beginning on the date of enactment of this Act and ending on October 1, 2014, the Secretary shall evaluate and report data regarding the costs of reviewing applications for biological products submitted under section 351(k) of the Public Health Service Act (as added by this Act) during such period.

(4) AUDIT.—(A) IN GENERAL.—On the date that is 2 years after first receiving a user fee applicable to an application for a biological product under section 351(k) of the Public Health Service Act (as added by this Act), the Secretary shall perform an audit of the costs of reviewing such applications under such section (k). Such an audit shall—

(1) follow-up on the costs of reviewing such applications under such section (k) to the amount of the user fee applicable to such applications; and

(2) determine whether the ratio of the costs of reviewing applications for biological products under section 351(k) to the amount of the user fee applicable to such applications under section 351(a). "(AA) ALTERNATION OF USER FEE.—If the audit performed under clause (i) indicates that the ratios compared under subclause (II) of such section differ by more than 5 percent, then the user fee applicable to applications submitted under section 351(k) to more appropriately account for the costs of reviewing such applications. Such an audit shall be performed by the Secretary during the year of the 2011 through 2015.

(5) REPORTS.—There is authorized to be appropriated to carry out this subsection such sums as may be necessary for each of fiscal years 2010 through 2018.

(6) APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection such sums as may be necessary for each of fiscal years 2010 through 2018.
"(B) if the biological product is designated under section 526 for a rare disease or condition, the period for such biological product referred to in section 527(a) is deemed to be 7 years and 6 months rather than 7 years and 6 months rather than 7 years and 6 months rather than 7 years; and

"(B) if the biological product is designated under section 526 for a rare disease or condition, the period for such biological product referred to in section 527(a) is deemed to be 7 years and 6 months rather than 7 years.

"(4) For a rare disease or condition, the Secretary determines that information relating to the pediatric population may produce health benefits in that population and makes a written request to the holder of an approved application (a) for pediatric studies (which include a timeframe for completing such studies), the holder agrees to the request, such studies are completed using investigational populations for a group for which the study is requested within any such timeframe, and the reports thereof are submitted and accepted in accordance with section 505A(d)(3) of the Federal Food, Drug, and Cosmetic Act—

"(A) the periods for such biological product referred to in subsection (k)(7) are deemed to be 4 years and 6 months rather than 4 years and 12 years and 6 months rather than 12 years and 6 months rather than 7 years; and

"(B) the periods for such biological product referred to in section 527(a) is deemed to be 7 years and 6 months rather than 7 years.

"(5) Subparagraph (A) may not extend a period referred to in paragraph (2)(A), (2)(B), (3)(A), or (3)(B) if the determination under section 505A(d)(3) is made after 7 years and 6 months prior to the expiration of such period.

"(2) STUDIES REGARDING PEDIATRIC USE—

"(A) PROGRAM FOR PEDIATRIC STUDY OF DRUGS.—Subsection (a)(1) of section 409I of the Public Health Service Act (42 U.S.C. 284m) is amended by inserting "biological products"

"(B) INSTITUTE OF MEDICINE STUDY.—Section 505P(a) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353b(p)) is amended by striking paragraphs (4) and (5) and inserting the following:

"(4) review and assess the number and importance of biological products for children that are being tested as a result of the amendments made by the Biologics Price Competition and Innovation Act of 2009 and the importance for children, health care providers, and others of labeling changes made as a result of such testing;

"(5) review and assess the number, importance, and prioritization of any biological product studies that are not being tested for pediatric use; and

"(6) offer recommendations for ensuring pediatric testing of biological products, in- cluding consideration of any incentives, such as those provided under this section or section 351(m) of the Public Health Service Act.

"(B) ORPHAN PRODUCTS.—If a reference product, as defined in section 351 of the Public Health Service Act (42 U.S.C. 262) (as amended by this Act) has been designated under section 526 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360b(b)) for a rare dis- ease or condition, a biological product seeking approval for such disease or condition under subsection (k) of such section 351 as biosimilar to, or interchangeable with, such reference product may be licensed by the Secretary only after the amount of savings to the Federal Government as a result of the enactment of this subtitle.

"(4) USE.—Nothing in any other provi- sion of this subtitle (or an amendment made by this subtitle), the savings to the Federal Government generated as a result of the enactment of this subtitle shall be used for defi- cit reduction.

"(B) MORE AFFORDABLE MEDICINES FOR CHILDREN AND URBANIZED COMMUNITIES

"(1) EXPANDED PARTICIPATION IN 340B PROGRAM.

"(a) EXPANSION OF COVERED ENTITIES RECEIVING DISCOUNTED PRICES.—Section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)) is amended by adding at the end the following:

"(M) A hospital's 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 hospital excluded from the Medicare prospective payment system pursuant to section 1886(d)(1)(B)(vi) of the Social Security Act, that would meet the requirements of subparagraph (B) if 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,

"(N) An entity that is a critical access hospital (as determined under section 1820(c)(2) of the Social Security Act), and that meets the requirements of subparagraph (L)(i).

"(O) An entity that is a rural referral center, as defined by section 1866(d)(5)(C)(i) of the Social Security Act, or a sole community hospital, as defined by section 1866(d)(5)(C)(ii) of such act, and that both meets the requirements of subparagraph (L)(i) and has a disproportionate share adjustment percentage equal to or greater than 8 percent.

"(b) EXTENSION OF DISCOUNT TO INPATIENT DRUGS.—Section 340B of the Public Health Service Act (42 U.S.C. 256b) is amended—

"(1) in paragraphs (2), (5), (7), and (9) of subsection (a), by striking "outpatient" each place it appears;

"(2) in subsection (b)—

"(A) by striking "OTHER DEFINITION" and all that follows through "in this section" and inserting the following: "OTHER DEFINITIONS.—

"(1) IN GENERAL.—In this section; and

"(B) by adding at the end the following new paragraph:

"(2) COVERED DRUG.—In this section, the term ‘covered drug’—

"(A) means a covered outpatient drug (as defined in section 257(k)(2) of the Social Security Act; and

"(B) includes, notwithstanding paragraph (3)(y) of section 1867(k) of such act, a drug used in an inpatient or outpatient service provided by a hospital described in subparagraph (L), (M), (N), or (O) of subsection (a)(4) that is enrolled to participate in the drug discount program under this section.

"(c) PROHIBITION ON GROUP PURCHASING ARRANGEMENTS.—Section 340C of the Public Health Service Act (42 U.S.C. 256c) is amended—

"(1) in paragraph (4), by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E); respect- ively; and

"(2) by inserting after paragraph (B), the following:

"(C) PROHIBITION ON GROUP PURCHASING ARRANGEMENTS.—

"(1) IN GENERAL.—A hospital described in sub- section (b)(1)(B) of this section (as amended by paragraph (4)) shall not obtain covered outpatient drugs through a group purchasing organi- zation or other group purchasing arrangement, except as permitted or provided for pursuant to clauses (ii) or (iii).

"(ii) INPATIENT DRUGS.—Clause (i) shall not apply to drugs purchased for inpatient use.

"(iii) EXCEPTIONS.—The Secretary shall estab- lish reasonable exceptions to clause (i) with respect to a covered outpatient drug that is unavailable to be purchased through the program under this section due to a drug shortage problem, manufacturer noncompliance, or any other circumstance beyond the hospital’s control.

"(II) to facilitate generic substitution when a generic covered outpatient drug is available at a lower price; or

"(III) to reduce in other ways the adminis- trative barriers to the purchase of inven- tories of drugs subject to this section and inven- tories of drugs that are not subject to this section, so long as the exceptions do not contribute to a drug shortage problem, manufacturer viola- tion of subparagraph (A) or a diversion problem in violation of subparagraph (B).

"(d) EXTENSION OF COVER TO INPATIENT DRUGS.—Section 340B(b)(4)(C) of the Public Health Service Act (42 U.S.C. 256b(b)(4)(C)) is amended—

"(1) in paragraph (a), by striking "outpatient" each place it appears;

"(2) in subsection (b)—

"(A) in clause (i), by adding "and" at the end;

"(B) in clause (ii), by striking "; and" and inserting a period; and

"(C) by striking clause (ii); and

"(3) in paragraph (5), as amended by subsection (b)—

"(a) INTEGRITY IMPROVEMENTS.—Subsection (d) of section 340B of the Public Health Service Act (42 U.S.C. 256b(a)) is amended to read as follows:

"(1) IMPROVEMENTS IN PROGRAM INTEG- RITY.—

"(A) MANUFACTURER COMPLIANCE.
“(A) IN GENERAL.—From amounts appropriated under paragraph (4), the Secretary shall provide for improvements in compliance by manufacturers with the requirements 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:

(1) The development of a system to enable the Secretary to verify the accuracy of ceiling prices calculated by manufacturers under subsection (a)(1) and charged to covered entities, with the following:

(a) Developing and publishing through an appropriate policy or regulatory issuance, precisely defined standards and methodology for the calculation of ceiling prices under such subsection.

(b) Comparing regularly the ceiling prices calculated by the Secretary with the quarterly pricing data that is reported by manufacturers to the Secretary.

(C) III. PERMISSIBLE LIMITS FOR ACCESS TO REVIEWED DATA.

(1) The establishment of procedures for manufacturers to issue refunds to covered entities in the event that there is an overcharge by the manufacturer, including the following:

(a) Providing the Secretary with an explanation of why and how the overcharge occurred, how the refunds will be calculated, and to whom the refunds will be issued.

(b) Oversight by the Secretary to ensure that such refunds are issued accurately and within a reasonable period of time, both in routine instances of retroactive adjustment to relevant pricing data and exceptional circumstances such as erroneous or intentional overcharging for covered drugs.

(c) The provision of access through the Internet website of the Department of Health and Human Services to the applicable ceiling prices for covered drugs as calculated and verified by the Secretary in accordance with this section, in a manner (such as through the use of password protection) that limits such access to covered entities and adequately assures security and protection of the privileged pricing data from unauthorized re-disclosure.

(2) The development of a mechanism by which:

(a) Rebates and other discounts provided by manufacturers to other purchasers subsequent to the sale of covered drugs to covered entities are reported to the Secretary; and

(b) Proper credits and refunds are issued to covered entities if such discounts or rebates have the effect of lowering the applicable ceiling price for the relevant quarter for the drugs involved.

(3) Selective auditing of manufacturers and wholesalers to ensure the integrity of the drug discount program under this section.

(4) The imposition of sanctions in the form of civil monetary penalties, which—

(a) shall be assessed according to standards established in no instances to be promulgated by the Secretary not later than 180 days after the date of enactment of the Patient Protection and Affordable Care Act; and

(b) shall not exceed $5,000 for each instance of overcharging a covered entity that may have occurred; and

(III) shall apply to any manufacturer with an agreement under subsection (a)(5)(D), negligently and intentionally charges a covered entity a price for purchase of a drug that exceeds the maximum applicable price under subsection (a)(1).}

“(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 disputes regarding discounted price provision and other requirements specified under subsection (a)(5).

(B) IMPROVEMENTS.—The improvements described in subparagraph (A) shall include the following:

(1) The development of procedures to enable covered entities to request regularly (at least annually) the information on the Internet website of the Department of Health and Human Services relating to this section.

(2) The development of a system for the Secretary to verify the accuracy of information regarding covered entities that is listed on the website described in clause (1).

(3) The development of more detailed guidance describing methodologies and options available to covered entities for billing for drugs charged in accordance with the requirements of this section in a manner that avoids duplicate discounts pursuant to subsection (a)(5)(A).

(4) 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 ordering, purchasing, and delivery of covered drugs under this section, including the processing of chargebacks for such drugs.

(5) The imposition of sanctions, in appropriate cases as determined by the Secretary, additional to those to which covered entities are subject under subsection (a)(5)(E), through one or more of the following actions:

(a) Where a covered entity knowingly and intentionally violates subsection (a)(5)(B), the covered entity shall be required to pay a monetary penalty to a manufacturer or manufacturer in the form of interest on sums for which the covered entity is found liable under subsection (a)(5)(E), such interest to be compounded monthly and equal to the current short term interest rate as determined by the Federal Reserve for the time period for which the covered entity is liable.

(b) Where the Secretary determines a violation of subsection (a)(4)(A) was systematic and egregious as well as knowing and intentional, removing the covered entity from the drug discount program under this section and discontinuing such pre-entry into such program for a reasonable period of time to be determined by the Secretary.

(c) Referring matters to appropriate Federal law enforcement authorities, the Food and Drug Administration, the Office of Inspector General of Department of Health and Human Services, or other Federal agencies for consideration of appropriate action under other Federal statutes, such as the Prescription Drug Marketing Act (21 U.S.C. 333).

(6) ADMINISTRATIVE DISPUTE RESOLUTION PROCEEDINGS.

(A) IN GENERAL.—Not later than 180 days after the date of enactment of the Patient Protection and Affordable Care Act, the Secretary shall promulgate regulations to establish and implement an administrative process for the resolution of claims by covered entities that have been overcharged for drugs charged under this section, and disputes arising from claims by manufacturers, after the conduct of audits as authorized by subsection (a)(5)(D), of violations of subsections (a)(5)(A) through (a)(5)(F) for the purpose of providing procedures for the provision of remedies and enforcement of determinations made pursuant to such process through mechanisms and sanctions described in paragraphs (1)(B) and (2)(B).

(B) DEADLINES AND PROCEDURES.—Regulations promulgated by the Secretary under subparagraph (A) shall—

(i) designate or establish a decision-making official or decision-making body within the Department of Health and Human Services to be responsible for reviewing and finally resolving claims by covered entities that have been charged prices for covered drugs in excess of the Medicare ceiling price as described in subsection (a)(1), and claims by manufacturers that violations of subsection (a)(5)(E) have occurred; and

(ii) establish such deadlines and procedures as may be necessary to ensure that claims shall be resolved fairly, efficiently, and expeditiously;

(iii) establish procedures by which a covered entity may discover and obtain such information and documents from manufacturers and third parties as may be relevant to demonstrate the merits of a claim that charges for a manufacturer’s product have exceeded the applicable ceiling price under this section and may submit such documents and information to the administrative official or body responsible for adjudicating such claims;

(iv) require that a manufacturer conduct an audit of a covered entity pursuant to subsection (a)(5)(D) as a prerequisite to initiating administrative dispute resolution proceedings, and

(v) permit the official or body designated under clause (1), at the request of a manufacturer or manufacturers, to consolidate claims brought by more than one manufacturer against the same covered entity where, in the judgment of such official or body, consolidation is appropriate and consistent with the goals of fairness and economy of resources; and

(vi) include provisions and procedures to permit multiple covered entities to jointly assert claims of overcharges by the same manufacturer for the same drug or drugs in one administrative proceeding, and permit such claims to be asserted on behalf of covered entities by associations or organizations representing the interests of such covered entities and of which the covered entity is a member.

(C) FINALITY OF ADMINISTRATIVE RESOLUTION.—The administrative resolution of a claim or claims under the regulations promulgated under subsection (B) shall be a final agency decision and shall be binding upon the parties involved, unless invalidated by an order of a court of competent jurisdiction.

(4) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subsection, such sums as may be necessary for fiscal years 2010 and each succeeding fiscal year:—

(b) CONFORMING AMENDMENTS.—Section 360B(a) of the Public Health Service Act (42 U.S.C. 256b(a)) is amended—

(1) in subsection (a)(1), by adding at the end the following: "Each such agreement shall require that the manufacturer furnish the Secretary with reports, on a quarterly basis, of the price for each covered drug subject to the agreement that, according to the manufacturer, represents the maximum price that covered entities may permissibly be required to pay for the drug (referred to in this section as the ‘ceiling price’), and shall state that the manufacturer agrees that each covered entity covered drugs for purchase at or below the applicable ceiling price, such drug is made available to any other purchaser at any lower price;”;

(2) in the first sentence of subsection (a)(5)(E), as redesignated by section 7101(c),
TITLE VIII—CLASS ACT

SEC. 8001. SHORT TITLE OF TITLE.
This title may be cited as the "Community Living Assistance Services and Supports Act" or the "CLASS Act".

SEC. 8002. ESTABLISHMENT OF NATIONAL Voluntary insurance program for PURCHASING COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS.

(a) Establishment of CLASS Program.—
(1) In general.—The Public Health Service Act (42 U.S.C. 201 et seq.), as amended by section 3203(a), is amended by adding at the end the following:

"TITLE XXXII—COMMUNITY LIVING ASSISTANCE SERVICES AND SUPPORTS

SEC. 3201. PURPOSE.
"The purpose of this title is to establish a voluntary insurance program for purchasing community living assistance services and supports in order to—
"(1) establish a new market for 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. 3202. 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 3204 and has paid any premiums due to maintain such enrolment.
"(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 at another location to which the individual is required to travel because of the individual’s employment; and
"(B) who is a member of the uniformed services, is on active duty and is physically able to perform the duties of the individual’s position; and
"(3) Activities of daily living.—The term ‘activities of daily living’ means each of the following activities specified in section 7702B(h)(2)(B) of the Internal Revenue Code of 1986:
"(A) Eating.
"(B) Dressing.
"(C) Transferring.
"(D) Bathing.
"(E) Using the toilet.
"(F) Chewing.
"(G) Swimming.
"(H) Transferring.
"(I) Pursuant to (A), the date described in this subparagraph is the date on which the initial determination that the individual is determined to have a functional limitation, as certified by a licensed professional, ends.
"(ii) means the date that begins on the date of the individual’s enrollment and ends on the date of such determination.
"(3) Eligible beneficiary.—
"(A) In general.—The term ‘eligible beneficiary’ means any individual who is an active enrollee in the CLASS program in accordance with section 3203(a) and, as of the date described in subparagraph (B)—
"(i) has paid premiums for enrollment in such program for at least 24 consecutive months;
"(ii) has paid premiums for enrollment in such program for at least 3 calendar years that occur during the first 60 months for which the individual has paid premiums for enrollment in such program, at least an amount equal to the amount of wages and self-employment income which an individual must have in order to be credited with a quarter of coverage under section 213(d) of the Social Security Act for the year; and
"(iii) has paid premiums for enrollment in such program for at least 90 days in 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.

"(4) 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.

"(5) Eligibility determinations for the CLASS program.—The entity established by the Secretary under section 3205(a)(2) to make functional eligibility determinations for the CLASS program, with the following requirements:
"(i) The entity established to make functional eligibility determinations for the CLASS program is established under section 3205(a)(2) to make functional eligibility determinations for the CLASS program.
"(ii) The entity established to make functional eligibility determinations for the CLASS program and, as of the date described in subparagraph (B) —
"(B) establish an infrastructure that will promote the program to further the program objectives.
"(C) GAO study to make recommendations on improving the 340B program.—
"(i) Report.—Not later than 18 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report that exam-ines whether those individuals served by the covered entities under the program under section 340B of the Public Health Service Act (42 U.S.C. 256b) (referred to in this section as the ‘‘340B program’’) are receiving optimal health care services.

"(B) Recommendations.—The report under subsection (a) shall include recommendations on the following:

"(i) Whether the 340B program should be expanded since it is anticipated that the 47,000 enrollees who are uninsured as of the date of enactment of this Act will have health care coverage once this Act is implemented.

"(ii) Whether mandatory sales of certain products by the 340B program could hinder patients access to those therapies through any provider.

"(iii) Whether income from the 340B program is being used by the covered entities under the program to further the program objectives.

"TITLE XXXIII—CLASS Independence Fund

SEC. 3301. PROCEDURE FOR DEVELOPMENT.
"(i) In general.—The Secretary, in consultation with appropriate actuaries and other experts, shall develop at least 3 actuarially sound benefit plans as alternatives for determination for consideration for inclusion by the Secretary as the CLASS Independence Benefit Plan under 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 consistent with the following requirements:

"(A) Premiums.—
"(i) In general.—Beginning with the first year of the CLASS program, and for each calendar year thereafter, (i), (ii), and (iii), the shall establish all premiums to be paid by enrollees for the year based on an actuarial analysis of the 75-year cost of the program and balances solvency throughout such 75-year period.

"(ii) Nominal premium for poorest individuals and full-time students.—
"(B) In general.—The monthly premium for enrollment in the CLASS program shall not exceed the applicable dollar amount per month determined under subclause (II) for—
"(aa) any individual whose income does not exceed the poverty line; and
"(bb) any individual who has not attained age 22, and is actively employed during any period in which the individual is a full-time student (as determined by the Secretary).

"(C) Applicable dollar amount.—The applicable dollar amount described in this subclause is the amount equal to $5, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for each of the 2 calendar years that occur during the tax year occurring after 2009 and before such year.

"(ii) Class independence fund reserves.—

"(A) Purpose.—
"(B) Vesting period.—A 5-year vesting period for eligibility for benefits.

"(C) 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 activities of daily living as are required under the plan for the provision of benefits without substantial assistance (as defined by the Secretary) for more than 90 days; and

"(ii) The individual requires substantial supervision to protect the individual from
threats to health and safety due to substantial cognitive impairment.

(ii) The individual has attained age 65.

(ii) has completed 5 years of enrollment in the program for at least 20 years; and

(iii) is not actively employed.

(B) RECALCULATED PREMIUM IF REENROLLMENT AFTER 5-YEAR LAMPS—In the case of an individual described in subsection (c)(1) before being eligible to receive benefits.

(ii) who—

(A) who has attained age 18;

(C) ADMINISTRATION—The Secretary and the Secretary of the Treasury, shall establish procedures under which each individual described in subsection (c) may be automatically enrolled in the CLASS program by an employer of such individual in the same manner as an employer may elect to automatically enroll an individual in a plan established by section 403(b), 404(b), or 457 of the Internal Revenue Code of 1986.

(ii) who self-attests that their income does not exceed for any year in which the program is in effect under this title, an amount equal to 3 percent of all premiums paid during the 5-year period described in subparagraph (B).

(C) RECALCULATED PREMIUM IF REENROLLMENT AFTER 5-YEAR LAMPS—In the case of an individual who reenrolls in the CLASS program after the end of the 5-year period described in subparagraph (C)(ii), 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-adjustments that apply to the individual’s age at the beginning of the 5-year period described in subparagraph (B).

(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-adjustments that apply to the individual’s age at the beginning of the 90-day period.

(i) in general—The Secretary shall designate a benefit plan as the CLASS Independence Benefit Plan. The Secretary shall—

(A) requires a reenrollment of an individual who reenrolls in the CLASS program after more than 3 months.

(A) Automatic Enrollment—Subject to paragraph (2), the Secretary, in coordination with the Secretary of the Treasury, shall establish procedures under which each individual described in subsection (c) may be automatically enrolled in the CLASS program by an employer of such individual.

(A) in general—Subject to paragraph (2), the Secretary, in coordination with the Secretary of the Treasury, shall establish procedures to ensure that an individual is not automatically enrolled in the CLASS program by more than 1 employer.

(B) form—Enrollment in the CLASS program shall be made in such manner as the Secretary may prescribe in order to establish such enrollment.

(C) election 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 and the Secretary of the Treasury shall prescribe.

(D) Individual described—For purposes of enrolling in the CLASS program, an individual described in this paragraph is an individual

(1) who has attained age 18;

(2) who—

(A) receives wages on which there is imposed a tax under section 212(a) of the Internal Revenue Code of 1986; or

(B) derives self-employment income on which there is imposed a tax under section 1245(a) of the Internal Revenue Code of 1986.

(C) who is not self-employed;

(D) who has more than 1 employer; or

(E) whose employer does not elect to participate in the automatic enrollment process established by the Secretary.

(3) ADMINISTRATION—The Secretary and the Secretary of the Treasury shall, by regulation, establish procedures to ensure that an individual is not automatically enrolled in the CLASS program by more than 1 employer.

(2) Alternative enrollment 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

(1) who has attained age 18;

(2) who—

(A) is self-employed;

(B) has more than 1 employer; or

(C) whose employer does not elect to participate in the automatic enrollment process established by the Secretary.

(3) administration—The Secretary and the Secretary of the Treasury shall, by regulation, establish procedures to ensure that an individual is not automatically enrolled in the CLASS program by more than 1 employer.

(2) Form—Enrollment in the CLASS program shall be made in such manner as the Secretary may prescribe in order to establish such enrollment.

(3) Election 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 and the Secretary of the Treasury shall prescribe.

(1) Individual described—For purposes of enrolling in the CLASS program, an individual described in this paragraph is an individual

(i) who has attained age 18;

(ii) has completed 5 years of enrollment in the program for at least 20 years; and

(iii) is not actively employed.
criminal offense or in connection with a verdict or finding described in section 1902(a)(1) of the Social Security Act (42 U.S.C. 1396n), or the State plan amendment under subsection (i) of such section does not include a waiver of the requirements of section 1115 of the Social Security Act (42 U.S.C. 1315) or a section 1115(a)(1) temporary or experimental program authorized under part 60 of that Act.

(II) THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The Secretary shall provide such assistance to the State, to make determinations for eligibility for benefits under theCLASS Independence Benefit Plan, and the Commissioner of Social Security has entered into an agreement, with respect to any State, to make disability determinations for purposes of title II or XVI of the Social Security Act (42 U.S.C. 410 or 1315), with respect to any individual and that may not occur more frequently than the average per day dollar limit applicable in the case of an eligible beneficiary who is entitled to a benefit under the CLASS Independence Benefit Plan.

(3) PRESUMPTIVE ELIGIBILITY.—The Department of Health and Human Services shall promulgate regulations to develop an expedited nationally equitable eligibility determination process, as certified by a licensed health care practitioner, an appeals process, and a redetermination process, as certified by a licensed health care practitioner, including whether an active enrollee is eligible for a cash benefit under the program and if so, the amount of the cash benefit (in accordance with the sliding scale established under the plan).

(4) ADMINISTRATIVE EXPENSES.—Advocacy services and advice and assistance counseling services under paragraphs (2) and (3) of this subsection shall include administrative expenses under section 3203(b)(3).

(5) PAYMENT OF BENEFITS.—(I) LIFE INDEPENDENCE ACCOUNT.—(A) IN GENERAL.—The Secretary shall establish procedures for administering the provision of benefits to eligible beneficiaries under theCLASS Independence Benefit Plan, including the payment of the cash benefit for the beneficiary into a Life Independence Account established by the Secretary on behalf of each eligible beneficiary.

(B) USE OF CASH BENEFITS.—Cash benefits paid into a Life Independence Account of an eligible beneficiary shall purchase nonmedical services and supports that the beneficiary needs to maintain his or her independence at home or in another residential setting, including whether an active enrollee is eligible for a cash benefit under the program and if so, the amount of the cash benefit (in accordance with the sliding scale established under the plan).

(6) ELECTRONIC MAINTENANCE OF FUNDS.—The Secretary shall establish procedures for—

(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 WHO ARE ENROLLED IN MEDICAID.—In the case of an eligible beneficiary who is enrolled in Medicaid, the following payment rules shall apply:

(1) PROVIDING PERSONALIZED BENEFICIARY.—If the beneficiary is a patient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases, the beneficiary shall retain an amount equal to 5 percent of the beneficiary’s daily or weekly cash benefit (as applicable) (which shall be in addition to the amount of the beneficiary’s personal needs allowance provided under Medicaid), and the remainder of such benefit shall be applied toward the facility’s costs of providing the beneficiary’s care, and Medicaid shall provide secondary coverage for such care.

(2) BENEFICIARIES RECEIVING HOME AND COMMUNITY-BASED SERVICES.—(I) 50 PERCENT OF BENEFIT RETAINED BY BENEFICIARY.—Subject to subclause (II), if a beneficiary is receiving medical assistance under the Medicaid program for home and community-based services, the beneficiary shall retain an amount equal to 50 percent of the beneficiary’s daily or weekly cash benefit (as applicable) (which shall be in addition to the amount of the beneficiary’s personal needs allowance provided under Medicaid), and the remainder of such benefit shall be applied toward the facility’s costs of providing the beneficiary’s care, and Medicaid shall provide secondary coverage for the remainder of any costs incurred in providing such assistance.

(II) REQUIREMENT FOR STATE OFFSET.—A State shall be paid the remainder of a beneficiary’s daily or weekly cash benefit under subclause (I) only if the State home and community-based waiver under section 1115 of the Social Security Act (42 U.S.C. 1315) or a section 1115(a)(1) temporary or experimental program authorized under part 60 of that Act.

(3) ADVOCACY SERVICES.—Advocacy services in accordance with subsection (d).

(4) ADMINISTRATIVE ADVICE AND ASSISTANCE.—Advice and assistance counseling in accordance with subsection (e).

(5) ADVOCACY SERVICES.—Advocacy services in accordance with subsection (d).

(6) ADMINISTRATIVE EXPENSES.—Advocacy services and advice and assistance counseling services under paragraphs (2) and (3) of this subsection shall include administrative expenses under section 3203(b)(3).

(7) PAYMENT OF BENEFITS.—(I) LIFE INDEPENDENCE ACCOUNT.—(A) IN GENERAL.—The Secretary shall establish procedures for administering the provision of benefits to eligible beneficiaries under theCLASS Independence Benefit Plan, including the payment of the cash benefit for the beneficiary into a Life Independence Account established by the Secretary on behalf of each eligible beneficiary.
care services, habilitation services, and respite care under such a waiver or State plan amendment.

"(III) DEFINITION OF HOME AND COMMUNITY-BASED SERVICES.—In this clause, the term ‘home and community-based services’ means any services which may be offered under a home and community-based waiver authorized for a State under section 1115 of the Social Security Act (42 U.S.C. 1315b) or subsection (c) or (d) of section 1915 of such Act (42 U.S.C. 1396n) or under a State plan amendment under subsection (i) of such section.

"(iii) BENEFICIARIES ENROLLED IN PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE).—

"(I) IN GENERAL.—Subject to clause (II), if a beneficiary is receiving medical assistance under Medicaid for PACE program services under section 1914 of the Social Security Act (42 U.S.C. 1396a-4), the beneficiary shall retain an amount equal to 50 percent of the beneficiary’s daily or weekly cash benefit (as applicable), and the remainder of the daily or weekly cash benefit shall be applied toward the cost to the State of providing such assistance (and shall not be used to claim Federal matching funds under Medicaid), and Medicaid funds shall be secondary coverage for the remainder of any costs incurred in providing such assistance.

"(II) DESIGNATED RECIPIENTS OF PACE PROGRAM SERVICES.—If a beneficiary receiving assistance under Medicaid for PACE program services is a patient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or an institution for mental diseases, the beneficiary shall be treated as in institutionalized beneficiary under clause (i).

"(2) AUTHORIZED REPRESENTATIVES.—

"(A) IN GENERAL.—The Secretary shall establish procedures to allow access to a beneficiary’s cash benefits by an authorized representative of the eligible beneficiary whose benefit such benefits are paid.

"(B) QUALITY ASSURANCE AND PROTECTION AGAINST FRAUD AND ABUSE.—The procedures established under paragraph (A) shall ensure that authorized representatives of eligible beneficiaries comply with standards of conduct established by the Secretary, that standards requiring that such representatives provide quality services on behalf of such beneficiaries, do not have conflicts of interest that would cause such beneficiaries to lose benefits paid on behalf of such beneficiaries or otherwise engage in fraud or abuse.

"(3) COMMENCEMENT OF BENEFITS.—Benefits shall be payable to the eligible beneficiary on the date that increase or decrease as a result of the determination of the beneficiary’s continued eligibility for receipt of benefits; and

"(B) submit records of expenditures attributable to the aggregate cash benefit received by the beneficiary in the preceding year.

"(7) SUPPLEMENT, NOT SUBSTITUTE HEALTH CARE BENEFITS.—Subject to the Medicaid payment rules under paragraph (5)(A), benefits received by an eligible beneficiary shall supplement, but not supplant, other health care benefits for which the beneficiary is eligible under Medicaid or any other Federal, State, or locally funded assistance program, or under the supplemen
tal nutritional assistance program established under the Food and Nutrition Act of 2008 (7 U.S.C. 1151 et seq.).

"(g) RULE OF CONSTRUCTION.—Nothing in this title shall be construed as prohibiting benefits paid under the CLASS Independence Benefit Plan from being used to compensate a family caregiver for providing community assistance services and supports to an eligible beneficiary.

"(h) PROTECTION AGAINST CONFLICT OF INTERESTS.—The Secretary shall establish procedures to ensure that the Eligibility Assessment System, the Protection and Advocacy System for a State, advocacy counselors for eligible beneficiaries, and any other entities that provide services to active enrollees and eligible beneficiaries under the CLASS program comply with the following:

"(1) The entity provides an active enrollee or beneficiary, to the best of its knowledge, including services available through other entities or providers.

"(2) The entity does not have an active enrollee or beneficiary to access desired services, regardless of the provider.

"(3) The entity reports the number of active enrollees and beneficiaries provided with assistance by age, disability, and whether such enrollees and beneficiaries receive services from the entity or another entity.

"(4) If the entity provides counseling or planning services, the entity must ensure that its interests, financial or otherwise, are not affected by the ability of the entity to access desired services.

"(5) SEC. 3206. CLASS INDEPENDENCE FUND.—There is established in the Treasury of the United States a trust fund to be known as the ‘CLASS Independence Benefit Fund’, to be established by the Secretary, to be served as Managing Trustee of such Fund. The Fund shall consist of all amounts derived from payments into the Fund under subsection (b), including additional amounts derived from income from such investments. The amounts invested in the Fund shall remain available without fiscal year limitation.
(1) to be held for investment on behalf of individuals enrolled in the CLASS program;

(2) to pay the administrative expenses related to the Fund and to investment under subsection (c); and

(3) to pay cash benefits to eligible beneficiaries under the CLASS Independence Benefit Plan.

(b) TREATMENT 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 Supplementary Medical Insurance Trust Fund may be invested and managed under subsections (c), (d), and (e) of section 361(d) of the Social Security Act (42 U.S.C. 1395t).

(c) BOARD OF TRUSTEES.—

(1) IN GENERAL.—With respect to the CLASS Independence Fund, there is hereby created 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’) composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President and confirmed by the Senate not later than 4 years after such term, and confirmed not later than 4 years after the expiration of such term. An individual nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term, and any member so nominated and confirmed shall serve in such capacity with respect to the Trust Fund for the remainder of such term. An individual nominated and confirmed to fill a vacancy occurring during a term shall be nominated and confirmed only for the remainder of such term. An individual nominated and confirmed shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

(2) DUTIES.—

(A) IN GENERAL.—It shall be the duty of the Board of Trustees to do the following:

(i) Ensure the solvency of the CLASS Independence Fund during the current fiscal year and each of the next 2 fiscal years;

(ii) Report to the Congress not later than each March 1 year, each of the next 2 fiscal years, and each of the next 2 fiscal years;

(iii) A statement of the actuarial status of the CLASS Independence Fund for the current fiscal year, each of the next 2 fiscal years, and each of the next 3 fiscal years;

(iv) An actuarial opinion by the Chief Actuary of the Centers for Medicare & Medicaid Services certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable;

(v) 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 3203(b)(1)(B)(i) and are unlikely to be resolved with reasonable premium increases or through other means, 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 determine to be appropriate, including whether or not to approve or to impose a temporary moratorium on new enrollments.

SEC. 3207. 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 not more than 15 individuals, not otherwise in the service of the Federal Government.

(A) who shall be appointed by the President without regard to the civil service laws and regulations; and

(B) a representative 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 require services and supports to maintain their independence at home or in another living arrangement; and employees of the community, individuals with expertise in long-term care or disability insurance, actuarial science, economics, and other relevant disciplines determined by the Secretary.

(2) TERMS.—

(A) IN GENERAL.—The members of the CLASS Independence Advisory Council shall serve for not more than 3 years (unless appointed to fill a vacancy occurring prior to the expiration of a term, in which case the individual shall serve for the remainder of the term).

(B) LIMITATION.—A member shall not be eligible to serve for more than 2 consecutive terms.

(c) DUTIES.—The CLASS Independence Advisory Council shall provide reports to the Congress immediately after holding public hearings that discuss the actuarial status of the CLASS Independence Fund and make recommendations to the Secretary concerning any investments made under this Act and the Secretary's reports to Congress. Such reports shall include recommendations for such legislative action as the Board of Trustees determines to be necessary.

(d) 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 under the program.

(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 ensure the solvency of the program, or prevent the occurrence of fraud or abuse.

SEC. 3209. 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. Such report shall include findings in the following areas:

(1) The eligibility determination process.

(2) The provision of benefits.

(3) Quality assurance and protection against waste, fraud, and abuse.

(4) Recoupment of unpaid and accrued benefits.

SEC. 3210. TAX TREATMENT OF PROGRAM

The CLASS program shall be treated for purposes of the Internal Revenue Code of 1986 in the same manner as a qualified long-term care insurance contract for qualified long-term care services.  

(2) CONFORMING AMENDMENTS TO MEDICAID.—Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by striking ‘‘CLASS’’ and inserting ‘‘CLASS Independence’’.
‘(8) 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 beneficiaries under the CLASS program established under title XXXII of the Public Health Service Act as the Secretary shall determine.

(b) ASSURANCE OF ADEQUATE INFRASTRUCTURE FOR THE PROVISION OF PERSONAL CARE ATTENDANTS.—Section 1909(b) of the Social Security Act (42 U.S.C. 1396a(a)), as amended by subsection (a)(2), is amended by inserting after paragraph (8) the following:

‘'(9) provide that, not later than 2 years after the date of enactment of the Community Living Assistance Services and Supports Act, each State shall—

‘‘(A) establish a Council to which entities such as providers of home care, home health services, home and community 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 employment-related 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) create such entities to serve as fiscal agents for, employers of, and providers of employment-related 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; and

‘‘(C) ensure that the designation or creation of such entities will not physically alter or impede existing programs, models, methods, or administration of service delivery that provide for consumer controlled or self-directed home and community services, including the ability to select, manage, dismiss, co-employ, or employ such workers or inhibit such individuals from exercising such benefits for income replacement.

TITLE IX—REVENUE PROVISIONS

Subtitle A—Revenue Offset Provisions

SECT. 9001. EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.

(a) IN GENERAL.—Chapter 43 of the Internal Revenue Code of 1986, as amended by section 1513, is amended by adding at the end the following:

‘‘SEC. 4980I. EXCISE TAX ON HIGH COST EMPLOYER-SPONSORED HEALTH COVERAGE.

‘‘(a) Imposition of Tax.—(1) in general.—(A) IN GENERAL.—The annual limitation which applies for any taxable year to employer-sponsored coverage of an employer at any time during a taxable period, and (B) APPLICABLE DOLLAR LIMIT.—Except as provided in subparagraph (C), the applicable dollar limit for any taxable year shall be an amount equal to 200 percent of the applicable aggregate cost for such calendar year which is not a multiple of $50, such amount as in effect for the calendar year preceding such year, increased by an amount equal to the product of—

‘‘(I) such amount as so in effect, multiplied by

‘‘(II) the amount of the cost-of-living adjustment determined under section 1.1513-1T for years beginning after December 31, 2009.

‘‘(ii) EXCEPTION.—The term ‘employer’ means each of the following:

‘‘(II) the dollar amount in clause (I)(ii) (determined after the application of subparagraph (D)) shall be increased by $1,350, and

‘‘(B) in clause (i)(I) (determined after the application of subparagraph (D)) shall be increased by $3,000.

‘‘(iii) Subsequent Years.—In the case of any calendar year after 2013, each of the dollar amounts under clauses (i) and (ii) shall be increased to the amount equal to such amount as in effect for the calendar year preceding such year, increased by an amount equal to the product of—

‘‘(I) such amount as so in effect, multiplied by

‘‘(II) the cost-of-living adjustment determined under section 1.1513-1T for such year (determined after substituting the calendar year that is 2 years before such year for ‘1992’ in subparagraph (B) thereof), increased by 1 percentage point.

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

‘‘(c) Transition Prov for States with Highest Cost Shares.

‘‘(1) IN GENERAL.—Each coverage provider shall pay the tax imposed by subsection (a) on its applicable share of the excess benefit with respect to an employee for any taxable period.

‘‘(2) COVERAGE PROVIDER.—For purposes of this subsection—

‘‘(A) IN GENERAL.—The term ‘coverage provider’ means each of the following:

‘‘(I) an employer

‘‘(ii) any group health plan (as defined under section 1256), and

‘‘(iii) the health insurance issuer.

‘‘(B) COVERAGE PROVIDER.—For purposes of this paragraph, the term ‘coverage provider’ means each of the following:

‘‘(i) an employer

‘‘(B) APPLICABLE DOLLAR LIMIT.—The applicable dollar limit for any taxable year shall be an amount equal to the applicable dollar limit determined under paragraph (3) for the calendar year in which the month occurs.

‘‘(C) ANNUAL LIMITATION.—For purposes of this subsection—

‘‘(B) APPLICABLE DOLLAR LIMIT.—The applicable dollar limit provided to the employee for the month, over

‘‘(iv) include information regarding the applicable dollar limit for such calendar year for any taxable period to the extent available.

‘‘(ii) include information regarding the applicable dollar limit for such calendar year for any taxable period to the extent available.

‘‘(C) APPLICABLE DOLLAR LIMIT.—Except as provided in subparagraph (A), the applicable dollar limit for any taxable period is the amount which bears the
same ratio to the amount of such excess benefit as—

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(A) the cost of the applicable employer-sponsored coverage provided to the provider by the employee under any group health plan providing health insurance coverage shall be treated as applicable employer-sponsored coverage if a deduction is allowable under section 162(l) with respect to such amount, and

(B) the aggregate cost of all applicable employer-sponsored coverage provided to the employee by all coverage providers during such period.
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(4) **Responsibility to calculate tax and applicable shares.**—

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(A) in general.—Each employer shall—

(i) calculate for each taxable period the amount of the excess benefit subject to the tax imposed by subsection (a) and the applicable employer-sponsored coverage provided to the employee by the employer for such period, and

(ii) notify, at such time and in such manner as the Secretary may prescribe, the Secretary and each coverage provider of the amount so determined for the provider.
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(B) **Special rule for multiemployer plans.**—In the case of applicable employer-sponsored coverage provided to employees through a multiemployer plan (as defined in section 1351(f)), the plan sponsor shall make the calculations, and provide the notice required by subparagraph (A).

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(C) applicability of rules.—For purposes of this section—

(1) **Applicable employer-sponsored coverage.**—

(A) in general.—The term ‘applicable employer-sponsored coverage’ means, with respect to any employer, coverage under any group health plan made available to the employee by an employer which is excludable from the employee’s gross income under section 106, or which would be so excludable if it were employer-provided coverage (within the meaning of such section 106).

(B) **coverage under group health plan.**—The term ‘applicable employer-sponsored coverage’ shall not include—

(i) any coverage (whether through insurance or otherwise) described in section 9832(c)(1)(A) or for long-term care, or

(ii) any coverage described in section 9832(c)(3) the amount for which is not excludable from gross income and for which a deduction under section 162(I) is not allowable.

(C) **Coverage includes employer paid portion.**—Coverage shall be treated as applicable employer-sponsored coverage without regard to whether the employer or employee pays for the coverage.

(D) **Self-employed individual.**—In the case of an individual who is an employee within the meaning of section 401(c)(1), coverage under any group health plan providing health insurance coverage shall be treated as applicable employer-sponsored coverage if a deduction is allowable under section 162(I) with respect to all or any portion of the cost of the coverage.

(E) **Governmental plans included.**—Applicable employer-sponsored coverage shall include coverage under any group health plan established and maintained primarily for its civilian employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any such government.

(2) **Determination of cost.**—

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(A) in general.—The cost of applicable employer-sponsored coverage shall be determined under rules similar to the rules of section 6908B(f)(4), except that in determining such cost—

(i) all of the cost of the coverage which is attributable to the tax imposed under this section shall not be taken into account and the amount of such cost shall be separately attributable for self-only coverage and other coverage. In the case of applicable employer-sponsored coverage which provides coverage to retired employees, the plan may elect to treat a retired employee who has not attained the age of 65 and a retired employee who has attained the age of 65 as separate beneficiaries.

(B) **Health insurance.**—In the case of applicable employer-sponsored coverage consisting of coverage under a flexible spending arrangement (as defined in section 125(f)(2)), the cost of the coverage shall be equal to the sum of—

(i) the amount of employer contributions under any salary reduction election under the arrangement, plus

(ii) the amount determined under subparagraph (A) with respect to any reimbursements under the excess of the contributions described in clause (i).

(C) **Archer MSAs and HSAs.**—In the case of applicable employer-sponsored coverage consisting of coverage under an arrangement under which the employer makes contributions described in subsection (b) or (d) of section 106, the cost of the coverage shall be equal to the amount of employer contributions under the arrangement.

(D) **Allocation on a monthly basis.**—If cost is determined on a monthly basis, the cost of the coverage shall be allocated in a taxable period on such basis as the Secretary may prescribe.

(E) **Penalty for failure to properly calculate employer contributions.**—

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(A) in general.—If, for any taxable period, the tax imposed by subsection (a) exceeds the tax determined under such subsection with respect to the total excess benefit calculated by the employer or plan sponsor under subsection (c)(4)—

(A) each coverage provider shall pay the tax on its pro rata share determined in the same manner as under subsection (c)(4) of the excess, but no penalty shall be imposed on the provider with respect to such amount, and

(B) the employer or plan sponsor shall, in addition to any tax imposed by subsection (a), pay a penalty in an amount equal to such excess, plus interest at the underpayment rate determined under section 6621 of the Code for the period beginning on the due date for the payment of tax imposed by subsection (a) to which the excess relates and ending on the date of payment of the penalty.

(2) **Limitations on penalty.**—

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(A) **Penalty not to apply where failure not due to reasonable diligence.**—No penalty shall be imposed by paragraph (1)(B) on any failure to properly calculate the excess benefit during any period to which it is established to the satisfaction of the Secretary that the employer or plan sponsor neither knew, nor exercising reasonable diligence would have known, that such failure existed.

(B) **Penalty not to apply to failures corrected within 30 days.**—No penalty shall be imposed by paragraph (1)(B) on any such failure if—

(i) the 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.

(C) **Waiver by Secretary.**—In the case of any such failure which is due to reasonable cause and not to willful neglect, the Secretary may waive part or all of the penalty imposed by paragraph (1)(B) in any case in which the Secretary determines that the payment of such penalty would be excessive or otherwise inequitable relative to the failure involved.

(3) **Other definitions and special rules.**—For purposes of this section—

(1) **Coverage determinations.**—

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amended by section 1513, is amended by adding
at the end the following new item:

Sec. 4980I. Excise tax on high cost employer-sponsored health coverage.

(c) Effective date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2012.

SEC. 9002. INCLUSION OF COST OF EMPLOYER-SUPPORTED HEALTH COVERAGE ON W-2.

(a) In General.—Section 6651(a) of the Internal Revenue Code of 1986 (relating to receipts for employees) is amended by striking “and”) at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting “; and”, and by adding after paragraph (13) the following new paragraph: “(14) the aggregate cost (determined under rules similar to the rules of section 4980B)(d) of applicable employer-supported coverage (as defined in section 4980D(d)(1)), except that this paragraph shall not apply to—

“(A) coverage to which paragraphs (11) and (12) apply, or

“(B) the amount of any salary reduction contributions to a flexible spending arrangement (within the meaning of section 125) or a health reimbursement arrangement (within the meaning of section 105).”

(e) Effective date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9003. LIMITATIONS ON MEDICARE QUALIFIED ONLY IF FOR PRESCRIBED DRUG OR INSULIN.

(a) HSA.—Subparagraph (A) of section 222(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection: “(13) in the case of property, unless the Secretary determines has the provision of hospitah care as its principal function or purpose.

(b) Archer MSAs.—Subparagraph (A) of section 222(d)(2) of the Internal Revenue Code of 1986 is amended by adding at the end of the following new subsection: “(14) in the case of property, unless the Secretary determines has the provision of hospital care as its principal function or purpose.

(c) Health Flexible Spending Arrangements and Health Reimbursment Arrangements.—Section 105 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection: “(13) in the case of property, unless the Secretary determines has the provision of hospital care as its principal function or purpose.

(d) Effective dates.—

(1) Distributions from Savings Accounts.—Sections 222(d)(2) of the Internal Revenue Code of 1986 is amended by striking “and”), and by adding after paragraph (13) the following new paragraph: “(14) the aggregate cost (determined under rules similar to the rules of section 4980B(d) of applicable employer-sponsored coverage (as defined in section 4980D(d)(1)), except that this paragraph shall not apply to—

“(A) coverage to which paragraphs (11) and (12) apply, or

“(B) the amount of any salary reduction contributions to a flexible spending arrangement (within the meaning of section 125) or a health reimbursement arrangement (within the meaning of section 105).”

(e) Effective date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9004. EXPANSION OF INFORMATION REPORTING REQUIREMENTS.

(a) In General.—Section 6041 of the Internal Revenue Code of 1986 is amended by adding after it the following new subsection: “(b) Application to Corporations.—For purposes of this section, the term ‘corporation’ includes any entity (including an employee benefit plan) treated as a corporation for Federal income tax purposes for purposes of this section or any other provision of the Internal Revenue Code of 1986.

(b) Effective date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9006. ADDITIONAL REQUIREMENTS FOR CHARITABLE HOSPITALS.

(a) Requirements.—Section 501(c)(3) Charitable Hospital Organization.—Section 501 of the Internal Revenue Code of 1986 (relating to exemption from tax under section 501(a)).

(b) Effective date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9007. ADDITIONAL REQUIREMENTS FOR CHARITABLE HOSPITALS.

(a) Requirements.—Section 501(c)(3) Charitable Hospital Organization.—Section 501 of the Internal Revenue Code of 1986 (relating to exemption from tax under section 501(a)).

(b) Effective date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9008. LIMITATION ON INFORMATION REPORTING REQUIREMENTS.

(a) HSA.—Subparagraph (A) of section 222(d)(2) of the Internal Revenue Code of 1986 is amended by striking “and”) at the end of paragraph (12), by striking the period at the end of paragraph (13) and inserting “; and”, and by adding after paragraph (13) the following new paragraph: “(14) the aggregate cost (determined under rules similar to the rules of section 4980B(d) of applicable employer-sponsored coverage (as defined in section 4980D(d)(1)), except that this paragraph shall not apply to—

“(A) coverage to which paragraphs (11) and (12) apply, or

“(B) the amount of any salary reduction contributions to a flexible spending arrangement (within the meaning of section 125) or a health reimbursement arrangement (within the meaning of section 105).”

(e) Effective date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9009. 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: “(i) Limitation on Health Flexible Spending Arrangements.—Except for purposes of this section, if a benefit is provided under a cafeteria plan 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 employee may not elect for any taxable year to have salary reduction contributions in excess of $2,500 made to such arrangement.”

(b) Effective Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9010. EXPANSION OF INFORMATION REPORTING REQUIREMENTS.

(a) In General.—Section 6041 of the Internal Revenue Code of 1986 is amended by adding after it the following new subsection: “(b) Application to Corporations.—For purposes of this section, the term ‘corporation’ includes any entity (including an employee benefit plan) treated as a corporation for Federal income tax purposes for purposes of this section or any other provision of the Internal Revenue Code of 1986.

(b) Effective date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9011. LIMITATION ON ADDITIONAL TAX ON DISCOUNTS FROM HSA AND ARCHER MSAS NOT USED FOR QUALIFIED MEDICARE EXPENSES.

(a) HSA.—Subsection 223(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking “10 percent” and inserting “20 percent”.

(b) Archer MSAs.—Section 223(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking “15 percent” and inserting “20 percent”.

(c) Effective date.—The amendments made by this section shall apply to distributions made after December 31, 2010.

SEC. 9005. 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: “(i) Limitation on Health Flexible Spending Arrangements.—Except for purposes of this section, if a benefit is provided under a cafeteria plan 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 employee may not elect for any taxable year to have salary reduction contributions in excess of $2,500 made to such arrangement.”

(b) Effective Date.—The amendments made by this section shall apply to taxable years beginning after December 31, 2010.

SEC. 9004. INCREASE IN ADDITIONAL TAX ON DISCOUNTS FROM HSA AND ARCHER MSAS NOT USED FOR QUALIFIED MEDICARE EXPENSES.

(a) HSA.—Subsection 223(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking “10 percent” and inserting “20 percent”.

(b) Archer MSAs.—Section 223(f)(4)(A) of the Internal Revenue Code of 1986 is amended by striking “15 percent” and inserting “20 percent”.

(c) Effective date.—The amendments made by this section shall apply to—

“(i) an organization which operates a facility which is required by a State to be licensed, registered, or similarly recognized as a hospital, and

“(ii) other organization which the Secretary determines has the provision of hospital care as its principal function or purpose constituting the basis for its exemption under subsection (c)(3) determined without regard to this subsection).

“(B) ORGANIZATIONS WITH MORE THAN 1 HOSPITAL FACILITY.—If a hospital organization operates more than one hospital facility—

“(i) the organization shall meet the requirements of this subsection separately with respect to each such facility, and

“(ii) the organization shall not be treated as described in subsection (c)(3) with respect to any such facility for which such requirements are not separately met.

“(3) COMMUNITY HEALTH NEEDS ASSESSMENTS.—

“(A) In General.—An organization meets the requirements of this paragraph with respect to any taxable year only if the organization—

“(i) takes into account input from persons who represent the broad interests of the community served by the hospital facility, including those with knowledge or expertise in public health,

“(ii) is made widely available to the public.

“(4) FINANCIAL ASSISTANCE POLICY.—An organization meets the requirements of this paragraph if the organization establishes the following policies:

“(A) FINANCIAL ASSISTANCE POLICY.—A written financial assistance policy which includes—

“(i) eligibility criteria for financial assistance, and whether such assistance includes free or discounted care

“(ii) the basis for calculating amounts charged to patients,

“(iii) measures for applying for financial assistance

“(iv) in the case of an organization which does not have a separate billing and collection policy, the actions the organization may take in the event of non-payment, including collections action and reporting to credit agencies, and

“(v) measures to widely publicize the policy within the community to be served by the organization.

“(B) POLICY RELATING TO EMERGENCY MEDICAL CARE.—A written policy explaining how the organization will provide, without discrimination, care for emergency medical conditions (within the meaning of section 1395dd of the Social Security Act (42 U.S.C. 1395dd)) to individuals regardless of their eligibility under the financial assistance policy described in subparagraph (A).

“(5) LIMITATION ON CHARGES.—An organization meets the requirements of this paragraph if the organization—

“(A) limits amounts charged for emergency medical care to—

“(i) amounts which are reasonable and necessary by care provided to individuals eligible for assistance under the financial assistance policy described in paragraph (4)(A) to not more than individuals who have insurance covering such care, and

“(B) prohibits the use of gross charges.
"(6) BILLING AND COLLECTION REQUIREMENTS.—An organization meets the requirement of this paragraph only if the organization does not engage in extraordinary collection actions. The organization shall have made reasonable efforts to determine whether the individual is eligible for assistance under the financial assistance policy described in paragraph (4)(A).

"(7) REGULATORY AUTHORITY.—The Secretary shall issue such regulations and guidance as may be necessary to carry out the provisions of this section. The organization, including guidance relating to what constitutes reasonable efforts to determine the eligibility of a patient under a financial assistance policy for purposes of paragraph (6)."

"(b) Excise Tax for Failures to Meet Hospital Exemption Requirements.—

(1) In general.—Subchapter D of chapter 42 of the Internal Revenue Code of 1986 (relating to failure by certain charitable organizations to meet certain qualification requirements) is amended by adding at the end the following new section:

"SEC. 4959. TAXES ON FAILURES BY HOSPITAL ORGANIZATIONS.

"If a hospital organization to which section 501(r) applies fails to meet the requirement of section 501(r)(3) for any taxable year, there is imposed on the organization a tax equal to $50,000."

"(2) Conforming Amendment.—The table of sections for subchapter D of chapter 42 of such Code is amended by adding at the end the following new item:

"(c) Mandatory Review of Tax Exemption for Hospitals.—The Secretary of the Treasury shall conduct a study on the financial status of each hospital organization, including the financial status of each organization's community benefit activities, and submit a report on the study to the Committees on Ways and Means, Education and Labor, and Energy and Commerce of the House of Representatives and the Committees on Finance and Health, Education, Labor, and Pensions of the Senate not later than the annual payment date of each calendar year after 2009 a fee in an amount determined under subsection (b)."

"(d) Annual Payment Date.—For purposes of this section, the term "annual payment date" means the last day of the calendar month that is more than 1 year but less than 2 years after the date of enactment of this Act.

"(e) Branded Prescription Drug Sales.—The requirements of section 501(r)(3) of the Internal Revenue Code of 1986, as added by subsection (a), shall apply to tax-exempt, taxable, and government-owned hospitals with respect to until the later of:

(1) The 75th percent of such Code is amended by striking "and" at the end of subparagraph (B), by inserting "and" at the end of subparagraph (C), and by adding at the end the following new subparagraph:

"(D) section 4959 (relating to taxes on failures by hospital organizations)."

"(f) Effective Dates.—

(1) In general.—Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply to taxable years beginning after the date of the enactment of this Act.

"SECT. 9008. IMPOSITION OF ANNUAL FEE ON BRANDED PRESCRIPTION PHARMACEUTICAL MANUFACTURERS AND IMPORTERS.

"(a) Imposition of Fee.—

(1) In general.—Each covered entity engaged in the business of manufacturing or importing branded prescription drugs shall pay to the Secretary of the Treasury the annual payment date which is:

(2) Annual Payment Date.—For purposes of this section, the term "annual payment date" means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

"(b) Determination of Fee Amount.—

(1) In general.—With respect to each covered entity, the fee for this section for any calendar year shall be equal to an amount that bears the same ratio to $2,300,000,000 as—

(A) the covered entity's branded prescription drug sales taken into account during the preceding calendar year, bear to

(B) the aggregate branded prescription drug sales of all covered entities taken into account during such preceding calendar year.

"(2) Sales Taken into Account.—For purposes of paragraph (1), the branded prescription drug sales of a covered entity shall be taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

<table>
<thead>
<tr>
<th>Sales Amount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $5,000,000</td>
<td>0 percent</td>
</tr>
<tr>
<td>$5,000,000 but not more than $25,000,000</td>
<td>10 percent</td>
</tr>
<tr>
<td>$25,000,000 but not more than $125,000,000</td>
<td>40 percent</td>
</tr>
<tr>
<td>More than $125,000,000</td>
<td>75 percent</td>
</tr>
<tr>
<td>More than $400,000,000</td>
<td>100 percent</td>
</tr>
</tbody>
</table>

"(3) Secretarial Determination.—The Secretary of the Treasury shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary of the Treasury shall determine such covered entity's branded prescription drug sales during the previous calendar year and shall include in computing covered entity's branded prescription drug sales only amounts that bears the same ratio to $2,300,000,000 as—

(A) the covered entity's branded prescription drug sales, bearing to

(B) the aggregate branded prescription drug sales of all covered entities, bearing to

(4) Transfer of Fees to Medicare Part B Trust Fund.—There is hereby appropriated to the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act an amount equal to the fees received by the Secretary of the Treasury under section 52 of such Code.

"(d) Covered Entity.—

(1) In general.—For purposes of this section, the term "covered entity" means any manufacturer or importer with gross receipts from its branded prescription drug sales.

(2) Controlled Groups.—

(A) In general.—For purposes of this section, all persons treated as a single employer under section 52 of such Code shall be treated as a single covered entity.

(B) Inclusion of Foreign Corporations.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, the term "covered drug sales" means—

(1) any prescription drug application for which was submitted under section 505(b)
of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(b)), or
(ii) any biological product the license for which was submitted under section 335(a) of the Public Health Service Act (22 U.S.C. 262(a)).

(B) PRESCRIPTION DRUG.—For purposes of subparagraph (A)(ii), the term "prescription drug" means any drug which is subject to section 503(b) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 353(b)).

(d) EXCLUSION OF ORPHAN DRUG SALES.—The term "specified prescription drug sales" shall not include sales of any drug or biological product with respect to which a credit was allowed under subchapter I of chapter 1 of part B of title XVIII of the Social Security Act, the Medicare Part B program under section 262(a) of the Social Security Act, or the Medicaid program under title XIX of the Social Security Act.

(f) TAX TREATMENT OF FEES.—The fees imposed by this section—

(1) for purposes of subtitle F of the Internal Revenue Code of 1986, the Secretary shall determine such receipt from medical device sales taken into account during any calendar year shall be equal to an amount that bears the same ratio to $2,000,000,000 as the percentage of gross receipts from medical device sales taken into account in any calendar year bears to $5,000,000,000 as of such Code to this section, section 1563 of such Code shall be treated as a single covered entity.

(2) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of subparagraph (A), with respect to any covered entity under the Medicare Part D program, the product of—

(i) the per-unit ingredient cost, minus any per-unit rebate paid by the covered entity under section 1927 of the Social Security Act and any State supplemental rebate, and

(ii) the number of units of the branded prescription drug paid for under the Medicare Part D program, for each covered entity and for each branded prescription drug of the covered entity, the total amount paid for each such branded prescription drug procured by the Department of Veterans Affairs under the TRICARE program, the product of—

(i) the per-unit ingredient cost, minus any per-unit rebate paid by the covered entity, and

(ii) the number of units of the branded prescription drug dispensed under such program, for each covered entity.

(3) MEDICAID PROGRAM.—The Secretary of Health and Human Services shall report, for each covered entity and for each branded prescription drug of the covered entity covered by the Medicare Part B program under section 1862(a) of the Social Security Act, the product of—

(A) the per-unit ingredient sales price as defined in section 1847A(c) of the Social Security Act or the per-unit Part B payment rate for separately payable prescription drug without a reported average sales price, and

(B) the number of units of the branded prescription drug paid for under the Medicare Part B program.

The Centers for Medicare and Medicaid Services shall establish a process for determining the use of any rebates and other price concessions allowed for any taxable year under section 52 of the Internal Revenue Code of 1986.

(h) SECRETARY.—For purposes of this section, the term "Secretary" includes the Secretary's delegate.

(k) CONFORMING AMENDMENT.—Section 1814(a) of the Social Security Act is amended by inserting "or section 9008(c) of the Patient Protection and Affordable Care Act of 2009" after "this part".

SECTION 9009. IMPOSITION OF ANNUAL FEE ON MEDICAL DEVICE MANUFACTURERS AND IMPORTERS

(a) IMPOSITION OF FEE.—

(1) IN GENERAL.—Each covered entity engaged in the business of manufacturing or importing medical devices shall pay to the Secretary not later than the annual payment date of each calendar year beginning after 2009 a fee in an amount determined under subsection (b).

(A) IN GENERAL.—For purposes of this section, the term "annual payment date" means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(B) DETERMINATION OF FEE AMOUNT.—

(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to $2,000,000,000 as the covered entity's gross receipts from medical device sales taken into account during the preceding calendar year, bears to $5,000,000,000 as of such Code to this section.

(A) the aggregate gross receipts of all covered entities from medical device sales taken into account during such preceding calendar year;

(B) the aggregate gross receipts of all covered entities from medical device sales taken into account during such preceding calendar year;

(2) GROSS RECEIPTS FROM SALES TAKEN INTO ACCOUNT.—For purposes of paragraph (1), the gross receipts from medical device sales taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

<table>
<thead>
<tr>
<th>Gross Receipts Taken into Account</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0,000,000 or less</td>
<td>0%</td>
</tr>
<tr>
<td>More than $5,000,000 but not more than $25,000,000</td>
<td>50%</td>
</tr>
<tr>
<td>More than $25,000,000</td>
<td>100%</td>
</tr>
</tbody>
</table>

(3) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity's gross receipts from medical device sales on the basis of reports submitted by the covered entity under subsection (f) and through the use of any other source of information available to the Secretary.

(c) COVERED ENTITY.—

(1) IN GENERAL.—For purposes of this section, the term "covered entity" means any manufacturer or importer with gross receipts from medical device sales.

(2) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under section 1563 of such Code shall be treated as a single covered entity.

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 1563 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

(d) MEDICAL DEVICE SALES.—For purposes of this section—

<table>
<thead>
<tr>
<th>Gross Receipts Taken into Account</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0,000,000 or less</td>
<td>0%</td>
</tr>
<tr>
<td>More than $5,000,000 but not more than $25,000,000</td>
<td>50%</td>
</tr>
<tr>
<td>More than $25,000,000</td>
<td>100%</td>
</tr>
</tbody>
</table>
(1) IN GENERAL.—The term "medical device sales" means sales for use in the United States of any medical device, other than the sales of a medical device that:
(A) has been classified in class II under section 513 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360c) and is primarily sold to consumers at retail for not more than $100 per unit, or
(B) has been classified in class I under such section.
(2) UNITED STATES.—For purposes of paragraph (1), the term "United States" means the several States, the District of Columbia, the Commonwealth of Puerto Rico, and the possessions of the United States.
(3) MEDICAL DEVICE.—For purposes of paragraph (1), the term "medical device" means any device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h))) intended for humans.

(b) DETERMINATION OF FEE AMOUNT.—
(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to $6,700,000,000 as
(A) the sum of—
(i) the covered entity's net premiums written with respect to any United States health risk,
(ii) in general, the aggregate net premiums written with respect to any United States health risk that are taken into account during the preceding calendar year, plus
(iii) 200 percent of the aggregate third party administration agreement fees that are taken into account during the preceding calendar year, bears to
(B) has been classified in class I under such section.

With respect to a covered entity's net premiums written during the calendar year that are:

Not more than $25,000,000 ................................................................. 0 percent
More than $25,000,000 but not more than $50,000,000 ................. 50 percent
More than $50,000,000 ........................................................................ 100 percent.

(B) THIRD PARTY ADMINISTRATION AGREEMENT FEES.—The third party administration agreement fees that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

With respect to a covered entity's third party administration agreement fees during the calendar year that are:

Not more than $5,000,000 ................................................................. 0 percent
More than $5,000,000 but not more than $10,000,000 ................. 50 percent
More than $10,000,000 ........................................................................ 100 percent.

(3) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity's net premiums written with respect to any United States health risk and third party administration agreement fees on the basis of reports submitted by the covered entity under subsection (g) and through the use of any other source of information available to the Secretary.

(c) COVERED ENTITY.—
(1) IN GENERAL.—For purposes of this section, the term "covered entity" means any entity which provides health insurance for any United States health risk.
(2) EXCLUSION.—Such term does not include
(A) any employer to the extent that such employer self-insures its employees' health risks, or
(B) any governmental entity (except to the extent such an entity provides health insurance coverage through the Medicare program).

(1) IN GENERAL.—Not later than the date determined by the Secretary following the end of any calendar year, each covered entity shall report to the Secretary, in such manner as the Secretary prescribes, the gross receipts from medical device sales of any covered entity during such calendar year.

(2) PENALTY FOR FAILURE TO REPORT.—
(A) IMPOSITION OF FEE.—Each covered entity engaged in the business of providing health insurance shall pay to the Secretary not later than the date determined by the Secretary, according to the following table:

With respect to such health insurance of all covered entities that are taken into account during each calendar year, bears to:

(A) the sum of—
(i) the covered entity's net premiums written with respect to any United States health risk, and
(ii) the sum of—
(A) the sum of—
(i) the aggregate net premiums written with respect to any United States health risk that are taken into account during the preceding calendar year, bears to
(B) the sum of—
(i) the aggregate net premiums written with respect to any United States health risk, plus
(ii) 200 percent of the aggregate third party administration agreement fees that are taken into account during the preceding calendar year.

The percentage of net premiums written that are taken into account is:

Not more than $25,000,000 ................................................................. 0 percent
More than $25,000,000 but not more than $50,000,000 ................. 50 percent
More than $50,000,000 ........................................................................ 100 percent.

The percentage of third party administration agreement fees that are taken into account is:

Not more than $5,000,000 ................................................................. 0 percent
More than $5,000,000 but not more than $10,000,000 ................. 50 percent
More than $10,000,000 ........................................................................ 100 percent.

(2) PENALTY FOR FAILURE TO REPORT.—
(A) IN GENERAL.—Not later than the date determined by the Secretary, each covered entity shall pay to the Secretary not later than the annual payment date of each calendar year beginning after 2009 a fee in an amount determined under subsection (b).

(2) PENALTY FOR FAILURE TO REPORT.—
(A) IMPOSITION OF FEE.—Each covered entity engaged in the business of providing health insurance shall pay to the Secretary not later than the date determined by the Secretary, according to the following table:

With respect to such health insurance of all covered entities that are taken into account during each calendar year, bears to:

(A) the sum of—
(i) the covered entity's net premiums written with respect to any United States health risk, and
(ii) the sum of—
(A) the sum of—
(i) the aggregate net premiums written with respect to any United States health risk that are taken into account during the preceding calendar year, bears to
(B) the sum of—
(i) the aggregate net premiums written with respect to any United States health risk, plus
(ii) 200 percent of the aggregate third party administration agreement fees that are taken into account during the preceding calendar year.

The percentage of net premiums written that are taken into account is:

Not more than $25,000,000 ................................................................. 0 percent
More than $25,000,000 but not more than $50,000,000 ................. 50 percent
More than $50,000,000 ........................................................................ 100 percent.

The percentage of third party administration agreement fees that are taken into account is:

Not more than $5,000,000 ................................................................. 0 percent
More than $5,000,000 but not more than $10,000,000 ................. 50 percent
More than $10,000,000 ........................................................................ 100 percent.
under an arrangement under which such em-
ployer self-insures the United States health
risk of its employees.

(f) **Tax Treatment of Fees.—The fees im-
posed under subparagraph (e) shall be consid-
ered to be a tax described in section 2103 of
the Internal Revenue Code of 1986, and which
are used to pay premiums to health insurance
providers for any United States health risk and
third party administration fees for such calendar
year.

(2) **Penalty for Failure to Report.—
(A) **In General.—In the case of any failure
by a covered employer to make a report contain-
ing the information required under paragraph (1) on the date pre-
scribed therefor (determined with regard to
any extension of time for filing), unless it is
shown that such failure is due to reasonable causes
which not less than 25 percent of the gross
income of the covered employer for any taxable year
beginning after December 31, 2012, may be taken into
account under this clause in computing the...

(g) **Reporting Requirement.—
(1) **In General.—Not later than the date de-
termined by the Secretary following the end of
any calendar year, each covered entity shall
report to the Secretary, in such manner as the Secretary prescribes, the cov-
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spect to health insurance for any United States
health risk and third party administration

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“(2) ADDITIONAL TAX.—In addition to the tax imposed by paragraph (1) and the preceding subsection, there is hereby imposed on every taxpayer (other than a corporation, estate, or trust) an additional tax equal to 0.5 percent of the wages which are received with respect to employment (as defined in section 3121(b)) during any taxable year beginning after December 31, 2012, and which are in excess of $200,000, and (B) in any other case, $200,000.

(2) Special Rules for Additional Tax.—

(1) in the case of a joint return, $250,000, and

(2) in any other case, $200,000.

(2) Tax Paid by Recipient.—If an employer, in violation of this chapter, fails to deduct and withhold the tax imposed by section 3101(b)(2) and thereby to pay the tax required to be paid by the employee, the tax so required to be deducted and withheld shall be collected from the employer, this paragraph shall in no case relieve the employer from liabili

(3) Tax Paid by Recipient.—If an employer, in violation of this chapter, fails to deduct and withhold the tax imposed by section 3101(b)(2) and thereby to pay the tax required to be paid by the employee, the tax so required to be deducted and withheld shall not be collected from the employer, but this paragraph shall in no case relieve the employer from liabili

(1) in the case of a joint return, $250,000, and

(2) in any other case, $200,000.

(2) Deduction for Additional Tax.—

(A) in General.—Section 1401(b)(2) of the Internal Revenue Code of 1986 is amended—(B) in any other case, $200,000.

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amended by redesignating subsections (j) and (k) as subsections (k) and (l), respectively, and by inserting after subsection (j) the following new subsection:

(3) SIMPLE CAFETERIA PLANS FOR SMALL BUSINESSES.—

"(1) IN GENERAL.—An eligible employer maintaining a cafeteria plan with respect to which the requirements of this subsection are met for any year shall be treated as meeting any applicable nondiscrimination requirement with respect to such year.

"(2) SIMPLE CAFETERIA PLAN.—For purposes of this subsection, the term 'simple cafeteria plan' means a cafeteria plan—

(A) which is established and maintained by an eligible employer, and

(B) with respect to which the contribution requirements of paragraph (3), and the eligibility and participation requirements of paragraph (4), are met.

(3) CONTRIBUTION REQUIREMENTS.—

(A) IN GENERAL.—The requirements of this paragraph are met if, under the plan the employer is required, without regard to whether a qualified employee makes any salary reduction contribution, to make a contribution to provide qualified benefits under the plan on behalf of each qualified employee in an amount equal to—

(i) 6 percent of the average of the employee's compensation for the plan year, or

(ii) an amount which is not less than the lesser of—

(A) 6 percent of the average of the employee's compensation for the plan year, or

(B) twice the amount of the salary reduction contributions of each qualified employee.

(B) MATCHING CONTRIBUTIONS ON BEHALF OF HIGHLY COMPENSATED AND KEY EMPLOYEES.—The requirements of subparagraph (A)(ii) shall not be treated as met if, under the plan, the rate of contributions with respect to any salary reduction contribution of a highly compensated or key employee at any rate of compensation greater than that with respect to an employee who is not a highly compensated or key employee.

(C) ADDITIONAL CONTRIBUTIONS.—Subject to subparagraph (B), nothing in this paragraph shall be treated as prohibiting an employer from making contributions to provide qualified benefits under the plan in addition to contributions required under subparagraph (A).

(D) DEFINITIONS.—For purposes of this paragraph—

(i) SALARY REDUCTION CONTRIBUTION.—The term 'salary reduction contribution' means, with respect to a cafeteria plan, any amount which is contributed to the plan at the election of the employee and which is not includible in gross income by reason of this section.

(ii) QUALIFIED EMPLOYEE.—The term 'qualified employee' means, with respect to a cafeteria plan, an employee who is not a highly compensated or key employee and who is eligible to participate in the plan.

(iii) HIGHLY COMPENSATED EMPLOYEE.—The term 'highly compensated employee' has the meaning given such term by section 1.414(q).

(iv) KEY EMPLOYEE.—The term 'key employee' has the meaning given such term by section 1.414(q).

(iv) KEY EMPLOYEE.—The term 'key employee' has the meaning given such term by section 1.414(q).

(4) MINIMUM ELIGIBILITY AND PARTICIPATION REQUIREMENTS.—

(A) IN GENERAL.—The requirements of this paragraph shall be treated as met with respect to any year if, under the plan—

(i) all employees who had at least 1,000 hours of service for the preceding plan year are eligible to participate, and

(ii) each employee eligible to participate in the plan may, subject to terms and conditions applicable to all participants, elect any benefit available under the plan.

(B) CERTAIN EMPLOYEES MAY BE EXCLUDED.—For purposes of subparagraph (A)(i), an eligible employee may elect to exclude under the plan employees—

(i) who have not attained the age of 21 before the close of a plan year,

(ii) who have been employed for less than 1 year of service with the employer as of any day during the plan year,

(iii) who are covered under an agreement between the employer and a labor organization which is a collective bargaining agreement if there is evidence that the benefits covered under the cafeteria plan were the subject of good faith bargaining between employee representatives and the employer,

(iv) who are described in section 410(b)(3)(C) (relating to nonresident aliens working outside the United States).

A plan may provide a shorter period of service or younger age for purposes of clauses (i) or (ii).

(5) ELIGIBLE EMPLOYER.—For purposes of this section—

(A) IN GENERAL.—The term 'eligible employer' means, with respect to any year, any employer if such employer employed an average of 200 or more employees on business days during either of the 2 preceding years. For purposes of this subparagraph, a year may only be taken into account if the employer was in existence throughout the year.

(B) EMPLOYERS NOT IN EXISTENCE DURING PRECEDING YEAR.—If an employer was not in existence in the preceding year, the determination under subparagraph (A) shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current year.

(C) GROWING EMPLOYERS TREAT AS SMALL EMPLOYER.—

(i) IN GENERAL.—If—

(A) an employer was an eligible employer for any year (a 'qualified year'), and

(B) such employer establishes a simple cafeteria plan for its employees for such year,

then, notwithstanding the fact the employer fails to meet the requirements of subparagraph (A) for any subsequent year, such employer shall be treated as an eligible employer for such subsequent year with respect to employees (whether or not employees during a qualified year) of any trade or business which was covered by the plan during any qualified year.

(ii) EXCEPTION.—This subparagraph shall cease to apply if the employer employs an average of 200 or more employees on business days during any year preceding any such subsequent year.

(D) SPECIAL RULES.—

(i) PREDECESSORS.—Any reference in this paragraph to an employer shall include a reference to any predecessor of such employer.

(ii) AGGREGATION RULES.—All persons treated as a single employer under subsection (a) or (b) of section 52, or subsection (n) or (o) of section 414, shall be treated as one person.

(5) APPLICATION OF SUBSECTION.—An investment credit made by this section shall apply to years beginning after December 31, 2010.

SEC. 9023. QUALIFYING THERAPEUTIC DISCOVERY PROJECT CREDIT.

(a) IN GENERAL.—Subpart E of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after section 46C the following new section:

"SEC. 46D. QUALIFYING THERAPEUTIC DISCOVERY PROJECT CREDIT.

"(a) IN GENERAL.—For purposes of section 46, the qualifying therapeutic discovery project credit for any taxable year is an amount equal to 50 percent of the qualified investment for such taxable year with respect to any qualifying therapeutic discovery project of an eligible taxpayer.

"(b) QUALIFIED INVESTMENT.—

"(1) IN GENERAL.—For purposes of subsection (a), the qualified investment for any taxable year is the lesser of—

(A) the amount equal to 50 percent of the costs paid or incurred in such taxable year for expenses necessary for and directly related to the conduct of a qualifying therapeutic discovery project,

(B) the amount of qualified therapeutic discovery project costs described in section 41(d).

"(2) LIMITATION.—The amount which is treated as qualified investment for all taxable years with respect to any qualifying therapeutic discovery project shall not exceed the amount certified by the Secretary as eligible for the credit under this section.

"(3) EXCLUSIONS.—The qualified investment for any taxable year with respect to any qualifying therapeutic discovery project shall not take into account any costs—

(A) for remuneration for an employee described in section 1292(f) of title 26, Code of Federal Regulations, or

(B) for interest expenses,

(C) for facility maintenance expenses,

(D) which is identified as a service cost under section 1.263A-4 of title 26, Code of Federal Regulations,

(E) for any other expense as determined by the Secretary as appropriate to carry out the purposes of this section.

"(4) CERTAIN PROGRESS EXPENDITURE RULES APPLICABLE.—In the case of costs described in paragraph (1) that are paid for property of a character subject to an allowance for depreciation, rules similar to the rules of subsections (c)(4) and (d) of section 46 (as in effect on the day before the date of the enactment of the Revenue Reconciliation Act of 1990) shall apply for purposes of this section.

"(5) APPLICABILITY OF SUBSECTION.—An investment credit shall be considered a qualified investment under this subsection only if such investment is made in a taxable year beginning in 2009 or 2010.

"(6) DEFINITIONS.—

"(1) QUALIFYING THERAPEUTIC DISCOVERY PROJECT.—The term 'qualifying therapeutic discovery project' means a project which is designed—

(A) to treat or prevent diseases or conditions by conducting pre-clinical activities, clinical trials, and clinical studies, or carrying out research protocols, for the purpose of securing approval of a product under section 505(b) of the Federal Food, Drug, and Cosmetic Act or section 351(a) of the Public Health Service Act,

(B) to diagnose diseases or conditions or to determine molecular factors related to diseases or conditions by developing molecular diagnostics to guide therapeutic decisions, or

(C) to develop a product, process, or technology to further the delivery or administration of therapeutics.

"(2) ELIGIBLE TAXPAYER.—

"(1) IN GENERAL.—The term 'eligible taxpayer' means—

(A) any business which has a taxable year not more than 250 employees in all businesses of such taxpayer, or

(B) any business which has a taxable year not more than 500 employees in all businesses of such taxpayer.
(m) or (o) of section 414, shall be so treated for purposes of this paragraph. 

(3) FACILITY MAINTENANCE EXPENSES.—The term ‘facility maintenance expenses’ means costs paid or incurred to maintain a facility, including—

(A) mortgage or rent payments, 

(B) insurance payments, 

(C) utility and maintenance costs, and 

(D) costs of employment of maintenance personnel.

(4) QUALIFYING THERAPEUTIC DISCOVERY PROJECT PROGRAM.—

(A) ESTABLISHMENT.—

(i) In general.—Not later than 60 days after the date of the enactment of this section, the Secretary may require during the period beginning on the date the Secretary establishes the program under paragraph (1) the Secretary to maintain and operate a qualifying therapeutic discovery project program to consider and award certifications for qualified investments eligible for credits under this section to qualifying therapeutic discovery project sponsors.

(ii) Limitation.—The total amount of credits that may be allocated under the program shall not exceed $1,000,000,000 for the 2-year period beginning with 2009.

(B) APPLICABILITY.—

(i) In general.—Each applicant for certification under this paragraph shall submit an application containing such information as the Secretary may require during the period beginning on the date the Secretary establishes the program under paragraph (1) at the stated election of the applicant.

(ii) Certification.—The Secretary shall take action to approve or deny any application under subparagraph (A) within 30 days of the submission of such application.

(C) MULTI-YEAR APPLICATIONS.—An application for certification under subparagraph (A) may include a request for an allocation of credits for more than 1 of the years described in paragraph (1)(B).

(D) SELECTION CRITERIA.—In determining the qualifying therapeutic discovery projects with respect to which qualified investments may be certified under this section, the Secretary—

(i) shall take into consideration only those projects that show reasonable potential—

(A) to result in new therapies—

(B) to prevent, detect, or treat chronic or acute diseases and conditions,

(C) to reduce long-term health care costs in the United States,

(D) to significantly advance the goal of curing cancer within the 30-year period beginning on the date the Secretary establishes the program under paragraph (1)

(E) to take into consideration which projects have the greatest potential—

(i) to create and sustain (directly or indirectly) high quality, high-paying jobs in the United States, and

(ii) to advance United States competitiveness in the fields of life, biological, and medical sciences.

(E) DISCLOSURE OF ALLOCATIONS.—The Secretary shall, upon making a certification under this subsection, publicly disclose the identity of the applicant and the amount of the credit with respect to such applicant.

(F) SPECIAL RULES.—

(A) BASIS ADJUSTMENT.—For purposes of this section, if a credit is allowed under this section for an expenditure related to property of a character subject to an allowance for depreciation, the basis of such property shall be reduced by the amount of such credit.

(B) DENIAL OF DOUBLE BENEFIT.—

(1) In general.—No credit shall be allowed under this section for any investment for which bonus depreciation is allowed under section 168(k)(1), 14001(b)(1), or 14001(d)(1).

(2) B&Ductions.—No deduction under this subtitle shall be allowed for the portion of the expenses otherwise allowable as a deduction taken into account in determining the credit under this section for the taxable year which is equal to the amount of the credit determined for such taxable year under subparagraph (A) attributable to such portion.

This subparagraph shall not apply to expenses related to property of a character subject to an allowance for depreciation which is reduced under paragraph (1), or which are described in section 280C(e).

(3) CREDIT FOR RESEARCH ACTIVITIES.—

(i) In general.—Except as provided in clause (ii), any expenses taken into account under this section for a taxable year shall not be taken into account for purposes of determining the credit allowable under section 41 or 45C for such taxable year.

(ii) Exclusion.—For purposes of applying section 41 to subse-

quent taxable years.

(4) COORDINATION WITH DEPARTMENT OF TREASURY GRANTS.—Except as provided in clause (ii), the amount of such grant shall be determined without regard to any reduction in the amount of the credit determined under such section (a) attributable to such portion. This subparagraph shall not apply to expenses related to property of a character subject to an allowance for depreciation the basis of which is reduced under paragraph (1), or which is equal to the amount of the credit determined for such taxable year under section 48D(a), reduced by—

(A) the amount disallowed as a deduction by reason of section 48D(d)(2)(B), and

(B) the amount of any basis reduction under section 48D(e)(1).

(5) SIMILAR RULE WHERE TAXPAYER CAPITALIZES RATHER THAN DEDUCTS EXPENSES.—

(A) In general.—No credit shall be allowed for any taxable year for expenses (as defined in section 41(b)) other-

wise allowable as a deduction for the taxable year which—

(i) would be qualified research expenses (as defined in section 41(b)), basic research expenses (as defined in section 41(e)(2)), or qualified clinical testing expenses (as defined in section 45C(b)) if those expenses were otherwise allowed with respect to such expenses for such taxable year, and

(ii) is reduced under paragraph (1), or which are described in section 280C(e).

(6) QUALIFYING THERAPEUTIC DISCOVERY PROJECT CREDIT.—

(A) In general.—No deduction shall be allowed for that portion of the qualified investment (as defined in section 48D(b)) otherwise allowable as a deduction for the taxable year which—

(i) would be qualified research expenses (as defined in section 41(b)), basic research expenses (as defined in section 41(e)(2)), or qualified clinical testing expenses (as defined in section 45C(b)) if those expenses were otherwise allowed with respect to such expenses for such taxable year, and

(ii) is equal to the amount of the credit determined for such taxable year under section 48D(a), reduced by—

(A) the amount of any basis reduction under section 48D(e)(1), and

(B) the amount of any reduction under section 48D(e)(2).

(7) APPLICATION.—

(A) IN GENERAL.—At the stated election of the applicant, an application for certification under section 48D(a)(1)(A) of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 48C the following new item:

"Sec. 48D. Qualifying therapeutic discovery project credit.

(8) GRANTS FOR QUALIFIED INVESTMENTS IN THERAPEUTIC DISCOVERY PROJECTS IN LIEU OF TAX CREDITS.—

(A) IN GENERAL.—Upon application, the Secretary of the Treasury shall, to the extent provided for in this subsection, provide a grant to each person who makes a qualified investment in a qualifying therapeutic discovery project in the United States who provides such investment. No grant shall be made under this subsection with respect to any investment unless such investment is made during a taxable year beginning in 2009 or 2010.

(B) GRANTS TO CONTROLLING GROUPS.—A grant shall include such information and be in such a form as to reflect—

(i) the amount of the credit determined for such taxable year with respect to such credit, exceeds

(ii) the amount allowable as a deduction for such taxable year for such expenses (determined without regard to paragraph (1)), the amount chargeable to capital account for the taxable year for such expenses shall be reduced by the amount of such excess.

(iii) 50 percent of such excess.

(iv) the requirements of this subsection, provide a grant to each person who makes a qualified investment in a qualifying therapeutic discovery project in the United States who provides such investment. No grant shall be made under this subsection with respect to any investment unless such investment is made during a taxable year beginning in 2009 or 2010.

(9) APPLICABILITY.—

(A) IN GENERAL.—At the stated election of the applicant, an application for certification under section 48D(a)(1)(A) of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 48C the following new item:

"Sec. 48D. Qualifying therapeutic discovery project credit.

(10) GRANTS FOR QUALIFIED INVESTMENTS IN THERAPEUTIC DISCOVERY PROJECTS IN LIEU OF TAX CREDITS.—

(A) IN GENERAL.—Upon application, the Secretary of the Treasury shall, to the extent provided for in this subsection, provide a grant to each person who makes a qualified investment in a qualifying therapeutic discovery project in the United States who provides such investment. No grant shall be made under this subsection with respect to any investment unless such investment is made during a taxable year beginning in 2009 or 2010.

(B) GRANTS TO CONTROLLING GROUPS.—A grant shall include such information and be in such a form as to reflect—

(i) the amount of the credit determined for such taxable year with respect to such credit, exceeds

(ii) the amount allowable as a deduction for such taxable year for such expenses (determined without regard to paragraph (1)), the amount chargeable to capital account for the taxable year for such expenses shall be reduced by the amount of such excess.

(iii) 50 percent of such excess.

(iv) the requirements of this subsection, provide a grant to each person who makes a qualified investment in a qualifying therapeutic discovery project in the United States who provides such investment. No grant shall be made under this subsection with respect to any investment unless such investment is made during a taxable year beginning in 2009 or 2010.

(11) APPLICABILITY.—

(A) IN GENERAL.—At the stated election of the applicant, an application for certification under section 48D(a)(1)(A) of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 48C the following new item:

"Sec. 48D. Qualifying therapeutic discovery project credit.

(12) GRANTS FOR QUALIFIED INVESTMENTS IN THERAPEUTIC DISCOVERY PROJECTS IN LIEU OF TAX CREDITS.—

(A) IN GENERAL.—Upon application, the Secretary of the Treasury shall, to the extent provided for in this subsection, provide a grant to each person who makes a qualified investment in a qualifying therapeutic discovery project in the United States who provides such investment. No grant shall be made under this subsection with respect to any investment unless such investment is made during a taxable year beginning in 2009 or 2010.

(B) GRANTS TO CONTROLLING GROUPS.—A grant shall include such information and be in such a form as to reflect—

(i) the amount of the credit determined for such taxable year with respect to such credit, exceeds

(ii) the amount allowable as a deduction for such taxable year for such expenses (determined without regard to paragraph (1)), the amount chargeable to capital account for such taxable year for such expenses shall be reduced by the amount of such excess.

(iii) 50 percent of such excess.

(iv) the requirements of this subsection, provide a grant to each person who makes a qualified investment in a qualifying therapeutic discovery project in the United States who provides such investment. No grant shall be made under this subsection with respect to any investment unless such investment is made during a taxable year beginning in 2009 or 2010.

(13) APPLICABILITY.—

(A) IN GENERAL.—At the stated election of the applicant, an application for certification under section 48D(a)(1)(A) of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 48C the following new item:

"Sec. 48D. Qualifying therapeutic discovery project credit.

(14) GRANTS FOR QUALIFIED INVESTMENTS IN THERAPEUTIC DISCOVERY PROJECTS IN LIEU OF TAX CREDITS.—

(A) IN GENERAL.—Upon application, the Secretary of the Treasury shall, to the extent provided for in this subsection, provide a grant to each person who makes a qualified investment in a qualifying therapeutic discovery project in the United States who provides such investment. No grant shall be made under this subsection with respect to any investment unless such investment is made during a taxable year beginning in 2009 or 2010.
such form as the Secretary may require to state the amount of the credit allowable (but for the receipt of a grant under this subsection) under section 48D for the taxable year to which the investment relates with respect to such application is made.

(3) TIME FOR PAYMENT OF GRANT.—

(A) IN GENERAL.—The Secretary of the Treasury shall make payment of the amount of any grant under paragraph (1) during the 30-day period beginning on the later of—

(i) the date of the application for such grant; or

(ii) the date the qualified investment for which the grant is being made is made.

(B) REGULATIONS.—In the case of investments of a nature, the Secretary shall issue regulations to determine the date on which a qualified investment shall be deemed to have been made for purposes of this paragraph.

(4) QUALIFIED INVESTMENT.—For purposes of this subsection, the term “qualified investment” means a qualified investment that is certified under section 48D(k) of the Internal Revenue Code of 1986 for purposes of the credit under such section 48D.

(5) APPLICATION OF CERTAIN RULES.—

(A) IN GENERAL.—In making grants under this subsection, the Secretary of the Treasury shall apply rules similar to the rules of section 50 of the Internal Revenue Code of 1986.

(B) EFFECTIVE DATE.—The amendments made by paragraphs (1) through (d) of this section shall apply to grants made after November 19, 2009.

(6) RECAPTURE OF EXCESSIVE GRANT AMOUNTS.—If the amount of a grant made under this subsection exceeds the amount allowable under a grant under this subsection, such excess shall be recaptured under subparagraph (A) as if the investment to which such excess portion of the grant relates had ceased to be a qualified investment immediately after such grant was made.

(ii) GRANT INFORMATION NOT TREATED AS RETURN INFORMATION.—In no event shall the amount of a grant made under this subsection exceed the amount allowable under a grant under this subsection.

(iv) EFFECTIVE DATE.—The amendments made by subsections (a) through (d) of this section shall apply to amounts paid or incurred in taxable years beginning after such date.

NOTICE OF HEARING

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. BINGAMAN. Mr. President, I would like to announce for the information of the Senate and the public that a hearing has been called before the Senate Committee on Energy and Natural Resources. The hearing will be held on Thursday, December 3, 2009, at 10 a.m., in room SD–366 of the Dirksen Senate Office Building.

The purpose of the hearing is to receive testimony on H.R. 3276, the American Medical Isotopes Production Act of 2009. Because of the limited time available for the hearing, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record may do so by sending it to the Committee on Energy and Natural Resources, United States Senate, Washington, D.C. 20510–6150, or by e-mail to Rosemarie Calabro at energy.senate.gov.

For further information, please contact Jonathan Epstein at (202) 224–3357 or Rosemarie Calabro at (202) 224–5039.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON ARMED SERVICES

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Armed Services be authorized to meet during the session of the Senate on November 19, 2009, at 9:30 a.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on November 19, 2009, at 10:30 a.m., in room SD–366 of the Dirksen Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON JUSTICE

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Justice be authorized to meet during the session of the Senate on November 19, 2009, at 2:30 p.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Transportation and Infrastructure be authorized to meet during the session of the Senate on November 19, 2009, at 3:30 p.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Energy and Natural Resources be authorized to meet during the session of the Senate on November 19, 2009, at 10 a.m., in room SD–366 of the Dirksen Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on November 19, 2009, at 3:30 p.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Health, Education, Labor, and Pensions be authorized to meet, during the session of the Senate, to conduct a hearing entitled “Hearing on Nominations for Commissioner for General Counsel of the Equal Employment Opportunity Commission” on November 19, 2009. The hearing will commence at 10 a.m. in room 430 of the Dirksen Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON HOME SECURITY AND GOVERNMENTAL AFFAIRS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Homeland Security and Governmental Affairs be authorized to meet during the session of the Senate on November 19, 2009, at 1:30 p.m., in room Dirksen Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON INDIAN AFFAIRS

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on Indian Affairs be authorized to meet during the session of the Senate on November 19, 2009, at 12:30 p.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON JUDICIARY

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate on November 19, 2009, at 10:30 a.m., in room Dirksen Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE SENATE

Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on the Senate be authorized to meet during the session of the Senate on November 19, 2009, at 9:30 a.m., in room Dirksen Senate Office Building.

The PRESIDING OFFICER. Without objection, it is so ordered.
Mr. DURBIN. Mr. President, I ask unanimous consent that the Committee on the Judiciary be authorized to meet during the session of the Senate on November 19, 2009, at 10 a.m. in SD-226 of the Dirksen Senate Office Building, to conduct an executive business meeting.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DURBIN. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on November 19, 2009, at 2:30 p.m.

The PRESIDING OFFICER. Without objection, it is so ordered.

PRIVILEGES OF THE FLOOR

Mr. AKAKA. Mr. President, I ask unanimous consent that Dr. Andrea Buck, a physician detailed to the Veterans' Affairs Committee staff from the VA Inspector General's Office be granted the privilege of the floor for the duration of the debate on S. 1963.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. LEAHY. Mr. President, I ask unanimous consent that Rachel Pelham of my staff be given the privilege of the floor for the rest of the day.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. Mr. President, I ask unanimous consent for Randee Dice, a detailee on my staff, Ben Bremen, Anne Pick, and Joseph Moon, interns on my staff, be granted the privileges of the floor during debate of H.R. 3590.

The PRESIDING OFFICER. Without objection, it is so ordered.

IRAN’S HUMAN RIGHTS VIOLATIONS

Mr. KAUFMAN. Mr. President, I ask unanimous consent that the Senate proceed to the immediate consideration of S. Res. 355, submitted earlier today.

The PRESIDING OFFICER. The clerk will report the resolution by title.

The legislative clerk read as follows:

A resolution (S. Res. 355) expressing the sense of the Senate that the Government of the Islamic Republic of Iran has systematically violated its obligations to uphold human rights provided for under its constitution and international law.

There being no objection, the Senate proceeded to consider the resolution.

Mr. GRASSLEY. Mr. President, recent events have made abundantly clear that the Government of the Islamic Republic of Iran is failing, and failing badly, to live up to its own professed ideals and its international commitments to protect the human rights of its citizens and others. I urge my colleagues to join with me in supporting a resolution, S. Res. 355, submitted today, condemning Iran’s deplorable human rights record, calling for an immediate release of those wrongfully imprisoned in violation of their rights, and urging the restoration of meaningful human rights to all of Iran’s citizens.

Iran’s 1979 constitution, the result of a revolution against years of political and human-rights abuses by the regime of the Shah, guarantees fundamental rights and freedoms. Moreover, Iran is a signatory to four major human rights treaties and yet its shameful record of executions that contravene international standards; of repression of the rights of women and minorities, including religious minorities; of outrageous attacks on the rights of peaceful assembly and protest; and of un warranted arrest and detention of foreigners, including Americans, all make a mockery of these commitments.

Just last week, the Iranian Government again demonstrated its contempt for human rights and the rule of law when it announced it would pursue espionage charges against three young Americans who crossed Iran’s border with Iraq. These allegations are just the latest telling example on a long list of abuses.

American Robert Levinson has been missing in Iran for more than two years, during which the Iranian regime has denied having any information on his whereabouts and has blocked international attempts to discover his fate. In January 2009, the Iranian Government jailed Iranian-American journalist Roxana Saberi and charged and convicted her of espionage after a one-hour show trial that mocked even the most basic standards of due process and law, and then sentenced her to eight years in prison before releasing her a few months later. Esha Momeni, a student at California State University, Northridge, was imprisoned last fall for her peaceful activities in support of women’s rights in Iran. The regime’s abuses have even touched Nobel peace prize winner Shirin Ebadi, whose Center for Defenders of Human Rights was forced to close by the government in December 2008.

None of these recent abuses, however, as deplorable as they are, have shocked the conscience of the world so severely as the Iranian Government’s actions in response to this year’s disputed presidential elections. Prompted by justifiable outrage, Wael al-Babb, who had been threatened in a rigged election, thousands of Iranian citizens took to the streets, firmly but peacefully exercising their rights and demanding the democracy their government purports to embody. The regime’s response was to launch violent, heavy-handed attacks against these peaceful protestors, using government security forces and paramilitary militias under government control to repress the legitimate expression of a valid grievance.

The United Nations High Commissioner for Human Rights reports that this violence resulted in at least a dozen deaths, and hundreds of injuries.

In the aftermath, the Iranian Government imprisoned dozens of its citizens and conducted a mass trial of more than 100 of them, many of whom bore clear signs of physical abuse. The government sentenced at least four of these prisoners to death on the basis of dubious confessions, likely produced under duress and abuse.

It is proper and appropriate for the Senate to make clear its determination that these acts violate international human rights standards, Iran’s own professed commitments, and common decency.

The resolution introduced today would record the Senate’s condemnation of Iran’s woeful human rights record; remind the Iranian government of its domestic and international commitments to human rights; call for the immediate release of all those held for their peaceful exercise of rights of free expression, assembly and association; and urge Iran to extend full legal rights to those imprisoned.

It is a tragic irony that the government perpetrating these deplorable acts of violence and abuse came to power three decades ago because the Iranian people rejected the abuses and violence of a previous regime. Now, following in the repressive footsteps of that previous regime, the current Iranian Government has been widely condemned by the community of nations. Passage of this resolution would add the U.S. Senate’s loud and clear voice of condemnation to the many voices inside Iran, and out, calling for the restoration of basic human rights for the Iranian people.

Mr. KAUFMAN. I ask unanimous consent that the resolution be agreed to, the preamble be agreed to, and the motions to reconsider be laid upon the table on bloc; that any statements relating to the resolution be printed in the Record without intervening action or debate.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 355) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. Res. 355

Whereas the 1979 Constitution of the Islamic Republic of Iran supposedly guarantees certain human rights and fundamental freedoms, which encompass civil and political rights, along with economic, social, and cultural rights;

Whereas the Islamic Republic of Iran is a party to four major United Nations human rights treaties: the Convention on the Rights of the Child (which it ratified on July 13, 1994), the International Convention on the
Elimination of All Forms of Racial Discrimination (which it ratified on August 29, 1968), and the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights (both of which it ratified on June 24, 1975); and

Whereas the Government of Iran has routinely violated the human rights of its citizens, including—

(1) torture and cruel, inhuman, or degrading treatment or punishment, including floggings, amputations;

(2) high incidence and increase in the rate of executions carried out in the absence of internationally recognized safeguards, including public executions and executions of juvenile offenders;

(3) stoning as a method of execution and persons in prison who continue to face sentences of execution by stoning;

(4) arrests, violent repression, and sentencing of women exercising their right to peaceful assembly, a campaign of intimidation against women’s rights defenders, and continuing discrimination against women and girls;

(5) increasing discrimination and other human rights violations against persons belonging to religious, ethnic, linguistic, or other minorities;

(6) ongoing, systematic, and serious restrictions on peaceful assembly and association and freedom of opinion and expression, including the continuing closures of media outlets, arrests of journalists, and the censorship of expression in online forums such as blogs and websites; and

(7) severe limitations and restrictions on freedom of religion and belief, including arbitrary and indefinite detention, and lengthy jail sentences for those exercising their right to freedom of religion or belief, including a provision in the proposed draft penal code that sets out a mandatory death sentence for apostasy, the abandoning of one’s faith;

Whereas, since March 9, 2007, Robert Levinson, a graduate student at California State University, Northridge, for her peace-}

Whereas the Government of Iran does not allow independent nongovernmental associations and labor unions to perform their role in peacefully defending the rights of all persons;

Whereas, on November 4, 2009, security forces in the Islamic Republic of Iran used lethal force against peaceful demonstrators, resulting in a number of injuries and arrests, in violation of international standards regarding the proportionate use of force against peaceful protesters;

Whereas the Government of Iran expelled students from universities, particularly over the past two years, in reprisal for their being critical of the government;

Whereas the Government of Iran has imposed restrictions on the travel of individuals, including journalists, on the recent elections, in reprisal for their political views or their criticism of the government, such as those presently imposed on human rights lawyer Abdolfattah Soltani, human rights activist Emad Baghi, film director Jafar Panahi, and actress Fatemeh Motamed Arya; and

Whereas, according to Amnesty International, at least 346 people were known to have been executed in 2008, including eight juvenile offenders and two men who were executed by stoning, therefore, be it

Resolved, That the Senate—

(1) calls for authorities in the Islamic Republic of Iran to respect the rights of the people of Iran to freedom of speech, press, religion, association, and assembly;

(2) condemns the Government of Iran’s human rights violations and calls on the Government of Iran to hold those responsible accountable for their actions;

(3) reminds the Government of Iran of its constitutional obligations under the Islamic Republic of Iran constitution and four international covenants to which it is a signatory;

(4) calls for the immediate release from detention of all political prisoners, human rights defenders, journalists, and all others held for peacefully exercising their right to expression, assembly, and association;

(5) urges the Government of Iran to ensure that anyone placed on trial for committing acts of violence or other clearly criminal acts benefits from all of his or her rights to a fair trial, including proceedings that are open to the public, the right to be represented by independent counsel, and guarantees that no statements shall be admitted into evidence that were obtained through torture, inhumane, or degrading treatment;

(6) calls for the Government of Iran to ensure that those suspects and detainees are treated humanely, to provide detainees immediate prompt access to their families, lawyers, and any medical treatment that may be needed, and calls for the Government of Iran to hold accountable those responsible for torture of detainees; and

(7) calls for authorities in the Islamic Republic of Iran, consistent with their obligations under the International Covenant on Civil and Political Rights, to guarantee all persons the “freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of his choice”.

ORDER FOR PRINTING OF AMENDMENT NO. 2786

Mr. KAUFMAN. I ask unanimous consent that amendment No. 2786 be printed.

The PRESIDING OFFICER. Without objection, it is so ordered.

APPOINTMENT

The PRESIDING OFFICER. The Chair, on behalf of the President pro tempore, and in consultation with the ranking member of the Senate Committee on Finance, pursuant to Public Law 103–256, appoints Jagadeesh Gokhale, of Maryland, vice Sylvester Schieber, of Michigan, as a member of the Social Security Advisory Board.

ORDERS FOR FRIDAY, NOVEMBER 20, 2009

Mr. KAUFMAN. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 9:45 a.m. tomorrow, Friday, November 20, that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume debate on the motion to proceed to H.R. 3590, as provided for under the previous order.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. KAUFMAN. Mr. President, there will be no rollover call votes during tomorrow’s session of the Senate. The next vote will occur at 8 p.m. on Saturday, November 21. That vote will be on the motion to invoke cloture on the motion to proceed to H.R. 3590.

ORDER FOR ADJOURNMENT

Mr. KAUFMAN. If there is no further business to come before the Senate, I ask unanimous consent that it adjourn under the previous order, following the remarks of Senators BROWNBACK and HATCH.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Utah.

Mr. HATCH. Mr. President, I thank my colleague.
HEALTH CARE REFORM

Mr. HATCH. Mr. President, I would like to take my time to talk about the critical issue of health care reform as this body stands at a historic crossroad on this national challenge.

We have never seen anything like the issue of health care reform being pushed in our country's history. The line between private businesses and public government has never been so blurred. Just look at this chart I have in the Chamber. Government effectively owns several of our Nation's institutions: financial institutions, banks and automobile manufacturers. CEOs have been fired by government bureaucrats, and Washington is now in the business of dictating salaries in the private sector. With government takeovers on the rise, drastic labor law changes being pushed forward, and sweeping new corporate taxes circling overhead, we are truly moving toward a European-style government at a time when most European countries are moving away from it.

I deliver these remarks with a heavy heart because what could have been a strong, bipartisan bill reflecting our collective and genuine desire for responsible health care reform on one-sixth of the American economy continues to be an extremely partisan exercise, pushing for more Federal spending, bigger government, and higher taxes as a flawed solution.

At the outset, let me make one point as clear as possible. We are all for reform, everybody on this floor. Every Republican colleague whom I have talked to wants to reform our current health care system. Ensuring access to affordable and quality health care for every American is not a Republican nor is it a Democrat issue or idea; it is an American issue. Our Nation expects us to solve this challenge in an open, honest, and responsible manner.

Clearly, health care spending continues to rise fast. This year will mark the largest ever 1-year jump in the health care share of our GDP—a full percentage point, to 17.6 percent. Growing health care costs translate directly into higher coverage costs.

Since the last decade, the cost of health coverage has increased by 120 percent—three times the growth of inflation and four times the growth of wages. Rising costs is the primary driver behind why we continue to see a rising number of our fellow Americans finding it hard to compete in a global market. Without addressing this central problem, we cannot have a real and sustainable health care reform bill.

Unfortunately, the Senate health bill, according to the nonpartisan Congressional Budget Office, will actually increase Federal spending by $160 billion in the next 10 years instead of lowering it. Mr. President, you heard me right—spending increases.

After the rushed stimulus bill, Americans are rightly concerned about what is being pushed through this Democratic Congress. The rush to pass something that will affect every American life and business has raised concerns all around our Nation. In a recent Gallup Poll, a majority of Americans believed their health care costs could actually get worse under the Democratic health care bill. Americans so skeptical and concerned? Because they are being promised the impossible. They are being told that this trillion-dollar addition of taxpayer dollars to our health care system will actually improve health care. So long as we don't raise their taxes, and it will reduce the Federal deficit. Even David Copperfield would be hard pressed to pull off this trick.

Many Americans recently had a firsthand encounter with the efficiency of the Federal Government in administering the H1N1 vaccination around the country. Their experience consisted of standing in long lines for several hours in sterile government buildings, only to be told they were suddenly out of doses.

Republicans in Congress agree with the majority of Americans who believe that just throwing more hard-earned taxpayer dollars at a problem will not deliver real health care benefits; it is simply telling the American people that the solution for solving a $2 trillion health care system is to simply spend another $2.5 trillion just does not make sense. With nearly a half trillion dollars in new taxes in this pile—this piece of equipment, this book—this paper is a textbook example of the liberal tax-and-spend philosophy. Now compare that with the Constitution of the United States. This little book contains the whole Constitution of the United States. Yet we have a health care bill that is 2,024 pages long. Come on. That is an example of the liberal tax-and-spend philosophy we see around here.

Here are some of the highlights of this piece of equipment, this bill, this massive, massive bill: I can hardly lift the darn thing—$28 billion in new taxes on employers through a mandate that will disproportionately affect low-income Americans, and all at a time when our unemployment rate stands at an unacceptable 10.2 percent; $8 billion in new taxes on Americans who fail to buy a Washington-defined level of health care coverage; $372 billion in new taxes on everything from prescription drugs, to hearing devices and wheelchairs—all of which are going to be passed on to the consumers, most all of whom are earning less than $20,000 a year. As I said, there is no such thing as a free lunch, especially when Washington is inviting you to partake.

Representatives from both the Congressional Budget Office, CBO, and the Joint Committee on Taxation, JCT, have testified before the Finance Committee that these taxes will be passed on to the consumers. That is you and me and every other constituent in this country. So even though the bill tries to hide these costs as indirect taxes, average Americans who purchase health plans, use prescription drugs, and buy medical devices—everything from hearing aids to crutches—will end up footing the bill.

By the way, we all know when this bill is fully implemented it will push the deficit significantly higher. Every time Washington tells you something will cost $1, you can count on it costing $10. History is a dismal problem. Medicare started off with a $65 million—that is with an “m”—a year budget and now it has a $400 billion, or $4 trillion, budget. So long as we don't raise their taxes, and it will reduce the Federal deficit. Even David Copperfield would be hard pressed to pull off this trick.

Let me also talk a little bit about the myth of this health care reform proposal actually reducing the deficit. Here is the harsh reality: The Congressional Budget Office recently reported that our national deficit for fiscal year 2009 alone was a shocking $1.4 trillion. We put this into perspective. We have exploding deficits. In 2008, it was $459 billion—the last year of the Bush administration. In the first year of the Obama administration, it is $1.4 trillion. It is more than three times our deficit from last year—last year was almost 10 percent of the entire economy. This is the largest yearly deficit since 1945. This should send shivers down the spine of every American out there. We are literally drowning this Nation and its future in this sea of red ink.

The biggest bait-and-switch on the American people about the bill’s impact on the deficit is a simple math trick. If something is expensive to do for a full 10-year period, just do it for 5 years and call it 10 years. Most of the major spending provisions of the bill do not go into effect until 2014 or even later—coincidentally, after the 2012 Presidential elections. So what we are doing is not a full 10-year score but, rather, a 5- to 6-year score.

Now chart 3: This is the real cost of the Senate plan. The CBO score—because it only scores, really, basically 5 or 6 years because major provisions of the bill are not implemented until 2014, in some respects up to 2015—they claim, is only $849 billion, or less than $1 trillion. But the full 10-year score, according to the Senate Budget Committee, fully implemented, if you do it for 10 years, is $2.5 trillion. The House bill is even at a more astonishing level of $3 trillion.

Let me go to chart 4, because in our current fiscal environment, where the government will have to borrow nearly 45 cents of every $1 it spends this year, let's think hard about what we are doing to our country and our future generations.

For months, I have been pushing for a fiscally responsible and step-by-step proposal that recognizes our current need for spending restraints while starting us on a path to sustainable health care reform. There are several areas of consensus that can form the
Republicans have put forth ideas, both comprehensive and incremental, through this health care reform debate, especially during committee considerations. These ideas were either summarily rejected on party line votes or simply stripped out in the dark of the night before the final version was released. And this version is no exception. This version was done in the back rooms of the Capitol with the White House and very few Senators cobbling together what they thought would be a compromise between the HELP bill and the Finance Committee bill, and maybe even with some consideration to the House bill. There was no real bipartisan work on this bill. There was no real attempt to try and bring people together. It was strictly a partisan bill, as have been the HELP Committee bill, primarily the Finance Committee bill, and above all, the House bill. I am absolutely disappointed that the President and the Democratic leadership in the House and the Senate have chosen to pursue the creation of a new government-run plan—one of the most divisive issues in health care reform—rather than focusing on broad areas of compromise toward a bipartisan health care reform legislation. At a time when major government programs such as Medicare and Medicaid are already on a path to fiscal insolvency, creating a brand new government-run plan too soon could weaken our long-term financial outlook. To put this in perspective, as of this year, Medicare has a liability of almost $38 trillion, which, in turn, translates into a financial burden of more than $300,000 per American family over time.

So what is the Washington solution to address this crisis? We will take up to $500 billion out of this bankrupt program and use it to expand another bankrupt program—Medicaid—and create a brand new government-run plan, a Washington government-run plan. I am not an economist, but I know that taking money out of one bankrupt program to create another is not a good idea. We should be reforming Medicare and Medicaid for our people, but instead we keep spending, and to take $500 billion out of Medicaid which has a $38 trillion unfunded liability to create another government run program I think is immoral. It is certainly not the right approach and not enough money to continue going, but the point here is simple: Washington is not the answer.

The impact of a new government program on families who currently have private insurance of their choice is also alarming. A recent study estimated that cost shifting from government payers already costs families with private insurance nearly $1,800 more per year. This is nothing more than an economic shell game, between you and me. It's just not enough. It is our friends over in Medicare who currently have coverage they like by making it more affordable—this means reducing costs by rewarding quality and coordinated care, by giving families more information on the cost and choices of coverage and payment options, by discouraging frivolous lawsuits, and by promoting prevention and wellness measures.

We should give States flexibility to design their own unique approaches to health care reform in accordance with their own demographics. Utah is not New York and New York is not Utah. Actually, what works in New York will most likely not work in New York, let alone in Utah. We need to move forward with health care reform, it is important to recognize that every State has its own unique mix of demographics and each State has developed its own institutions to address its challenges. And each has successes.

There is an enormous reservoir of expertise, experience, and field-tested reform out there. We should take advantage of that by placing States at the center of health care reform efforts so they can use approaches that best reflect their needs and challenges. We should utilize the principle of federalism by having 50 State laboratories where we can look at the other States and see what works and what doesn't work. Utah is a State where we have a tremendous health care system. It is rated one of the top three in this Nation. Wouldn't other States be benefited by looking at the Utah system, or Minnesota? The Minnesota system is a very good system, according to what they tell me. We could learn from them. You could learn from all 50 States what to do and what not to do. Utah is a model and important and innovative steps toward sustainable health care reform. The current efforts to introduce a defined contribution health benefits system and implement the Utah Health Exchange are laudable accomplishments.

Just like you, I strongly believe a one-size-fits-all Washington solution is not the right approach. We should empower small businesses and self-employed—the job-creating engines and lifeblood of our economy—to buy affordable coverage by giving them the same purchasing advantages as the large companies.

Unfortunately, the path we are taking in Washington right now is simply spend another $2.5 trillion of taxpayer money to further expand the role of the Federal Government. Republicans want to sit down and write a bill together to achieve sustainable reform that we can all afford. We do not believe in the “our way or the highway” approach on an issue that will affect every American life and every American business.

The impact of a new government program on families who currently have private insurance of their choice is also alarming. A recent study estimated that cost shifting from government payers already costs families with private insurance nearly $1,800 more per year. This is nothing more than another hidden government tax. Do you think Congress can do this kind of work in 72 hours? This is a shell bill. If they proceed, then they will bring up a substitute bill which will be the bill they have worked on for 6 weeks in closed rooms. It will be a shell bill that will get it done. It is a shell game, between you and me. It is our friends over in Washington by people who believe the Federal Government is the last answer to everything.

As a bill that affects every American life and every American business, 2,074 pages is too big and it is too important not to have full public review. In fact, I think 72 hours is not enough. We need a lot more time. We are talking about one-sixth of the American economy. To enact true health care reform, we have to come together as one to write a responsible bill for the American families who are faced with rising unemployment and out-of-control health care costs.

Our national debt is ready to double in the next 5 years. Look at that. The red lines are projected national debt under the current administration. That debt is projected to double in the next 5 years and triple in the next 10 years. Let me tell you who catches onto this. It is our friends over in China to whom we owe $800 billion. Think about it. They are concerned about the devaluation of the American dollar because they see us being profligate here in Washington.

Let's slow down and think about what we are doing to our future generations. I think there is still time to press the reset button and write a bill together that every one of us can support and be proud of. Right now, Republicans aren't just standing in the way. We actually believe we can do a bipartisan bill if we had a chance, if we had a real, good faith effort by both sides. The HELP Committee bill wasn't done that way. We did have a markup in the HELP Committee and almost every one of our amendments was voted down on a party line vote. The same thing basically happened in the Finance Committee, although I have to...
say that the distinguished Senator from Montana, the chairman of the Finance Committee, made every effort to try and bring people together. I give him a lot of credit for it. But he was so severely restricted by his side that there was no way he could succeed at it. I was a member of the Gang of 7, but I began to realize what the final bill was going to be. I couldn’t support it, so I thought the honorable thing to do, instead of coming out of every one of our meetings and finding fault with what they were talking about, was to leave the Gang of 7, and I did that. I felt bad doing it because I wanted to help work on a bipartisan bill. But the distinguished chairman was so restricted by his side that there was no way we could have a bipartisan bill out of that committee. It is disappointing to me, as somebody who has worked on so many health care matters over the years—everything from Hatch-Waxman to the orphan drug bill to the CHIP bill—to do anything that would have the guts or the ability to sit down and work this thing out together.

Now we are going to get sold a bill of goods here that doesn’t make sense. This is a travesty. It is a travesty. It is hard to believe they think they can pawn this off on the American people. My gosh. I know some of the folks who have done this are well intentioned, but not for this stuff. I was going to say something else, but I want to be very kind.

The Constitution—this is the whole Constitution, the most important document, political document in the history of the world. Plus it has a lot of interesting material in the back, plus an index and so forth, but that is it, right there. Here is what one-sixth of the American economy is going to be if we allow it to go forward. I personally believe we ought to kill this bill and then we ought to sit down and work it out the way there were a real bona fide attempt to do that, I have no doubt we could do it. We have done it in the past.

One of the things I found most disappointing is that the polls show that 85 percent of the people who have insurance are relatively happy with it. Yes, they would like premiums to go down, they would like to be able to have it done better, but they are basically happy with their health care coverage. I think we have the 6 million people who work for businesses that provide health insurance but they don’t take it—they would rather have the money—and you deduct the 11 million people who qualify for CHIP, the child health care program, which is a Hatch-Kennedy bill by the way; or they qualified for Medicaid—if you deduct those 11 million people, and then you deduct the 9 million people who earn over $75,000 a year and can afford their own health insurance, and then you subtract the 2 million who are illegal aliens, it comes down to 7 million to 12 million people who need health insurance. Think about that. We are going to throw out the whole system of health care that 85 percent of the people basically believe is worthwhile over. 7 to 12 million people whom we could help in a way that would be reasonable; and we are going to change our health care system in the ground even further, as they have Medicare and Medicaid, without the appropriate reforms that would keep those programs that could be great programs and are great programs in some ways, going. They will say, well, aren’t those government programs? Yes, they are government programs, and they are both deeply in debt, Medicare goes into insolvency by 2017. Medicaid is also going bankrupt. What are we going to do, saddle our young people for the rest of their lives? That saddles them with this huge stack of paper? My gosh. No wonder are in such deep financial difficulties in this country.

If we are going to rely on the Federal Government to solve our problems, we are making the most tragic mistake we possibly can. The Federal Government could participate, but let me tell you, if we work on a bipartisan bill, let me make one last point. If you have a bill that affects the American economy—and whatever passes here, if it does, will be a bill that will concern with one-sixth of our American economy—if you have a bill that is that important and you can’t get 75 or 80 votes in the Senate, you know that is a lousy bill, and you know it is a partisan bill, and you know that hasn’t been well thought out, and you know it is one sided, and you know it is going to cause an uproar throughout this country; this country has been through this before—it already is—and you know it won’t work, yet we are going to saddle this country with this monstrosity. I have to tell you, I can hardly believe it. I can hardly lift it. I am not exactly weak. All I can say is that it is a huge monstrosity.

Think of the Constitution. There is the whole Constitution right there, yet we have a health care bill this big. I am concerned about it, as you can see, and I am concerned about it, because there are some of us who would like to work together and do a bipartisan bill, but we have to be honest about it, there hasn’t been any chance to do it. This bill in particular has been worked on in the back rooms between the White House and very few Senators, and without any input from our side at all, frankly, ignoring many of the good things that have been expressed on our side.

I hope we will think this through and I hope we won’t pass this. I hope we can then sit down and do a bill that will work, that will not burden our future generations.

I yield the floor.

Mr. PRESIDING OFFICER. The Senator from Kansas is recognized.

Mr. BROWNBACK. Mr. President, I am glad to follow my colleague from Utah. I have great admiration and affection for him. He has done a lot of good, bipartisan legislation. I hope my colleagues will listen to him. He is good to his word, and he would be willing to do a bipartisan bill.

On top of that, if the Democratic leadership would back up and do a bipartisan bill, the American people would cheer. They would think this was an extraordinary, and we could get something substantive done and not this monster.

I am ranking member of the Joint Economic Committee, and we had Secretary Geithner in to testify today. I disagree with a number of things he has done. He is a bright and energetic man with a lot of experience. I noted to him—and he knows this is the case—that we have $12 trillion in the hole. We are hemorrhaging money at the Federal level. Why on Earth we would do this on top of hemorrhaging money at the Federal level. Why on Earth we would do this on top of hemorrhaging money at the Federal level, when we have $12 trillion in the hole and hemorrhaging Federal money, and you have the President just back from seeing the bankers in China, who have nearly a trillion dollars of our debt? As a Senator and as an American, I don’t like that we are dependent upon the Chinese for that much money. I don’t think the American people like that. Why on Earth would we do this? He said that people are mad out there. We talked ahead of time, and he said that people are upset across the country. I said, yes, they are, and it is because of this. They are mad and they are scared. Neither of those is a situation where you ought to try to force something through on people who are mad and scared about it. They are mad about things being rammed through, and they are scared about the level of debt and deficit, and they are adding this scale of entitlement on top of an already broken fiscal situation.

The rest of the world is yelling at the United States to get your fiscal house in order, and we are going to add a multitrillion dollar entitlement program, when we all know we ought to get our fiscal house in order. Then the banker in China exclaims $12 trillion in the hole and hemorrhaging money at the Federal level. Why on Earth we would do this on top of hemorrhaging money at the Federal level, when we have $12 trillion in the hole and hemorrhaging Federal money, and you have the President just back from seeing the bankers in China, who have nearly a trillion dollars of our debt? As a Senator and as an American, I don’t like that we are dependent upon the Chinese for that much money. I don’t think the American people like that. Why on Earth would we do this? He said that people are mad out there. We talked ahead of time, and he said that people are upset across the country. I said, yes, they are, and it is because of this. They are mad and they are scared. Neither of those is a situation where you ought to try to force something through on people who are mad and scared about it. They are mad about things being rammed through, and they are scared about the level of debt and deficit, and they are adding this scale of entitlement on top of an already broken fiscal situation.

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Then there is the idea that we are going to cut $400 billion out of Medicare, which is already on a fiscally irresponsible track and going broke. We are going to take $400 billion out of that. That is not going to happen. If it did happen, it would wreck Medicare. This is a bad idea at a bad time. We should not do this. We should not do it this way.

I want to focus more of my comments on a narrower piece of this, which has gotten a lot of focus in the House and should get focus in the Senate. It is the radical expansion of Federal funding of abortions that is in this bill. Let's put it on its bottom line. They should put the Stupak language in the Senate bill, and instead the Capps language is in the bill. The Capps language will expand Federal financing of abortion—Federal taxpayer funding of abortion. The Stupak language is something we have supported here for 30 years. It is the Hyde language. The Hyde language that 64 Democrats voted for in the House. Instead, in this bill you have Federal taxpayer funding of abortions, something we have not done for 30 years. They are going to build it into this bill. The President has said that he wants—he has said multiple times it is one of his goals to lower the incidence of abortion. This bill, if we pass it, will provide, for the first time in 30 years, taxpayer funding of abortion and will expand abortions—counter to what the President has said multiple times.

Nobody who is pro-life should vote for this bill. This is a radical expansion of abortion funding. It is a radical expansion of abortion. I was and remain very disappointed that the Senate leadership and my Democratic colleagues have attempted to insert radical abortion policy through the Democratic health care bill. Abortion is not health care. Any Senator who votes on the motion to proceed to this health care bill, if we pass it, will provide, for the first time in 30 years, taxpayer funding of abortion and will expand abortions—counter to what the President has said multiple times.

Representative STUPAK explained the issue very clearly in an op-ed. He wrote yesterday:

"The Hyde amendment simply says we will not use Federal funds for abortion, which is what a majority of Americans support. The Hyde amendment has always enjoyed bipartisan support since its inception in 1977, over three decades ago."

What we should have in the health bill is language that applies the Hyde amendment as it already applies to all other federally funded health care programs, including SCHIP, Medicare, Medicaid, Indian health services, veterans health, military health care programs, and the Federal Employees Health Benefits Program. That is what should be in this.

Representative STUPAK explained the issue very clearly in an op-ed. He wrote yesterday:

The Capps amendment (which is the basis of the Senate language) departed from Hyde in several important and troubling ways: by mandating that at least one plan in the health insurance exchange provide abortion coverage, by requiring a minimum $1 monthly charge for all covered individuals that would go toward paying for abortions and by allowing individuals receiving federal affordability credits to purchase health insurance plans that cover abortion. . . .

I commend Representative STUPAK for his hard work and ability to reach across the aisle to engage his Democratic and Republican colleagues on this issue. A quarter of the Democrats found the Stupak-Pitts compromise worthy of support. But a majority of the American people disapprove of the Hyde principles in the Senate health care bill.

I hope we can convince our colleagues in the Senate to follow Mr. STUPAK's lead and do the right thing and vote against the motion to proceed. Voting for the motion to proceed is to endorse the Capps language, which is an expansion of Federal taxpayer funding of abortion. The American people agree with the Stupak compromise, not the phony language in the Senate bill that would federally fund abortions.

The American people agree it is wrong to smudge radical abortion policy into this health care bill. The American people do not allow funds to flow from a U.S. Treasury account to reimburse for abortion services.

Beyond the funding issue, the Senate bill also does not include the codification of the Hyde-Weldon conscience provision. Instead, it replaces real conscience protections with language that violates the human dignity and religious freedom of organizations and religious institutions that have moral objections to participating in abortion.

No individual health care provider or health care facility may be discriminated against because of a willingness or unwillingness, if doing so is contrary to the religious or moral beliefs of the provider or facility, to provide, pay for, provide coverage of, or refer for abortion.

One other objection for the pro-life community is that there is nothing in the bill that would prevent school-based health clinics from referring for abortion or helping minors make arrangements for abortions without parental knowledge.

The administrators running the Medicaid program from 1973 to 1976 were funded as many as 300,000 abortions per year, until the Hyde amendment was enacted in 1976. In the past, in that period from 1973 to 1976, when there was Federal funding of abortions, the Federal government—those taxpayers—funded as many as 300,000 abortions per year with taxpayer dollars. That was until the Hyde amendment was enacted in 1976, because the American people despire
Mr. WHITEHOUSE. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. WHITEHOUSE. Mr. President, I rise in the receptacle of debate, this greatest deliberative body, to speak about the upcoming debate on health care on which, thanks to the extraordinary work of our leader, Senator HARRY REID, we are about to embark. I am here to urge that we in the Senate lift the tone and direction of our national debate.

Let me start by saying I appreciate and enjoy vigorous debate. Senator BYRD gave an eloquent eulogy for Senator Kennedy, noting that our beloved, late colleague saw politics as a contact sport. There is nothing wrong with a clean hit in the public arena. Nobody here needs to tiptoe around. A well-marshaled argument, buttressed by the facts, is a beautiful thing, even when delivered with truth and vigour.

The biggest vote on abortion in the Senate this is considered covered “outpatient medical care.” The Federal Government should not go down this road.

As stated earlier, the President has stated on multiple occasions that it is his goal to lower the incidence of abortion. The current language of the Senate bill would accomplish the opposite and increase abortions. If you are a pro-life Senator, you cannot vote for this bill. This is an expansion. You cannot vote for the procedural vote to go to the bill for the expansion that this will do.

In summary, I will make it clear that the Senate language is what we need to fix the shell game that would allow public funds to pay for the destruction of innocent human life in the Senate health bill. Unfortunately, language currently within the health bill is a nonstarter and is wrong. It doesn’t apply to the longstanding principles of the Hyde amendment. Let’s maintain the status quo and not get into the business of publicly funding abortions in America.

I urge my colleagues to think seriously about the precedent being lined out in the health bill if the Senate decides it is going to force the American public to pay for abortions, whether they agree or not.

I urge my colleagues to vote against the motion to proceed to this health care bill. This is not just a procedural vote. It is an enormously important vote because it is the one opportunity for the Senate to stand for life and against taxpayer funding of abortions. Voting in favor of this motion to proceed is a vote against life.

I remind my colleagues, this is the biggest vote on abortion in the Senate in years. Let’s not change our current Federal policy to force the American public to pay for government-subsidized abortions, please.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.
their doctors. But none of these claims is true.

The respected head of the Mayo Clinic recently described the health care antics we have witnessed as “mud” and “scare tactics.”

A well-regarded Washington Post writer with a quarter century of experience, married to a Bush administration official, noted about the House health care bill: “The appalling amount of misinformation being peddled by its opponents.” She called it a “flood of sheer factual misstatements about the health-care bill” and noted of the House Republicans that “[t]he falsehood-peddling began at the top.

Her ultimate question was this: Are the Republican arguments against the bill so weak that they have to resort to these misrepresentations and distortions?

Where does this lead? The ill-informed, the gullible, those already on the razor’s edge of anger about the very election of this President may well be tipped by all this poisonous propaganda into actions we would all regret—I hope we would all regret. When do anger and frustration foment in this debate begin to spill over into dangerous or violent acts? When does some havoc occur, such that we all look back with sorrow and wish we had better leashed our dogs of rhetorical war? Where do we restore civility and reason to the health care debate before it gets too late?

I say history’s charge to the Senate is to rise above the poison of our recent public debate. This greatest deliberative body is intended to set an example for public argument, not get swept into its downward spiral. We may find agreement; we may not. At the end of the day, some of us may be happy and others of us not. Some may lose and some may win. But the Senate will go on.

After the health care debate has raged through this great Chamber, other debates will follow, and ultimately what will matter more than the outcome of those debates is whether our proud American democracy has come through them with its head held high.

When debate and our democracy lose its footing in the facts, when things are said for public effect without regard to whether they are true, when the din of strife blots out the voice of reason, something of great and lasting value to America is lost.

Democracy does not prosper on a diet of propaganda and fear. The current tone of much of our debate is, frankly, unworthy of us. Most in America agree something must be done to fix our health care system. If we can agree something must be done, it should not be difficult to debate our differences as to what must be done in a civil, thoughtful, and factual manner. Let the Senate be the place where we take a stand, rejecting the incivility and falsehood that has surrounded us on our public airwaves. Through history, that is what this Chamber, at its best, has always achieved and needs now to achieve again.

UNANIMOUS CONSENT AGREEMENT—H.R. 3590

Mr. WHITEHOUSE. Mr. President, I ask unanimous consent that the Senate resume the motion to proceed to H.R. 3590 at 10 a.m. under the debate limitations previously ordered.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. WHITEHOUSE. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. WHITEHOUSE. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

ADJOURNMENT UNTIL 9:45 A.M. TOMORROW

The PRESIDING OFFICER. Under the previous order, the Senate stands adjourned until 9:45 a.m. tomorrow.

Thereupon, the Senate, at 7:51 p.m., adjourned until Friday, November 20, 2009, at 9:45 a.m.

NOMINATIONS

Executive nominations received by the Senate:

BROADCASTING BOARD OF GOVERNORS

VICTOR H. ASHER, OF TENNESSEE, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2012, VICE JAMES K. GLASSMAN, RESIGNED.

WALTER ISAACSON, OF LOUISIANA, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2012, VICE STRIVEN J. SIMMONS, TERM EXPIRED.

WALTER ISAACSON, OF LOUISIANA, TO BE CHAIRMAN OF THE BROADCASTING BOARD OF GOVERNORS, VICE JAMES K. GLASSMAN, RESIGNED.

MICHAEL LYNNON, OF CALIFORNIA, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2012, VICE MARK MCKINNON, TERM EXPIRED.

SUSAN MCCUE, OF VIRGINIA, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2012, VICE JASEQUN F. BLAYA, TERM EXPIRED.

MICHAEL P. MEHAN, OF VIRGINIA, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2012, VICE JEFFREY HIRSCHBERG, TERM EXPIRED.

DENNIS MULHAUPT, OF CALIFORNIA, TO BE A MEMBER OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2012, VICE D. JEFFREY BLANQUITA, TERM EXPIRED.

MICHAEL S. PATTIZ, TERM EXPIRED.

WALTER E. KAUFMAN, RESIGNED.

TERMS EXPIRING AUGUST 13, 2011, VICE BLANQUITA W. CULUM, TERM EXPIRED.

WALTER ISAACSON, OF LOUISIANA, TO BE CHAIRMAN OF THE BROADCASTING BOARD OF GOVERNORS FOR A TERM EXPIRING AUGUST 13, 2012, VICE MARK MCKINNON, TERM EXPIRED.

JAMES K. GLASSMAN, RESIGNED.

THE JUDICIARY

Executive nomination confirmed by the Senate, Thursday, November 19, 2009:

DAVID F. HAMILTON, OF INDIANA, TO BE UNITED STATES CIRCUIT JUDGE FOR THE SEVENTH CIRCUIT.