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

SA 3165. Mr. BINGAMAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3166. Mr. BINGAMAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3167. Mr. BINGAMAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3168. Mr. CASEY (for himself and Mrs. GILLIBRAND) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3169. Mr. CORNYN (for himself and Mr. COBURN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3170. Mr. PRYOR (for himself and Mr. BAYH) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3171. Mr. PRYOR submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3172. Mr. BROWN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3173. Mr. MERKLEY (for himself and Mr. FRANKEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3174. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3175. Mr. SPECTER (for himself, Mr. BROWN, and Mr. CASEY) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3176. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3177. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3178. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3179. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3180. Mr. GRASSLEY (for himself and Mr. ROBERTS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3181. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3182. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3183. Mr. BAUCUS submitted an amendment intended to be proposed by him to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3184. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3185. Mr. BROWN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3186. Mr. BROWN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3187. Mr. WYDEN (for himself and Mr. CRAPO) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3188. Ms. CANTWELL submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3189. Mr. ENZI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3190. Mr. ENZI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3191. Mr. ENZI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3192. Mr. ENZI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3193. Mr. ENZI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3194. Mr. ENZI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3195. Mr. ENZI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3196. Mr. ENZI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3197. Mr. ENZI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

SA 3198. Mr. CORNYN (for himself and Mr. LEMIEUX) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 3164. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 330, strike lines 7 through 11 and inserting the following:

''individual is—

''(i) a member of a recognized religious sect or division thereof which is described in section 1402(g)(1), and

''(ii) an adherent of established tenets or teachings of such sect or division as described in such section.

SA 3165. Mr. BINGAMAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1395, strike line 11 and all that follows through ''**SEC. 778.**'' on line 15 and insert the following:

SEC. 5314. FELLOWSHIP TRAINING IN PUBLIC HEALTH.

Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by inserting after section 311 the following:

''SEC. 311A.

SA 3166. Mr. BINGAMAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

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

SEC. 3115. GAO STUDY AND REPORT ON MEDICARE BENEFICIARY ACCESS.

(a) STUDY.—The Comptroller General of the United States (in this section referred to as the ''Comptroller General'') shall conduct a study on the ability of Medicare beneficiaries to fully access available health care services during the 5-year period following enactment of this Act. Such study shall include the following:

(1) A detailed analysis regarding levels of access to health care services for different groups or populations of Medicare beneficiaries, including a breakdown—

(A) by location, including rural areas (as defined in section 1886(d)(2)(D) of the Social Security Act), health professional shortage areas (as designated under section 332 of the Public Health Service Act), medically underserved communities (as defined in section 799B(6) of such Act), and medically underserved populations (as defined in section 330(b)(3) of such Act);

(B) by type of health care service, including physician services and primary care services; and

(C) by any other measure determined appropriate by the Comptroller General.

(2) A summary that identifies—

(A) any groups or populations of Medicare beneficiaries that lack adequate access to health care services; and

(B) any types of health care services that are not fully accessible to Medicare beneficiaries.

(b) REPORT.—

(1) INTERIM REPORT.—Not later than 30 months after the date of enactment of this Act, the Comptroller General shall prepare and submit an interim report to Congress that contains the preliminary results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(2) FINAL REPORT.—Not later than 60 months after the date of enactment of this Act, the Comptroller General shall prepare and submit a final report to Congress that contains the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(c) MEDICARE BENEFICIARY.—In this section, the term ''Medicare beneficiary'' means an individual entitled to benefits under part A of title XVIII of the Social Security Act, enrolled under part B of such title, or both.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

SA 3167. Mr. BINGAMAN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 1413 and insert the following:

SEC. 1413. STREAMLINING OF PROCEDURES FOR ENROLLMENT THROUGH AN EXCHANGE AND STATE MEDICAID, CHIP, AND HEALTH SUBSIDY PROGRAMS.

(a) IN GENERAL.—The Secretary shall establish a system meeting the requirements of this section under which residents of each State may apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in, applicable State health subsidy programs. Such system shall ensure that if an individual applying to an Exchange, to a State Medicaid program under title XIX of the Social Security Act, or to a State children's health insurance program (CHIP) under title XXI of such Act, is found to be ineligible for the program to which the individual applied, the individual shall be screened for eligibility for all other potentially applicable such programs and shall be enrolled in the program for which the individual qualifies.

(b) REQUIREMENTS RELATING TO FORMS AND NOTICE.—

(1) REQUIREMENTS RELATING TO FORMS.—

(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; and

(iv) is structured to maximize an applicant's ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for applicable State health subsidy programs.

(B) STATE AUTHORITY TO ESTABLISH FORM.—A State may develop and use its own single, streamlined form as an alternative to the form developed under subparagraph (A) if the alternative form is consistent with standards promulgated by the Secretary under this section.

(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) RELEVANCE.—The forms described in subparagraphs (A) and (B) shall not require the applicant to answer any questions that are irrelevant to establishing eligibility for applicable State health subsidy programs. The Secretary shall establish procedures that avoid any need for such requirements, which shall include determining the amounts expended for medical assistance that are described in subsection (y)(1) of section 1905 of the Social Security Act (as added by section 2001(a)(3) of this Act) through the use of the post-enrollment procedures described in section 1903(u)(1)(C) of the Social Security Act.

(2) NOTICE.—The Secretary shall provide that an applicant filing a form under paragraph (1) shall receive notice of eligibility for an applicable State health subsidy program without any need to provide additional information or paperwork unless such information or paperwork is specifically required by law when information provided on the form is inconsistent with data used for the electronic verification under paragraph (3) or is otherwise insufficient to determine eligibility.

(c) REQUIREMENTS RELATING TO ELIGIBILITY BASED ON DATA EXCHANGES.—

(1) DEVELOPMENT OF SECURE INTERFACES.—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 for all such 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);

(B) applies only to individuals who—

(i) receive assistance from an applicable State health subsidy program; or

(ii) apply for such assistance—

(I) by filing a form described in subsection (b); or

(II) notwithstanding section 1411(b), by requesting a determination of eligibility and authorizing disclosure of the information described in paragraph (3) to applicable State health coverage subsidy programs for purposes of determining and establishing eligibility; and

(C) is consistent with standards promulgated by the Secretary, including the privacy and data security safeguards described in section 1942 of the Social Security Act or that are otherwise applicable to such 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 arrangement, provided that if such data do not establish an individual's eligibility for medical assistance under title XIX of the Social Security Act, the rules described in section 1902(e)(14)(H) of such Act shall apply to such individual.

(B) EXCEPTION.—This paragraph shall not apply in circumstances with respect to which the Secretary determines that the administrative and other costs of use 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.—

(1) AGREEMENTS.—Subject to section 1411 and section 6103(l)(21) of the Internal Revenue Code of 1986 and any other requirement providing safeguards of privacy and data integrity, the Secretary may establish model

agreements, and enter into agreements, for the sharing of data under this section.

(2) AUTHORITY OF EXCHANGE TO CONTRACT OUT.—Nothing in this section shall be construed to—

(A) prohibit contractual arrangements through which a State medicaid agency determines eligibility for all applicable State health subsidy programs, but only if such agency complies with the Secretary's requirements ensuring reduced administrative costs, eligibility errors, and disruptions in coverage; or

(B) change any requirement under title XIX that eligibility for participation in a State's medicaid program must be determined by a public agency.

(e) APPLICABLE STATE HEALTH SUBSIDY PROGRAM.—In this section, the term ''applicable State health subsidy program'' means—

(1) the program under this title for the determination of eligibility for premium tax credits 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 the Social Security Act;

(3) a State children's health insurance program (CHIP) under title XXI of such Act; and

(4) a State program under section 1331 establishing qualified basic health plans.

SA 3168. Mr. CASEY (for himself and Mrs. GILLIBRAND) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 466, between lines 5 and 6, insert the following:

SEC. 2305. OPTIONAL COVERAGE OF NURSE HOME VISITATION SERVICES.

(a) IN GENERAL.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by sections 2001(a)(3), 2006, and 2301(a)(1), is amended—

(1) in subsection (a)—

(A) in paragraph (28), by striking ''and'' at the end;

(B) by redesignating paragraph (29) as paragraph (30); and

(C) by inserting after paragraph (28) the following new paragraph:

''(29) nurse home visitation services (as defined in subsection (z)); and''; and

(2) by inserting after subsection (y) the following new subsection:

''(z) The term 'nurse home visitation services' means voluntary home visits that are provided by trained nurses to a family with a first-time pregnant woman, or a child (under 2 years of age), who is eligible for medical assistance under this title, but only, to the extent determined by the Secretary based upon evidence, that such services are effective in achieving 1 or more of the following:

''(1) Improving maternal or child health and pregnancy outcomes or increasing birth intervals between pregnancies.

''(2) Reducing the incidence of child abuse, neglect, and injury, improving family stability (including reduction in the incidence of intimate partner violence), or reducing maternal and child involvement in the criminal justice system.

''(3) Increasing economic self-sufficiency, employment advancement, school-readiness, and educational achievement, or reducing dependence on public assistance.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2010.

(c) CONSTRUCTION.—Nothing in the amendments made by this section shall be construed as affecting the ability of a State under title XIX or XXI of the Social Security Act to provide nurse home visitation services as part of another class of items and services falling within the definition of medical assistance or child health assistance under the respective title, or as an administrative expenditure for which payment is made under section 1903(a) or 2105(a) of such Act, respectively, on or after the date of the enactment of this Act.

SA 3169. Mr. CORNYN (for himself and Mr. COBURN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 6001.

SA 3170. Mr. PRYOR (for himself and Mr. BAYH) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

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

SEC. 3130. RESTORING STATE AUTHORITY TO WAIVE THE 35-MILE RULE FOR MEDICARE CRITICAL ACCESS HOSPITAL DESIGNATIONS.

Section 1820(c)(2)(B)(i)(II) of the Social Security Act (42 U.S.C. 1395i–4(c)(2)(B)(i)(II)) is amended by inserting ''or on or after the date of enactment of the Patient Protection and Affordable Care Act'' after ''January 1, 2006,''.

SA 3171. Mr. PRYOR submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1999, between lines 20 and 21, insert the following:

SEC. 9005A. ANNUAL ROLLOVER OF HEALTH FSA BALANCES.

(a) IN GENERAL.—Subsection (i) of section 125 of the Internal Revenue Code of 1986, as added by section 9005(a)(2), is amended—

(1) by striking all matter before ''if a benefit'' and inserting the following:

''(i) SPECIAL RULES APPLICABLE TO HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—

''(1) LIMITATION ON CONTRIBUTIONS TO HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—For purposes of this section,'', and

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

''(2) ALLOWANCE OF CARRYOVER OF UNUSED AMOUNTS IN HEALTH FLEXIBLE SPENDING ARRANGEMENTS.—

''(A) IN GENERAL.—For purposes of this title, a plan or other arrangement shall not fail to be treated as a cafeteria plan solely because under the plan or arrangement a participant is permitted access to any unused amounts attributable to salary reduction contributions under such plan or arrangement in the manner provided under subparagraph (B).

''(B) CARRYOVER OF UNUSED AMOUNTS.—A plan or arrangement may permit a participant in a health flexible spending arrangement to elect to carry over so much of the unused amounts attributable to salary reduction contributions under such plan or arrangement as of the close of any calendar year as does not exceed $1,000 to the immediately succeeding calendar year.

''(C) AMOUNTS NOT DEFERRED COMPENSATION.—No amount shall be treated as deferred compensation for purposes of this title by reason of any carryover under this paragraph.

''(D) COORDINATION WITH CONTRIBUTION LIMIT.—The maximum amount which may be contributed to a health flexible spending arrangement under paragraph (1) for any calendar year to which an unused amount is carried over under this paragraph shall be reduced by such amount.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to calendar years beginning after December 31, 2010.

SA 3172. Mr. BROWN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 18, between lines 15 and 16, insert the following:

''SEC. 2713A. COVERAGE OF CERTAIN CARE.

''A group health plan and a health insurance issuer offering group or individual health insurance coverage shall provide coverage for wound-care supplies that are medically necessary for the treatment of epidermolysis bullosa and are administered under the direction of a physician.''.

SA 3173. Mr. MERKLEY (for himself and Mr. FRANKEN) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 354, between lines 2 and 3, insert the following:

(D) APPLICATION TO CONSTRUCTION INDUSTRY EMPLOYERS.—In the case of any employer the substantial annual gross receipts of which are attributable to the construction industry—

(i) subparagraph (A) shall be applied by substituting ''who employed an average of at least 5 full-time employees on business days during the preceeding calendar year or whose annual payroll expenses exceed $250,000 for such preceeding calendar year'' for ''who employed an average of at least 50 full-time employees on business days during the preceeding calendar year'', and

(ii) subparagraph (B) shall be applied by substituting ''5'' for ''50''.

SA 3174. Ms. SNOWE submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At after title IX, insert the following:

TITLE X—HEALTH CARE REFORM OVERSIGHT COMMITTEE

SEC. 10001. HEALTH CARE REFORM OVERSIGHT COMMITTEE.

(a) ESTABLISHMENT.—There is established a committee to be known as the Health Care Reform Oversight Committee (referred to in this section as the ''Committee''), for the purpose of maintaining close oversight of the implementation of the requirements of this Act (including the amendments made by this Act), including with regard to the affordability criteria set forth in this Act, the impact of this Act on small businesses, and pricing trends resulting from implementation of this Act.

(b) MEMBERSHIP.—The Committee shall be composed of 12 members, selected by the President pro tempore of the Senate and the Speaker of the House of Representatives, in consultation with the majority and minority leaders of the Senate and of the House of Representatives, from among members of the public experienced in health care administration, tax policy, small business, actuarial science, health insurance plan design or sales, or a profession that would lend credibility to the work of the Committee. Not more than 3 members of the Committee may be Federal employees.

(c) CHAIRPERSON.—The Committee shall select a Chairperson from among its members.

(d) MEETINGS.—The Committee shall meet at the call of the chairperson, or as voted by 7 members, as is necessary to maintain close oversight of the implementation of the requirements of this Act (including the amendments made by this Act), to address specific problems raised by such implementation, or to address constituent concerns.

(e) QUORUM.—A quorum shall consist of a total of 7 members of the Committee, except that a total of 5 members shall be present to conduct hearings, unless such requirement that 5 members be present to conduct hearings is waived by a majority of the Committee.

(f) DUTIES OF THE COMMITTEE.—The Committee shall provide close oversight of all aspects of the requirements of this Act, including the amendments made by this Act.

(g) POWERS OF THE COMMITTEE.—

(1) HEARINGS.—The Committee may, for the purpose of carrying out this section—

(A) hold such hearings, sit and act at such times and places, take such testimony, receive such evidence, administer such oaths; and

(B) require, by subpoena or otherwise, the attendance and testimony of such witnesses and the production of such books, records, correspondence, memoranda, papers, documents, tapes, and materials as the Committee considers advisable.

(2) REPORTS AND RECOMMENDATIONS.—The Committee may issues reports and findings as it deems appropriate, including offering suggestions for legislation to improve the requirements and activities under this Act (including the amendments made by this Act).

(3) ISSUANCE AND ENFORCEMENT OF SUBPOENAS.—

(A) ISSUANCE.—Subpoenas issued under paragraph (1) shall bear the signature of the Chairperson of the Committee and shall be served by any person or class of persons designated by the Chairperson for that purpose.

(B) ENFORCEMENT.—In the case of contumacy or failure to obey a subpoena issued under paragraph (1), the United States district court for the judicial district in which the subpoenaed person resides, is served, or may be found may issue an order requiring such person to appear at any designated place to testify or to produce documentary or other evidence. Any failure to obey the order of the court may be punished by the court as a contempt that court.

(4) WITNESS ALLOWANCES AND FEES.—Section 1821 of title 28, United States Code, shall apply to witnesses requested or subpoenaed to appear at any hearing of the Committee. The per diem and mileage allowances for witnesses shall be paid from funds available to pay the expenses of the Committee.

(5) INFORMATION FROM FEDERAL AGENCIES.—The Committee may secure directly from any Federal department or agency such information as the Committee considers necessary to carry out this Act. Upon request of the Chairperson of the Committee, or of another member of the Committee representing a majority vote, the head of such department or agency shall furnish such information to the Committee.

(6) POSTAL SERVICES.—The Committee may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(7) GIFTS.—The Committee may accept, use, and dispose of gifts or donations of services or property.

(h) COMPENSATION OF MEMBERS.—

(1) IN GENERAL.—Each member of the Committee who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Committee. All members of the Committee who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(2) TRAVEL EXPENSES.—The members of the Committee shall be allowed 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 Committee.

(i) TERMINATION OF THE COMMITTEE.—The Committee shall terminate 5 years after the date of enactment of this Act.

(j) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.

SA 3175. Mr. SPECTER (for himself, Mr. BROWN, and Mr. CASEY) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

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

SEC. 3115. EXCLUSION OF CUSTOMARY PROMPT PAY DISCOUNTS EXTENDED TO WHOLESALERS FROM MANUFACTURER'S AVERAGE SALES PRICE FOR PAYMENTS FOR DRUGS AND BIOLOGICALS UNDER MEDICARE PART B.

Section 1847A(c)(3) of the Social Security Act (42 U.S.C. 1395w–3a(c)(3)) is amended—

(1) in the first sentence, by inserting after ''prompt pay discounts'' the following: ''(other than, for drugs and biologicals that are sold on or after January 1, 2011, and before January 1, 2016, customary prompt pay discounts extended to wholesalers, but only to the extent such discounts do not exceed 2 percent of the wholesale acquisition cost)''; and

(2) in the second sentence, by inserting after ''other price concessions'' the following: ''(other than, for drugs and biologicals that are sold on or after January 1, 2011, and before January 1, 2016, customary prompt pay discounts extended to wholesalers, but only to the extent such discounts do not exceed 2 percent of the wholesale acquisition cost)''.

SA 3176. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 334, between lines 18 and 19, insert the following:

''(E) SPECIAL RULE FOR INDIVIDUALS BETWEEN THE AGES OF 55 AND 64.—

''(i) IN GENERAL.—In the case of an applicable individual who has attained the age of 55 but has not attained the age of 65 before the beginning of a calendar year, this paragraph shall be applied to such individual for months during such calendar year by substituting '5 percent' for '8 percent' in subparagraphs (A) and (D).

''(ii) USE OF INCREASED FEDERAL FUNDS.—

''(I) IN GENERAL.—The amount available for any calendar year for expenditure under the early retiree reinsurance program under section 1102 of the Patient Protection and Affordable Care Act shall be increased by the amount the Secretary of Health and Human Services estimates under subclause (II) for the calendar year. Notwithstanding section 1102(a)(1) of such Act, amounts made available under this subclause for any calendar year after 2014 may be used to make payments under such reinsurance program.

''(II) ESTIMATES.—The Secretary of Health and Human Services, in consultation with the Secretary, shall estimate for each calendar year after 2013 the net increase (if any) in Federal revenues, and the net decrease (if any) in Federal outlays, by reason of the application of clause (i). The sum of such amounts (expressed as a positive number)

shall be the amount taken into account under subclause (I). The Secretary shall adjust the estimate for any calendar year to correct any errors in an estimate for any preceding calendar year.

SA 3177. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 336, between lines 16 and 17, insert the following:

''(6) COLLEGE STUDENTS.—

''(A) IN GENERAL.—Any applicable individual for any month which occurs within an academic period during which the individual is a student (whether full-time or part-time) who meets the requirements of section 484(a)(1) of the Higher Education Act of 1965 (20 U.S.C. 1091(a)(1)) at an institution of higher education (including a community college or trade school) described in such section. For purposes of the preceding sentence, any month between 2 consecutive academic periods shall be treated as occurring during an academic period.

''(B) USE OF INCREASED FEDERAL FUNDS.—

''(i) IN GENERAL.—The amount available for any calendar year for expenditure under the reinsurance program under section 1341 of the Patient Protection and Affordable Care Act shall be increased by the amount the Secretary of Health and Human Services estimates under clause (11) for the calendar year. Notwithstanding section 1341(b)(4) of such Act, amounts made available under this subclause for any calendar year after 2018 may be used to make payments under any reinsurance program of a State in the individual market in effect during such calendar year.

''(ii) ESTIMATES.—The Secretary of Health and Human Services, in consultation with the Secretary, shall estimate for each calendar year after 2013 the net increase (if any) in Federal revenues, and the net decrease (if any) in Federal outlays, by reason of the application of subparagraph (A). The sum of such amounts (expressed as a positive number) shall be the amount taken into account under clause (i). The Secretary shall adjust the estimate for any calendar year to correct any errors in an estimate for any preceding calendar year.

SA 3178. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 156, beginning with line 4, strike all through page 157, line 7, and insert the following:

(D) PRESIDENT, VICE PRESIDENT, MEMBERS OF CONGRESS, POLITICAL APPOINTEES, AND CONGRESSIONAL STAFF IN THE EXCHANGE.—

(i) IN GENERAL.—Notwithstanding chapter 89 of title 5, United States Code, or any provision of this title—

(I) the President, Vice President, each Member of Congress, each political appointee, and each Congressional employee shall be treated as a qualified individual entitled to the right under this paragraph to enroll in a qualified health plan in the individual market offered through an Exchange in the State in which the individual resides; and

(II) any employer contribution under such chapter on behalf of the President, Vice President, any Member of Congress, any political appointee, and any Congressional employee may be paid only to the issuer of a qualified health plan in which the individual enrolled in through such Exchange and not to the issuer of a plan offered through the Federal employees health benefit program under such chapter.

(ii) PAYMENTS BY FEDERAL GOVERNMENT.—The Secretary, in consultation with the Director of the Office of Personnel Management, shall establish procedures under which—

(I) the employer contributions under such chapter on behalf of the President, Vice President, and each political appointee are determined and actuarially adjusted for age; and

(II) the employer contributions may be made directly to an Exchange for payment to an issuer.

(iii) POLITICAL APPOINTEE.—In this subparagraph, the term ''political appointee'' means any individual who—

(I) is employed in a position described under sections 5312 through 5316 of title 5, United States Code, (relating to the Executive Schedule);

(II) is a limited term appointee, limited emergency appointee, or noncareer appointee in the Senior Executive Service, as defined under paragraphs (5), (6), and (7), respectively, of section 3132(a) of title 5, United States Code; or

(III) is employed in a position in the executive branch of the Government of a confidential or policy-determining character under schedule C of subpart C of part 213 of title 5 of the Code of Federal Regulations.

(iv) CONGRESSIONAL EMPLOYEE.—In this subparagraph, the term ''Congressional employee'' means an employee whose pay is disbursed by the Secretary of the Senate or the Clerk of the House of Representatives.

SA 3179. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 334, between lines 18 and 19, insert the following:

''(E) SPECIAL RULE FOR INDIVIDUALS UNDER AGE 30.—

''(i) IN GENERAL.—In the case of an applicable individual who has not attained age 30 before the beginning of a calendar year, this paragraph shall be applied to such individual for months during such calendar year by substituting '5 percent' for '8 percent' in subparagraphs (A) and (D).

''(ii) USE OF INCREASED FEDERAL FUNDS.—

''(I) IN GENERAL.—The amount available for any calendar year for expenditure under the reinsurance program under section 1341 of the Patient Protection and Affordable Care Act shall be increased by the amount the Secretary of Health and Human Services estimates under subclause (II) for the calendar year. Notwithstanding section 1341(b)(4) of such Act, amounts made available under this subclause for any calendar year after 2018 may be used to make payments under any reinsurance program of a State in the individual market in effect during such calendar year.

''(II) ESTIMATES.—The Secretary of Health and Human Services, in consultation with the Secretary, shall estimate for each calendar year after 2013 the net increase (if any) in Federal revenues, and the net decrease (if any) in Federal outlays, by reason of the application of clause (i). The sum of such amounts (expressed as a positive number) shall be the amount taken into account under subclause (I). The Secretary shall adjust the estimate for any calendar year to correct any errors in an estimate for any preceding calendar year.

SA 3180. Mr. GRASSLEY (for himself and Mr. ROBERTS) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

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

SEC. 3403A. PROTECTING SENIORS FROM HIGHER PREMIUMS, REDUCED BENEFITS, AND RATIONING OF LIFE-SAVING CARE UNDER MEDICARE PARTS C AND D.

Section 1899A(c)(2)(A) of the Social Security Act, as added by section 3403, is amended—

(1) in clause (ii), by striking ''under section 1818, 1818A, or 1839''; and

(2) by striking clause (iv).

SA 3181. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 909, strike line 21 and all that follows through page 910, line 19.

SA 3182. Mr. GRASSLEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end, add the following:

TITLE X—ENSURING THAT SAVINGS FROM MEDICAL CARE ACCESS PROTECTION ARE USED TO REDUCE THE COVERAGE GAP UNDER MEDICARE PART D

Subtitle A—Reducing the Coverage Gap Under Medicare Part D

SEC. 10001. REDUCING THE COVERAGE GAP.

Section 1860D–2(b) of the Social Security Act (42 U.S.C. 1395w–102(b)), as amended by section 3315, is further amended—

(1) in paragraph (3)(A), by striking ''and (7)'' and inserting '', (7), and (8)'';

(2) in paragraph (7), by striking subparagraph (C); and

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

''(8) INCREASE IN INITIAL COVERAGE LIMIT IN SUBSEQUENT YEARS.—

''(A) IN GENERAL.—For plan years beginning on or after January 1, 2011, the initial coverage limit described in paragraph (3)(B) otherwise applicable shall be increased by an amount which the Chief Actuary of the Centers for Medicare & Medicaid Services determines is equal to the estimated amount of savings during the plan year as a result of the provisions of the Medical Care Access Protection Act of 2009.

''(B) CONSIDERATIONS.—In determining the amount of the increase under subparagraph (A) for a plan year, the Secretary shall take into account—

''(i) any increase under such paragraph during the preceding year or years; and

''(ii) any estimated increase in utilization as a result of the application of this paragraph.

''(C) APPLICATION.—The provisions of subparagraph (B) of paragraph (7) shall apply to the application of subparagraph (A) of this subparagraph in the same manner as such provisions apply to the application of subparagraph (A) of paragraph (7).''.

Subtitle B—Medical Care Access Protection

SEC. 10101. SHORT TITLE.

This subtitle may be cited as the ''Medical Care Access Protection Act of 2009'' or the ''MCAP Act''.

SEC. 10102. FINDINGS AND PURPOSE.

(a) FINDINGS.—

(1) EFFECT ON HEALTH CARE ACCESS AND COSTS.—Congress finds that our current civil justice system is adversely affecting patient access to health care services, better patient care, and cost-efficient health care, in that the health care liability system is a costly and ineffective mechanism for resolving claims of health care liability and compensating injured patients, and is a deterrent to the sharing of information among health care professionals which impedes efforts to improve patient safety and quality of care.

(2) EFFECT ON INTERSTATE COMMERCE.—Congress finds that the health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States are activities that affect interstate commerce by contributing to the high costs of health care and premiums for health care liability insurance purchased by health care system providers.

(3) EFFECT ON FEDERAL SPENDING.—Congress finds that the health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

(B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent to provide them with health insurance benefits; and

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

(b) PURPOSE.—It is the purpose of this subtitle to implement reasonable, comprehensive, and effective health care liability reforms designed to—

(1) improve the availability of health care services in cases in which health care liability actions have been shown to be a factor in the decreased availability of services;

(2) reduce the incidence of ''defensive medicine'' and lower the cost of health care liability insurance, all of which contribute to the escalation of health care costs;

(3) ensure that persons with meritorious health care injury claims receive fair and adequate compensation, including reasonable noneconomic damages;

(4) improve the fairness and cost-effectiveness of our current health care liability system to resolve disputes over, and provide compensation for, health care liability by reducing uncertainty in the amount of compensation provided to injured individuals; and

(5) provide an increased sharing of information in the health care system which will reduce unintended injury and improve patient care.

SEC. 10103. DEFINITIONS.

In this subtitle:

(1) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system that provides for the resolution of health care lawsuits in a manner other than through a civil action brought in a State or Federal court.

(2) CLAIMANT.—The term ''claimant'' means any person who brings a health care lawsuit, including a person who asserts or claims a right to legal or equitable contribution, indemnity or subrogation, arising out of a health care liability claim or action, and any person on whose behalf such a claim is asserted or such an action is brought, whether deceased, incompetent, or a minor.

(3) COLLATERAL SOURCE BENEFITS.—The term ''collateral source benefits'' means any amount paid or reasonably likely to be paid in the future to or on behalf of the claimant, or any service, product or other benefit provided or reasonably likely to be provided in the future to or on behalf of the claimant, as a result of the injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident, or workers' compensation law;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(4) COMPENSATORY DAMAGES.—The term ''compensatory damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities, damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature. Such term includes economic damages and noneconomic damages, as such terms are defined in this section.

(5) CONTINGENT FEE.—The term ''contingent fee'' includes all compensation to any person or persons which is payable only if a recovery is effected on behalf of one or more claimants.

(6) ECONOMIC DAMAGES.—The term ''economic damages'' means objectively verifiable monetary losses incurred as a result of the provision of, use of, or payment for (or failure to provide, use, or pay for) health care services or medical products, such as past and future medical expenses, loss of past and future earnings, cost of obtaining domestic services, loss of employment, and loss of business or employment opportunities.

(7) HEALTH CARE GOODS OR SERVICES.—The term ''health care goods or services'' means any goods or services provided by a health care institution, provider, or by any individual working under the supervision of a health care provider, that relates to the diagnosis, prevention, care, or treatment of any human disease or impairment, or the assessment of the health of human beings.

(8) HEALTH CARE INSTITUTION.—The term ''health care institution'' means any entity licensed under Federal or State law to provide health care services (including but not limited to ambulatory surgical centers, assisted living facilities, emergency medical services providers, hospices, hospitals and hospital systems, nursing homes, or other entities licensed to provide such services).

(9) HEALTH CARE LAWSUIT.—The term ''health care lawsuit'' means any health care liability claim concerning the provision of health care goods or services affecting interstate commerce, or any health care liability action concerning the provision of (or the failure to provide) health care goods or services affecting interstate commerce, brought in a State or Federal court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of claimants, plaintiffs, defendants, or other parties, or the number of claims or causes of action, in which the claimant alleges a health care liability claim.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal Court or pursuant to an alternative dispute resolution system, against a health care provider or a health care institution regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action, in which the claimant alleges a health care liability claim.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a demand by any person, whether or not pursuant to ADR, against a health care provider or health care institution, including third-party claims, cross-claims, counter-claims, or contribution claims, which are based upon the provision of, use of, or payment for (or the failure to provide, use, or pay for) health care services, regardless of the theory of liability on which the claim is based, or the number of plaintiffs, defendants, or other parties, or the number of causes of action.

(12) HEALTH CARE PROVIDER.—

(A) IN GENERAL.—The term ''health care provider'' means any person (including but not limited to a physician (as defined by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)), registered nurse, dentist, podiatrist, pharmacist, chiropractor, or optometrist) required by State or Federal law to be

licensed, registered, or certified to provide health care services, and being either so licensed, registered, or certified, or exempted from such requirement by other statute or regulation.

(B) TREATMENT OF CERTAIN PROFESSIONAL ASSOCIATIONS.—For purposes of this subtitle, a professional association that is organized under State law by an individual physician or group of physicians, a partnership or limited liability partnership formed by a group of physicians, a nonprofit health corporation certified under State law, or a company formed by a group of physicians under State law shall be treated as a health care provider under subparagraph (A).

(13) MALICIOUS INTENT TO INJURE.—The term ''malicious intent to injure'' means intentionally causing or attempting to cause physical injury other than providing health care goods or services.

(14) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of society and companionship, loss of consortium (other than loss of domestic service), hedonic damages, injury to reputation, and all other nonpecuniary losses of any kind or nature.

(15) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded, for the purpose of punishment or deterrence, and not solely for compensatory purposes, against a health care provider or health care institution. Punitive damages are neither economic nor noneconomic damages.

(16) RECOVERY.—The term ''recovery'' means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim, including all costs paid or advanced by any person. Costs of health care incurred by the plaintiff and the attorneys' office overhead costs or charges for legal services are not deductible disbursements or costs for such purpose.

(17) STATE.—The term ''State'' means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territory of the Pacific Islands, and any other territory or possession of the United States, or any political subdivision thereof.

SEC. 10104. ENCOURAGING SPEEDY RESOLUTION OF CLAIMS.

(a) IN GENERAL.—Except as otherwise provided for in this section, the time for the commencement of a health care lawsuit shall be 3 years after the date of manifestation of injury or 1 year after the claimant discovers, or through the use of reasonable diligence should have discovered, the injury, whichever occurs first.

(b) GENERAL EXCEPTION.—The time for the commencement of a health care lawsuit shall not exceed 3 years after the date of manifestation of injury unless the tolling of time was delayed as a result of—

(1) fraud;

(2) intentional concealment; or

(3) the presence of a foreign body, which has no therapeutic or diagnostic purpose or effect, in the person of the injured person.

(c) MINORS.—An action by a minor shall be commenced within 3 years from the date of the alleged manifestation of injury except that if such minor is under the full age of 6 years, such action shall be commenced within 3 years of the manifestation of injury, or prior to the eighth birthday of the minor, whichever provides a longer period. Such time limitation shall be tolled for minors for any period during which a parent or guardian and a health care provider or health care institution have committed fraud or collusion in the failure to bring an action on behalf of the injured minor.

(d) RULE 11 SANCTIONS.—Whenever a Federal or State court determines (whether by motion of the parties or whether on the motion of the court) that there has been a violation of Rule 11 of the Federal Rules of Civil Procedure (or a similar violation of applicable State court rules) in a health care liability action to which this subtitle applies, the court shall impose upon the attorneys, law firms, or pro se litigants that have violated Rule 11 or are responsible for the violation, an appropriate sanction, which shall include an order to pay the other party or parties for the reasonable expenses incurred as a direct result of the filing of the pleading, motion, or other paper that is the subject of the violation, including a reasonable attorneys' fee. Such sanction shall be sufficient to deter repetition of such conduct or comparable conduct by others similarly situated, and to compensate the party or parties injured by such conduct.

SEC. 10105. COMPENSATING PATIENT INJURY.

(a) UNLIMITED AMOUNT OF DAMAGES FOR ACTUAL ECONOMIC LOSSES IN HEALTH CARE LAWSUITS.—In any health care lawsuit, nothing in this subtitle shall limit the recovery by a claimant of the full amount of the available economic damages, notwithstanding the limitation contained in subsection (b).

(b) ADDITIONAL NONECONOMIC DAMAGES.—

(1) HEALTH CARE PROVIDERS.—In any health care lawsuit where final judgment is rendered against a health care provider, the amount of noneconomic damages recovered from the provider, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties other than a health care institution against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(2) HEALTH CARE INSTITUTIONS.—

(A) SINGLE INSTITUTION.—In any health care lawsuit where final judgment is rendered against a single health care institution, the amount of noneconomic damages recovered from the institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence.

(B) MULTIPLE INSTITUTIONS.—In any health care lawsuit where final judgment is rendered against more than one health care institution, the amount of noneconomic damages recovered from each institution, if otherwise available under applicable Federal or State law, may be as much as $250,000, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence, except that the total amount recovered from all such institutions in such lawsuit shall not exceed $500,000.

(c) NO DISCOUNT OF AWARD FOR NONECONOMIC DAMAGES.—In any health care lawsuit—

(1) an award for future noneconomic damages shall not be discounted to present value;

(2) the jury shall not be informed about the maximum award for noneconomic damages under subsection (b);

(3) an award for noneconomic damages in excess of the limitations provided for in subsection (b) shall be reduced either before the entry of judgment, or by amendment of the judgment after entry of judgment, and such reduction shall be made before accounting for any other reduction in damages required by law; and

(4) if separate awards are rendered for past and future noneconomic damages and the combined awards exceed the limitations described in subsection (b), the future noneconomic damages shall be reduced first.

(d) FAIR SHARE RULE.—In any health care lawsuit, each party shall be liable for that party's several share of any damages only and not for the share of any other person. Each party shall be liable only for the amount of damages allocated to such party in direct proportion to such party's percentage of responsibility. A separate judgment shall be rendered against each such party for the amount allocated to such party. For purposes of this section, the trier of fact shall determine the proportion of responsibility of each party for the claimant's harm.

SEC. 10106. MAXIMIZING PATIENT RECOVERY.

(a) COURT SUPERVISION OF SHARE OF DAMAGES ACTUALLY PAID TO CLAIMANTS.—

(1) IN GENERAL.—In any health care lawsuit, the court shall supervise the arrangements for payment of damages to protect against conflicts of interest that may have the effect of reducing the amount of damages awarded that are actually paid to claimants.

(2) CONTINGENCY FEES.—

(A) IN GENERAL.—In any health care lawsuit in which the attorney for a party claims a financial stake in the outcome by virtue of a contingent fee, the court shall have the power to restrict the payment of a claimant's damage recovery to such attorney, and to redirect such damages to the claimant based upon the interests of justice and principles of equity.

(B) LIMITATION.—The total of all contingent fees for representing all claimants in a health care lawsuit shall not exceed the following limits:

(i) 40 percent of the first $50,000 recovered by the claimant(s).

(ii) 33⅓ percent of the next $50,000 recovered by the claimant(s).

(iii) 25 percent of the next $500,000 recovered by the claimant(s).

(iv) 15 percent of any amount by which the recovery by the claimant(s) is in excess of $600,000.

(b) APPLICABILITY.—

(1) IN GENERAL.—The limitations in subsection (a) shall apply whether the recovery is by judgment, settlement, mediation, arbitration, or any other form of alternative dispute resolution.

(2) MINORS.—In a health care lawsuit involving a minor or incompetent person, a court retains the authority to authorize or approve a fee that is less than the maximum permitted under this section.

(c) EXPERT WITNESSES.—

(1) REQUIREMENT.—No individual shall be qualified to testify as an expert witness concerning issues of negligence in any health care lawsuit against a defendant unless such individual—

(A) except as required under paragraph (2), is a health care professional who—

(i) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

(ii) typically treats the diagnosis or condition or provides the type of treatment under review; and

(B) can demonstrate by competent evidence that, as a result of training, education, knowledge, and experience in the evaluation, diagnosis, and treatment of the disease or injury which is the subject matter of the lawsuit against the defendant, the individual was substantially familiar with applicable standards of care and practice as they relate to the act or omission which is the subject of the lawsuit on the date of the incident.

(2) PHYSICIAN REVIEW.—In a health care lawsuit, if the claim of the plaintiff involved

treatment that is recommended or provided by a physician (allopathic or osteopathic), an individual shall not be qualified to be an expert witness under this subsection with respect to issues of negligence concerning such treatment unless such individual is a physician.

(3) SPECIALTIES AND SUBSPECIALTIES.—With respect to a lawsuit described in paragraph (1), a court shall not permit an expert in one medical specialty or subspecialty to testify against a defendant in another medical specialty or subspecialty unless, in addition to a showing of substantial familiarity in accordance with paragraph (1)(B), there is a showing that the standards of care and practice in the two specialty or subspecialty fields are similar.

(4) LIMITATION.—The limitations in this subsection shall not apply to expert witnesses testifying as to the degree or permanency of medical or physical impairment.

SEC. 10107. ADDITIONAL HEALTH BENEFITS.

(a) IN GENERAL.—The amount of any damages received by a claimant in any health care lawsuit shall be reduced by the court by the amount of any collateral source benefits to which the claimant is entitled, less any insurance premiums or other payments made by the claimant (or by the spouse, parent, child, or legal guardian of the claimant) to obtain or secure such benefits.

(b) PRESERVATION OF CURRENT LAW.—Where a payor of collateral source benefits has a right of recovery by reimbursement or subrogation and such right is permitted under Federal or State law, subsection (a) shall not apply.

(c) APPLICATION OF PROVISION.—This section shall apply to any health care lawsuit that is settled or resolved by a fact finder.

SEC. 10108. PUNITIVE DAMAGES.

(a) PUNITIVE DAMAGES PERMITTED.—

(1) IN GENERAL.—Punitive damages may, if otherwise available under applicable State or Federal law, be awarded against any person in a health care lawsuit only if it is proven by clear and convincing evidence that such person acted with malicious intent to injure the claimant, or that such person deliberately failed to avoid unnecessary injury that such person knew the claimant was substantially certain to suffer.

(2) FILING OF LAWSUIT.—No demand for punitive damages shall be included in a health care lawsuit as initially filed. A court may allow a claimant to file an amended pleading for punitive damages only upon a motion by the claimant and after a finding by the court, upon review of supporting and opposing affidavits or after a hearing, after weighing the evidence, that the claimant has established by a substantial probability that the claimant will prevail on the claim for punitive damages.

(3) SEPARATE PROCEEDING.—At the request of any party in a health care lawsuit, the trier of fact shall consider in a separate proceeding—

(A) whether punitive damages are to be awarded and the amount of such award; and

(B) the amount of punitive damages following a determination of punitive liability.

If a separate proceeding is requested, evidence relevant only to the claim for punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether compensatory damages are to be awarded.

(4) LIMITATION WHERE NO COMPENSATORY DAMAGES ARE AWARDED.—In any health care lawsuit where no judgment for compensatory damages is rendered against a person, no punitive damages may be awarded with respect to the claim in such lawsuit against such person.

(b) DETERMINING AMOUNT OF PUNITIVE DAMAGES.—

(1) FACTORS CONSIDERED.—In determining the amount of punitive damages under this section, the trier of fact shall consider only the following:

(A) the severity of the harm caused by the conduct of such party;

(B) the duration of the conduct or any concealment of it by such party;

(C) the profitability of the conduct to such party;

(D) the number of products sold or medical procedures rendered for compensation, as the case may be, by such party, of the kind causing the harm complained of by the claimant;

(E) any criminal penalties imposed on such party, as a result of the conduct complained of by the claimant; and

(F) the amount of any civil fines assessed against such party as a result of the conduct complained of by the claimant.

(2) MAXIMUM AWARD.—The amount of punitive damages awarded in a health care lawsuit may not exceed an amount equal to two times the amount of economic damages awarded in the lawsuit or $250,000, whichever is greater. The jury shall not be informed of the limitation under the preceding sentence.

(c) LIABILITY OF HEALTH CARE PROVIDERS.—

(1) IN GENERAL.—A health care provider who prescribes, or who dispenses pursuant to a prescription, a drug, biological product, or medical device approved by the Food and Drug Administration, for an approved indication of the drug, biological product, or medical device, shall not be named as a party to a product liability lawsuit invoking such drug, biological product, or medical device and shall not be liable to a claimant in a class action lawsuit against the manufacturer, distributor, or product seller of such drug, biological product, or medical device.

(2) MEDICAL PRODUCT.—The term ''medical product'' means a drug or device intended for humans. The terms ''drug'' and ''device'' have the meanings given such terms in sections 201(g)(1) and 201(h) of the Federal Food, Drug and Cosmetic Act (21 U.S.C. 321), respectively, including any component or raw material used therein, but excluding health care services.

SEC. 10109. AUTHORIZATION OF PAYMENT OF FUTURE DAMAGES TO CLAIMANTS IN HEALTH CARE LAWSUITS.

(a) IN GENERAL.—In any health care lawsuit, if an award of future damages, without reduction to present value, equaling or exceeding $50,000 is made against a party with sufficient insurance or other assets to fund a periodic payment of such a judgment, the court shall, at the request of any party, enter a judgment ordering that the future damages be paid by periodic payments in accordance with the Uniform Periodic Payment of Judgments Act promulgated by the National Conference of Commissioners on Uniform State Laws.

(b) APPLICABILITY.—This section applies to all actions which have not been first set for trial or retrial before the effective date of this subtitle.

SEC. 10110. EFFECT ON OTHER LAWS.

(a) GENERAL VACCINE INJURY.—

(1) IN GENERAL.—To the extent that title XXI of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a vaccine-related injury or death—

(A) this subtitle shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this subtitle in conflict with a rule of law of such title XXI shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a vaccine-related injury or death to which a Federal rule of law under title XXI of the Public Health Service Act does not apply, then this subtitle or otherwise applicable law (as determined under this subtitle) will apply to such aspect of such action.

(b) SMALLPOX VACCINE INJURY.—

(1) IN GENERAL.—To the extent that part C of title II of the Public Health Service Act establishes a Federal rule of law applicable to a civil action brought for a smallpox vaccine-related injury or death—

(A) this subtitle shall not affect the application of the rule of law to such an action; and

(B) any rule of law prescribed by this subtitle in conflict with a rule of law of such part C shall not apply to such action.

(2) EXCEPTION.—If there is an aspect of a civil action brought for a smallpox vaccine-related injury or death to which a Federal rule of law under part C of title II of the Public Health Service Act does not apply, then this subtitle or otherwise applicable law (as determined under this subtitle) will apply to such aspect of such action.

(c) OTHER FEDERAL LAW.—Except as provided in this section, nothing in this subtitle shall be deemed to affect any defense available, or any limitation on liability that applies to, a defendant in a health care lawsuit or action under any other provision of Federal law.

SEC. 10111. STATE FLEXIBILITY AND PROTECTION OF STATES' RIGHTS.

(a) HEALTH CARE LAWSUITS.—The provisions governing health care lawsuits set forth in this subtitle shall preempt, subject to subsections (b) and (c), State law to the extent that State law prevents the application of any provisions of law established by or under this subtitle. The provisions governing health care lawsuits set forth in this subtitle supersede chapter 171 of title 28, United States Code, to the extent that such chapter—

(1) provides for a greater amount of damages or contingent fees, a longer period in which a health care lawsuit may be commenced, or a reduced applicability or scope of periodic payment of future damages, than provided in this subtitle; or

(2) prohibits the introduction of evidence regarding collateral source benefits.

(b) PREEMPTION OF CERTAIN STATE LAWS.—No provision of this subtitle shall be construed to preempt any State law (whether effective before, on, or after the date of the enactment of this Act) that specifies a particular monetary amount of compensatory or punitive damages (or the total amount of damages) that may be awarded in a health care lawsuit, regardless of whether such monetary amount is greater or lesser than is provided for under this subtitle, notwithstanding section 10105(a).

(c) PROTECTION OF STATE'S RIGHTS AND OTHER LAWS.—

(1) IN GENERAL.—Any issue that is not governed by a provision of law established by or under this subtitle (including the State standards of negligence) shall be governed by otherwise applicable Federal or State law.

(2) RULE OF CONSTRUCTION.—Nothing in this subtitle shall be construed to—

(A) preempt or supersede any Federal or State law that imposes greater procedural or substantive protections (such as a shorter statute of limitations) for a health care provider or health care institution from liability, loss, or damages than those provided by this subtitle;

(B) preempt or supercede any State law that permits and provides for the enforcement of any arbitration agreement related to a health care liability claim whether enacted prior to or after the date of enactment of this Act;

(C) create a cause of action that is not otherwise available under Federal or State law; or

(D) affect the scope of preemption of any other Federal law.

SEC. 10112. APPLICABILITY; EFFECTIVE DATE.

This subtitle shall apply to any health care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of the enactment of this Act, except that any health care lawsuit arising from an injury occurring prior to the date of enactment of this Act shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

SA 3183. Mr. BAUCUS submitted an amendment intended to be proposed by him to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place, insert the following:

SEC. ___. PROTECTING MIDDLE CLASS FAMILIES FROM TAX INCREASES.

It is the sense of the Senate that the Senate should reject any procedural maneuver that would raise taxes on middle class families, such as a motion to commit the pending legislation to the Committee on Finance, which is designed to kill legislation that provides tax cuts for American workers and families, including the affordability tax credit and the small business tax credit.

SA 3184. Mr. CASEY submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the appropriate place in title IX, insert the following:

Subtitle—Expansion of Adoption Credit and Adoption Assistance Programs

SEC. __01. EXPANSION OF ADOPTION CREDIT AND ADOPTION ASSISTANCE PROGRAMS.

(a) INCREASE IN DOLLAR LIMITATION.—

(1) ADOPTION CREDIT.—

(A) IN GENERAL.—Paragraph (1) of section 23(b) of the Internal Revenue Code of 1986 (relating to dollar limitation) is amended by striking ''$10,000'' and inserting ''$15,000''.

(B) CHILD WITH SPECIAL NEEDS.—Paragraph (3) of section 23(a) of such Code (relating to $10,000 credit for adoption of child with special needs regardless of expenses) is amended—

(i) in the text by striking ''$10,000'' and inserting ''$15,000'', and

(ii) in the heading by striking ''$10,000'' and inserting ''$15,000''.

(C) CONFORMING AMENDMENT TO INFLATION ADJUSTMENT.—Subsection (h) of section 23 of such Code (relating to adjustments for inflation) is amended to read as follows:

''(h) ADJUSTMENTS FOR INFLATION.—

''(1) DOLLAR LIMITATIONS.—In the case of a taxable year beginning after December 31, 2009, each of the dollar amounts in subsections (a)(3) and (b)(1) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2008' for 'calendar year 1992' in subparagraph (B) thereof.

If any amount as increased under the preceding sentence is not a multiple of $10, such amount shall be rounded to the nearest multiple of $10.

''(2) INCOME LIMITATION.—In the case of a taxable year beginning after December 31, 2002, the dollar amount in subsection (b)(2)(A)(i) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2001' for 'calendar year 1992' in subparagraph (B) thereof.

If any amount as increased under the preceding sentence is not a multiple of $10, such amount shall be rounded to the nearest multiple of $10.''.

(2) ADOPTION ASSISTANCE PROGRAMS.—

(A) IN GENERAL.—Paragraph (1) of section 137(b) of the Internal Revenue Code of 1986 (relating to dollar limitation) is amended by striking ''$10,000'' and inserting ''$15,000''.

(B) CHILD WITH SPECIAL NEEDS.—Paragraph (2) of section 137(a) of such Code (relating to $10,000 exclusion for adoption of child with special needs regardless of expenses) is amended—

(i) in the text by striking ''$10,000'' and inserting ''$15,000'', and

(ii) in the heading by striking ''$10,000'' and inserting ''$15,000''.

(C) CONFORMING AMENDMENT TO INFLATION ADJUSTMENT.—Subsection (f) of section 137 of such Code (relating to adjustments for inflation) is amended to read as follows:

''(f) ADJUSTMENTS FOR INFLATION.—

''(1) DOLLAR LIMITATIONS.—In the case of a taxable year beginning after December 31, 2009, each of the dollar amounts in subsections (a)(2) and (b)(1) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2008' for 'calendar year 1992' in subparagraph (B) thereof.

If any amount as increased under the preceding sentence is not a multiple of $10, such amount shall be rounded to the nearest multiple of $10.

''(2) INCOME LIMITATION.—In the case of a taxable year beginning after December 31, 2002, the dollar amount in subsection (b)(2)(A) shall be increased by an amount equal to—

''(A) such dollar amount, multiplied by

''(B) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which the taxable year begins, determined by substituting 'calendar year 2001' for 'calendar year 1992' in subparagraph thereof.

If any amount as increased under the preceding sentence is not a multiple of $10, such amount shall be rounded to the nearest multiple of $10.''.

(b) CREDIT MADE REFUNDABLE.—

(1) CREDIT MOVED TO SUBPART RELATING TO REFUNDABLE CREDITS.—The Internal Revenue Code of 1986 is amended—

(A) by redesignating section 23, as amended by subsection (a), as section 36B, and

(B) by moving section 36B (as so redesignated) from subpart A of part IV of subchapter A of chapter 1 to the location immediately before section 37 in subpart C of part IV of subchapter A of chapter 1.

(2) CONFORMING AMENDMENTS.—

(A) Section 24(b)(3)(B) of such Code is amended by striking ''23,''.

(B) Section 25(e)(1)(C) of such Code is amended by striking ''23,'' both places it appears.

(C) Section 25A(i)(5)(B) of such Code is amended by striking ''23, 25D,'' and inserting ''25D''.

(D) Section 25B(g)(2) of such Code is amended by striking ''23,''.

(E) Section 26(a)(1) of such Code is amended by striking ''23,''.

(F) Section 30(c)(2)(B)(ii) of such Code is amended by striking ''23, 25D,'' and inserting ''25D''.

(G) Section 30B(g)(2)(B)(ii) of such Code is amended by striking ''23,''.

(H) Section 30D(c)(2)(B)(ii) of such Code is amended by striking ''sections 23 and'' and inserting ''section''.

(I) Section 36B of such Code, as so redesignated, is amended—

(i) by striking paragraph (4) of subsection (b), and

(ii) by striking subsection (c).

(J) Section 137 of such Code is amended—

(i) by striking ''section 23(d)'' in subsection (d) and inserting ''section 36B(d)'', and

(ii) by striking ''section 23'' in subsection (e) and inserting ''section 36B''.

(K) Section 904(i) of such Code is amended by striking ''23,''.

(L) Section 1016(a)(26) is amended by striking ''23(g)'' and inserting ''36B(g)''.

(M) Section 1400C(d) of such Code is amended by striking ''23,''.

(N) The table of sections for subpart A of part IV of subchapter A of chapter 1 of such Code of 1986 is amended by striking the item relating to section 23.

(O) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting ''36B,'' after ''36A,''.

(P) 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. Adoption expenses.''.

(c) EXTENSION OF CREDIT AND ADOPTION ASSISTANCE PROGRAMS.—

(1) IN GENERAL.—Section 36B of the Internal Revenue Code of 1986, as redesignated by subsection (b), is amended by adding at the end the following new subsection:

''(i) TERMINATION.—This section shall not apply to expenses paid or incurred in taxable years beginning after December 31, 2014.''.

(2) IN GENERAL.—Section 137 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(g) TERMINATION.—This section shall not apply to expenses paid or incurred in taxable years beginning after December 31, 2014.''.

(3) SUNSET FOR MODIFICATIONS MADE BY EGTRRA TO ADOPTION CREDIT REMOVED.—Title IX of the Economic Growth and Tax Relief Reconciliation Act of 2001 shall not apply to the amendments made by section 202 of such Act.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2009.

SA 3185. Mr. BROWN submitted an amendment intended to be proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

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

SEC. 2721. INCREASED PAYMENTS FOR PEDIATRIC CARE UNDER MEDICAID.

(a) IN GENERAL.—

(1) FEE-FOR-SERVICE PAYMENTS.—Section 1902 of the Social Security Act (42 U.S.C. 1396b), as amended by section 2001(b)(2), is amended—

(A) in subsection (a)(13)—

(i) by striking ''and'' at the end of subparagraph (A);

(ii) by adding ''and'' at the end of subparagraph (B); and

(iii) by adding at the end the following new subparagraph:

''(C) payment for pediatric care services (as defined in subsection (hh)(1)) furnished by physicians (as defined in section 1861(r)) (or for services furnished by other health care professionals that would be pediatric care services under such subsection if furnished by a physician) at a rate not less than 80 percent of the payment rate that would be applicable if the adjustment described in subsection (hh)(2) were to apply to such services under part B of title XVIII (or, if there is no payment rate for such services under part B of title XVIII, the payment rate for the most comparable services, as determined by the Secretary in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1900 and adjusted as appropriate for a pediatric population) for services furnished in 2010, 90 percent of such adjusted payment rate for such services furnished in 2011, and 100 percent of such adjusted payment rate for such services furnished in 2012 and each subsequent year;''; and

(B) by adding at the end the following new subsection:

''(hh) INCREASED PAYMENT FOR PEDIATRIC CARE.—For purposes of subsection (a)(13)(C):

''(1) PEDIATRIC CARE SERVICES DEFINED.—The term 'pediatric care services' means evaluation and management services, without regard to the specialty of the physician or hospital furnishing the services, that are procedure codes (for services covered under title XVIII) for services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System (established by the Secretary under section 1848(c)(5) as of December 31, 2009, and as subsequently modified by the Secretary) and that are furnished to an individual who is enrolled in the State plan under this title who has not attained age 19. Such term includes procedure codes established by the Secretary, in consultation with the Medicaid and CHIP Payment and Access Commission established under section 1900, for services furnished under State plans under this title to individuals who have not attained age 19 and for which there is not an a procedure code (or a procedure code that the Secretary, in consultation with such Commission, determines is comparable) established under the Healthcare Common Procedure Coding System.

''(2) ADJUSTMENT.—The adjustment described in this paragraph is the substitution of 1.25 percent for the update otherwise provided under section 1848(d)(4) for each year beginning with 2010.''.

(2) UNDER MEDICAID MANAGED CARE PLANS.—Section 1932(f) of such Act (42 U.S.C. 1396u–2(f)) is amended—

(A) in the heading, by adding at the end the following: ''; ADEQUACY OF PAYMENT FOR PEDIATRIC CARE SERVICES''; and

(B) by inserting before the period at the end the following: ''and, in the case of pediatric care services described in section 1902(a)(13)(C), consistent with the minimum payment rates specified in such section (regardless of the manner in which such payments are made, including in the form of capitation or partial capitation)''.

(b) INCREASED FMAP.—Section 1905 of such Act (42 U.S.C. 1396d), as amended by sections 2006 and 4107(a)(2), is amended

(1) in the first sentence of subsection (b), by striking ''and'' before ''(4)'' and by inserting before the period at the end the following: '', and (5) 100 percent (for periods beginning with 2010) with respect to amounts described in subsection (cc)''; and

(2) by adding at the end the following new subsection:

''(cc) For purposes of section 1905(b)(5), the amounts described in this subsection are the following:

''(1)(A) The portion of the amounts expended for medical assistance for services described in section 1902(a)(13)(C) furnished on or after January 1, 2010, that is attributable to the amount by which the minimum payment rate required under such section (or, by application, section 1932(f)) exceeds the payment rate applicable to such services under the State plan as of the date of enactment of the Patient Protection and Affordable Care Act.

''(B) Subparagraph (A) shall not be construed as preventing the payment of Federal financial participation based on the Federal medical assistance percentage for amounts in excess of those specified under such subparagraph.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2010.

SA 3186. Mr. BROWN submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Beginning on page 729, strike line 21 and all that follows through line 13 on page 730, and insert the following:

''(xv) Promoting—

''(I) improved quality and reduced cost by developing a collaborative of high-quality, low-cost health care institutions that is responsible for—

''(aa) developing, documenting, and disseminating best practices and proven care methods;

''(bb) implementing such best practices and proven care methods within such institutions to demonstrate further improvements in quality and efficiency; and

''(cc) 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.

''(II) improved quality and reduced cost by developing a similarly focused collaborative of pediatric providers and institutions through the Medicaid and CHIP programs.''.

SA 3187. Mr. WYDEN (for himself and Mr. CRAPO) submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

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

SEC. 3130. MEDICARE CRITICAL ACCESS HOSPITAL PROVISIONS.

(a) FLEXIBILITY IN THE MANNER IN WHICH BEDS ARE COUNTED FOR PURPOSES OF DETERMINING WHETHER A HOSPITAL MAY BE DESIGNATED AS A CRITICAL ACCESS HOSPITAL UNDER THE MEDICARE PROGRAM.—

(1) IN GENERAL.—Section 1820(c)(2)(B) of the Social Security Act (42 U.S.C. 1395i–4(c)(2)(B)) is amended—

(A) in clause (iii), by inserting ''(or 20, as determined on an annual, average basis)'' after ''25''; and

(B) by adding at the end the following flush sentence:

''In determining the number of beds for purposes of clause (iii), only beds that are occupied shall be counted.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on January 1, 2010.

(b) CRITICAL ACCESS HOSPITAL INPATIENT BED LIMITATION EXEMPTION FOR BEDS PROVIDED TO CERTAIN VETERANS.—

(1) IN GENERAL.—Section 1820(c) of the Social Security Act (42 U.S.C. 1395i–4(c)) is amended by adding at the end the following new paragraph:

''(3) EXEMPTION FROM BED LIMITATION.—For purposes of this section, no acute care inpatient bed shall be counted against any numerical limitation specified under this section for such a bed (or for inpatient bed days with respect to such a bed) if the bed is provided for an individual who is a veteran and the Department of Veterans Affairs referred the individual for care in the hospital or is coordinating such care with other care being provided by such Department.''.

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

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SA 3188. Ms. CANTWELL submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

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

SEC. _____. TREATMENT OF HRAS.

For purposes of the provisions of, and amendments made by, this Act, and the provisions of any other law, funds from a health reimbursement arrangement used in whole or in part by an individual to purchase an individual or family health benefits plan shall not be considered or construed as an employer contribution and such individual or family plan shall not be considered or construed as a group health benefits plan.

SA 3189. Mr. ENZI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

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

SEC. 3404. AUTHORITY TO VARY THE AMOUNT OF THE MEDICARE PART B PREMIUM FOR NEW BENEFICIARIES THAT SMOKE AND BENEFICIARIES THAT MAKE HEALTHY CHOICES.

Section 1839 of the Social Security Act (42 U.S.C. 1395r) is amended—

(1) in subsection (a)(2), by striking ''and (i)'' and inserting ''(i), and (j)''; and

(2) by adding at the end the following new subsection:

''(j) AUTHORITY TO VARY THE AMOUNT OF THE PREMIUM FOR BENEFICIARIES THAT SMOKE AND BENEFICIARIES THAT MAKE HEALTHY CHOICES.—With respect to the monthly premium amount for individuals who enroll under this part after the date of the enactment of the Patient Protection and Affordable Care Act, the Secretary shall vary the amount of such premium for such an individual if the individual smokes or makes healthy choices to improve health outcomes (as defined by the Secretary).''.

SA 3190. Mr. ENZI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 245, between lines 14 and 15, and insert the following:

(B) SPECIAL RULE FOR CERTAIN INDIVIDUALS ELIGIBLE FOR MEDICAID.—If a taxpayer is an individual described in section 1902(k)(3) of the Social Security Act who elects, in accordance with procedures established by a State under that section, to enroll in a qualified health plan and whose household income does not exceed 100 percent of an amount equal to the poverty line for a family of the size involved, the taxpayer shall—

(i) for purposes of the credit under this section, be treated as an applicable taxpayer and the applicable percentage with respect to such taxpayer shall be 2.0 percent; and

(ii) for purposes of reduced cost-sharing under section 1402 of the Patient Protection and Affordable Care Act, shall be treated as having household income of more than 100 percent but less than 150 percent of the poverty line (as so defined) applicable to a family of the size involved.

On page 404, between lines 13 and 14, insert the following:

''(3) The State shall establish procedures to ensure that any individual eligible for medical assistance under the State plan or under a waiver of the plan (under any subclause of subsection (a)(10)(A) or otherwise) who is not elderly or disabled may elect to enroll in a qualified health plan through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act instead of enrolling in the State plan under this title or a waiver of the plan. An individual making such an election shall waive being provided with medical assistance under the State plan or waiver while enrolled in the qualified health plan. In the case of an individual who is a child, the child's parent may make such an election on behalf of the child.

SA 3191. Mr. ENZI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

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

SEC. 4403. TERMINATION OF PROGRAMS.

Notwithstanding any other provision of this Act (or an amendment made by this Act), the Secretary of Health and Human Services shall terminate a program established under this title if the Secretary of Health and Human Services determines that such program has not reduced health care costs for the Federal government and beneficiaries under such program.

SA 3192. Mr. ENZI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

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

''(f) LIMITATION.—If in any calendar year the national unemployment rate (as determined by the Bureau of Labor Statistics) exceeds 6 percent, then, notwithstanding any other provision of law, this section shall not apply for the remainder of such calendar year.''.

SA 3193. Mr. ENZI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 1142, strike lines 8 through 16 and insert the following:

(c) USE OF FUND.—Notwithstanding any other provision of this Act (or an amendment made by this Act), the Secretary shall allocate amounts in the Fund to the high risk pool program under section 1101 and the reinsurance program for individual and small group markets in each State under section 1341, in order to lower health care premiums for Americans.

SA 3194. Mr. ENZI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle E of title IV, insert the following:

SEC. 4403. PROHIBITION ON THE USE OF FUNDS FOR THE CONSTRUCTION OF SIDEWALKS, PLAYGROUNDS, OR JUNGLE GYMS.

Notwithstanding any other provision of this Act (or an amendment made by this Act), no funds appropriated under this Act (or an amendment made by this Act) shall be allocated to pay for the construction of sidewalks, playgrounds, or jungle gyms.

SA 3195. Mr. ENZI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 101, between lines 19 and 20, insert the following:

(3) INCLUSION OF HIGH DEDUCTIBLE HEALTH PLANS.—If a health plan is a high deductible health plan (as defined in section 223(c)(2) of the Internal Revenue Code of 1986) that meets all requirements under such section to be offered in connection with a health savings account—

(A) such plan shall be treated as a qualified health plan under this section, and as minimum essential coverage under section 5000A of such Code, for purposes of this Act and the amendments made by this Act;

(B) no requirement imposed by any provision of, or any amendment made by, this Act shall apply with respect to the plan or issuer thereof.

SA 3196. Mr. ENZI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

On page 54, between lines 19 and 20, insert the following:

(g) USE OF FUND.—Notwithstanding any other provision of this Act (or an amendment made by this Act), the Secretary shall allocate amounts appropriated under subsection (e) to the high risk pool program under section 1101 and the reinsurance program for individual and small group markets in each State under section 1341, in order to lower health care premiums for Americans.

SA 3197. Mr. ENZI submitted an amendment intended to be proposed to amendment SA 2786 proposed by Mr. REID (for himself, Mr. BAUCUS, Mr. DODD, and Mr. HARKIN) to the bill H.R. 3590, to amend the Internal Revenue Code of 1986 to modify the first-time homebuyers credit in the case of members of the Armed Forces and certain other Federal employees, and for other purposes; which was ordered to lie on the table; as follows:

Strike the matter proposed to be inserted and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Small Business Health Plans Act of 2009''.

TITLE I—ENHANCED MARKETPLACE POOLS

SEC. 101. RULES GOVERNING ENHANCED MARKETPLACE POOLS.

(a) IN GENERAL.—Subtitle B of title I of the Employee Retirement Income Security Act of 1974 is amended by adding after part 7 the following new part:

"PART 8—RULES GOVERNING ENHANCED MARKETPLACE POOLS

"SEC. 801. SMALL BUSINESS HEALTH PLANS.

''(a) IN GENERAL.—For purposes of this part, the term 'small business health plan' means a fully insured group health plan whose sponsor is (or is deemed under this part to be) described in subsection (b).

''(b) SPONSORSHIP.—The sponsor of a group health plan is described in this subsection if such sponsor—

''(1) is organized and maintained in good faith, with a constitution and bylaws specifically stating its purpose and providing for periodic meetings on at least an annual basis, as a bona fide trade association, a bona fide industry association (including a rural electric cooperative association or a rural telephone cooperative association), a bona fide professional association, or a bona fide chamber of commerce (or similar bona fide business association, including a corporation or similar organization that operates on a cooperative basis (within the meaning of section 1381 of the Internal Revenue Code of 1986)), for substantial purposes other than that of obtaining medical care;

''(2) is established as a permanent entity which receives the active support of its members and requires for membership payment on a periodic basis of dues or payments necessary to maintain eligibility for membership;

''(3) does not condition membership, such dues or payments, or coverage under the plan on the basis of health status-related factors with respect to the employees of its members (or affiliated members), or the dependents of such employees, and does not condition such dues or payments on the basis of group health plan participation; and

''(4) does not condition membership on the basis of a minimum group size.

Any sponsor consisting of an association of entities which meet the requirements of paragraphs (1), (2), (3), and (4) shall be deemed to be a sponsor described in this subsection.

"SEC. 802. ALTERNATIVE MARKET POOLING ORGANIZATIONS.

''(a) IN GENERAL.—The Secretary, not later than 1 year after the date of enactment of this part, shall promulgate regulations that apply the rules and standards of this part, as necessary, to circumstances in which a pooling entity other (hereinafter 'Alternative Market Pooling Organizations') is not made up principally of employers and their employees, or not a professional organization or such small business health plan entity identified in section 801.

''(b) ADAPTION OF STANDARDS.—In developing and promulgating regulations pursuant to subsection (a), the Secretary, in consultation with the Secretary of Health and Human Services, small business health plans, small and large employers, large and small insurance issuers, consumer representatives, and state insurance commissioners, shall—

''(1) adapt the standards of this part, to the maximum degree practicable, to assure balanced and comparable oversight standards for both small business health plans and alternative market pooling organizations;

''(2) permit the participation as alternative market pooling organizations unions, churches and other faith-based organizations, or other organizations composed of individuals and groups which may have little or no association with employment, provided however, that such alternative market pooling organizations meet, and continue meeting on an ongoing basis, to satisfy standards, rules, and requirements materially equivalent to those set forth in this part with respect to small business health plans;

''(3) conduct periodic verification of such compliance by alternative market pooling organizations, in consultation with the Secretary of Health and Human Services and the National Association of Insurance Commissioners, except that such periodic verification shall not materially impede market entry or participation as pooling entities comparable to that of small business health plans;

''(4) assure that consistent, clear, and regularly monitored standards are applied with respect to alternative market pooling organizations to avert material risk-selection within or among the composition of such organizations;

''(5) the expedited and deemed certification procedures provided in section 805(d) shall not apply to alternative market pooling organizations until sooner of the promulgation of regulations under this subsection or the expiration of one year following enactment of this Act; and

''(6) make such other appropriate adjustments to the requirements of this part as the Secretary may reasonably deem appropriate to fit the circumstances of an individual alternative market pooling organization or category of such organization, including but not limited to the application of the membership payment requirements of section 801(b)(2) to alternative market pooling organizations composed primarily of church- or faith-based membership.

"SEC. 803. CERTIFICATION OF SMALL BUSINESS HEALTH PLANS.

''(a) IN GENERAL.—Not later than 6 months after the date of enactment of this part, the applicable authority shall prescribe by interim final rule a procedure under which the applicable authority shall certify small business health plans which apply for certification as meeting the requirements of this part.

''(b) REQUIREMENTS APPLICABLE TO CERTIFIED PLANS.—A small business health plan with respect to which certification under this part is in effect shall meet the applicable requirements of this part, effective on the date of certification (or, if later, on the date on which the plan is to commence operations).

''(c) REQUIREMENTS FOR CONTINUED CERTIFICATION.—The applicable authority may provide by regulation for continued certification of small business health plans under this part. Such regulation shall provide for the revocation of a certification if the applicable authority finds that the small business health plan involved is failing to comply with the requirements of this part.

''(d) EXPEDITED AND DEEMED CERTIFICATION.—

''(1) IN GENERAL.—If the Secretary fails to act on an application for certification under this section within 90 days of receipt of such application, the applying small business health plan shall be deemed certified until such time as the Secretary may deny for cause the application for certification.

''(2) CIVIL PENALTY.—The Secretary may assess a civil penalty against the board of trustees and plan sponsor (jointly and severally) of a small business health plan that is deemed certified under paragraph (1) of up to $500,000 in the event the Secretary determines that the application for certification of such small business health plan was willfully or with gross negligence incomplete or inaccurate.

"SEC. 804. REQUIREMENTS RELATING TO SPONSORS AND BOARDS OF TRUSTEES.

''(a) SPONSOR.—The requirements of this subsection are met with respect to a small business health plan if the sponsor has met (or is deemed under this part to have met) the requirements of section 801(b) for a continuous period of not less than 3 years ending with the date of the application for certification under this part.

''(b) BOARD OF TRUSTEES.—The requirements of this subsection are met with respect to a small business health plan if the following requirements are met:

''(1) FISCAL CONTROL.—The plan is operated, pursuant to a plan document, by a board of trustees which pursuant to a trust agreement has complete fiscal control over the plan and which is responsible for all operations of the plan.

''(2) RULES OF OPERATION AND FINANCIAL CONTROLS.—The board of trustees has in effect rules of operation and financial controls, based on a 3-year plan of operation, adequate to carry out the terms of the plan and to meet all requirements of this title applicable to the plan.

''(3) RULES GOVERNING RELATIONSHIP TO PARTICIPATING EMPLOYERS AND TO CONTRACTORS.—

''(A) BOARD MEMBERSHIP.—

''(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), the members of the board of trustees are individuals selected from individuals who are the owners, officers, directors, or employees of the participating employers or who are partners in the participating employers and actively participate in the business.

''(ii) LIMITATION.—

''(I) GENERAL RULE.—Except as provided in subclauses (II) and (III), no such member is an owner, officer, director, or employee of, or partner in, a contract administrator or other service provider to the plan.

''(II) LIMITED EXCEPTION FOR PROVIDERS OF SERVICES SOLELY ON BEHALF OF THE SPONSOR.—Officers or employees of a sponsor which is a service provider (other than a contract administrator) to the plan may be members of the board if they constitute not more than 25 percent of the membership of the board and they do not provide services to the plan other than on behalf of the sponsor.

''(III) TREATMENT OF PROVIDERS OF MEDICAL CARE.—In the case of a sponsor which is an association whose membership consists primarily of providers of medical care, subclause (I) shall not apply in the case of any service provider described in subclause (I) who is a provider of medical care under the plan.

''(iii) CERTAIN PLANS EXCLUDED.—Clause (i) shall not apply to a small business health plan which is in existence on the date of the enactment of the Small Business Health Plans Act of 2009.

''(B) SOLE AUTHORITY.—The board has sole authority under the plan to approve applications for participation in the plan and to contract with insurers.

''(c) TREATMENT OF FRANCHISES.—In the case of a group health plan which is established and maintained by a franchiser for a franchisor or for its franchisees—

''(1) the requirements of subsection (a) and section 801(a) shall be deemed met if such requirements would otherwise be met if the franchisor were deemed to be the sponsor referred to in section 801(b) and each franchisee were deemed to be a member (of the sponsor) referred to in section 801(b); and

''(2) the requirements of section 804(a)(1) shall be deemed met.

For purposes of this subsection the terms 'franchisor' and 'franchisee' shall have the

meanings given such terms for purposes of sections 436.2(a) through 436.2(c) of title 16, Code of Federal Regulations (including any such amendments to such regulation after the date of enactment of this part).

"SEC. 805. PARTICIPATION AND COVERAGE REQUIREMENTS.

''(a) COVERED EMPLOYERS AND INDIVIDUALS.—The requirements of this subsection are met with respect to a small business health plan if, under the terms of the plan—

''(1) each participating employer must be—

''(A) a member of the sponsor;

''(B) the sponsor; or

''(C) an affiliated member of the sponsor, except that, in the case of a sponsor which is a professional association or other individual-based association, if at least one of the officers, directors, or employees of an employer, or at least one of the individuals who are partners in an employer and who actively participates in the business, is a member or such an affiliated member of the sponsor, participating employers may also include such employer; and

''(2) all individuals commencing coverage under the plan after certification under this part must be—

''(A) active or retired owners (including self-employed individuals), officers, directors, or employees of, or partners in, participating employers; or

''(B) the dependents of individuals described in subparagraph (A).

''(b) INDIVIDUAL MARKET UNAFFECTED.—The requirements of this subsection are met with respect to a small business health plan if, under the terms of the plan, no participating employer may provide health insurance coverage in the individual market for any employee not covered under the plan which is similar to the coverage contemporaneously provided to employees of the employer under the plan, if such exclusion of the employee from coverage under the plan is based on a health status-related factor with respect to the employee and such employee would, but for such exclusion on such basis, be eligible for coverage under the plan.

''(c) PROHIBITION OF DISCRIMINATION AGAINST EMPLOYERS AND EMPLOYEES ELIGIBLE TO PARTICIPATE.—The requirements of this subsection are met with respect to a small business health plan if—

''(1) under the terms of the plan, all employers meeting the preceding requirements of this section are eligible to qualify as participating employers for all geographically available coverage options, unless, in the case of any such employer, participation or contribution requirements of the type referred to in section 2711 of the Public Health Service Act are not met;

''(2) information regarding all coverage options available under the plan is made readily available to any employer eligible to participate; and

''(3) the applicable requirements of sections 701, 702, and 703 are met with respect to the plan.

"SEC. 806. OTHER REQUIREMENTS RELATING TO PLAN DOCUMENTS, CONTRIBUTION RATES, AND BENEFIT OPTIONS.

''(a) IN GENERAL.—The requirements of this section are met with respect to a small business health plan if the following requirements are met:

''(1) CONTENTS OF GOVERNING INSTRUMENTS.—

''(A) IN GENERAL.—The instruments governing the plan include a written instrument, meeting the requirements of an instrument required under section 402(a)(1), which—

''(i) provides that the board of trustees serves as the named fiduciary required for plans under section 402(a)(1) and serves in the capacity of a plan administrator (referred to in section 3(16)(A)); and

''(ii) provides that the sponsor of the plan is to serve as plan sponsor (referred to in section 3(16)(B)).

''(B) DESCRIPTION OF MATERIAL PROVISIONS.—The terms of the health insurance coverage (including the terms of any individual certificates that may be offered to individuals in connection with such coverage) describe the material benefit and rating, and other provisions set forth in this section and such material provisions are included in the summary plan description.

''(2) CONTRIBUTION RATES MUST BE NONDISCRIMINATORY.—

''(A) IN GENERAL.—The contribution rates for any participating small employer shall not vary on the basis of any health status-related factor in relation to employees of such employer or their beneficiaries and shall not vary on the basis of the type of business or industry in which such employer is engaged, subject to subparagraph (B) and the terms of this title.

''(B) EFFECT OF TITLE.—Nothing in this title or any other provision of law shall be construed to preclude a health insurance issuer offering health insurance coverage in connection with a small business health plan that meets the requirements of this part, and at the request of such small business health plan, from—

''(i) setting contribution rates for the small business health plan based on the claims experience of the small business health plan so long as any variation in such rates for participating small employers complies with the requirements of clause (ii), except that small business health plans shall not be subject, in non-adopting states, to subparagraphs (A)(ii) and (C) of section 2912(a)(2) of the Public Health Service Act, and in adopting states, to any State law that would have the effect of imposing requirements as outlined in such subparagraphs (A)(ii) and (C); or

''(ii) varying contribution rates for participating small employers in a small business health plan in a State to the extent that such rates could vary using the same methodology employed in such State for regulating small group premium rates, subject to the terms of part I of subtitle A of title XXIX of the Public Health Service Act (relating to rating requirements), as added by title II of the Small Business Health Plans Act of 2009.

''(3) EXCEPTIONS REGARDING SELF-EMPLOYED AND LARGE EMPLOYERS.—

''(A) SELF EMPLOYED.—

''(i) IN GENERAL.—Small business health plans with participating employers who are self-employed individuals (and their dependents) shall enroll such self-employed participating employers in accordance with rating rules that do not violate the rating rules for self-employed individuals in the State in which such self-employed participating employers are located.

''(ii) GUARANTEE ISSUE.—Small business health plans with participating employers who are self-employed individuals (and their dependents) may decline to guarantee issue to such participating employers in States in which guarantee issue is not otherwise required for the self-employed in that State.

''(B) LARGE EMPLOYERS.—Small business health plans with participating employers that are larger than small employers (as defined in section 808(a)(10)) shall enroll such large participating employers in accordance with rating rules that do not violate the rating rules for large employers in the State in which such large participating employers are located.

''(4) REGULATORY REQUIREMENTS.—Such other requirements as the applicable authority determines are necessary to carry out the purposes of this part, which shall be prescribed by the applicable authority by regulation.

''(b) ABILITY OF SMALL BUSINESS HEALTH PLANS TO DESIGN BENEFIT OPTIONS.—Nothing in this part or any provision of State law (as defined in section 514(c)(1)) shall be construed to preclude a small business health plan or a health insurance issuer offering health insurance coverage in connection with a small business health plan from exercising its sole discretion in selecting the specific benefits and services consisting of medical care to be included as benefits under such plan or coverage, except that such benefits and services must meet the terms and specifications of part II of subtitle A of title XXIX of the Public Health Service Act (relating to lower cost plans), as added by title II of the Small Business Health Plans Act of 2009.

''(c) DOMICILE AND NON-DOMICILE STATES.—

''(1) DOMICILE STATE.—Coverage shall be issued to a small business health plan in the State in which the sponsor's principal place of business is located.

''(2) NON-DOMICILE STATES.—With respect to a State (other than the domicile State) in which participating employers of a small business health plan are located but in which the insurer of the small business health plan in the domicile State is not yet licensed, the following shall apply:

''(A) TEMPORARY PREEMPTION.—If, upon the expiration of the 90-day period following the submission of a licensure application by such insurer (that includes a certified copy of an approved licensure application as submitted by such insurer in the domicile State) to such State, such State has not approved or denied such application, such State's health insurance licensure laws shall be temporarily preempted and the insurer shall be permitted to operate in such State, subject to the following terms:

''(i) APPLICATION OF NON-DOMICILE STATE LAW.—Except with respect to licensure and with respect to the terms of subtitle A of title XXIX of the Public Health Service Act (relating to rating and benefits as added by the Small Business Health Plans Act of 2009), the laws and authority of the non-domicile State shall remain in full force and effect.

''(ii) REVOCATION OF PREEMPTION.—The preemption of a non-domicile State's health insurance licensure laws pursuant to this subparagraph, shall be terminated upon the occurrence of either of the following:

''(I) APPROVAL OR DENIAL OF APPLICATION.—The approval of denial of an insurer's licensure application, following the laws and regulations of the non-domicile State with respect to licensure.

''(II) DETERMINATION OF MATERIAL VIOLATION.—A determination by a non-domicile State that an insurer operating in a non-domicile State pursuant to the preemption provided for in this subparagraph is in material violation of the insurance laws (other than licensure and with respect to the terms of subtitle A of title XXIX of the Public Health Service Act (relating to rating and benefits added by the Small Business Health Plans Act of 2009)) of such State.

''(B) NO PROHIBITION ON PROMOTION.—Nothing in this paragraph shall be construed to prohibit a small business health plan or an insurer from promoting coverage prior to the expiration of the 90-day period provided for in subparagraph (A), except that no enrollment or collection of contributions shall occur before the expiration of such 90-day period.

''(C) LICENSURE.—Except with respect to the application of the temporary preemption provision of this paragraph, nothing in this part shall be construed to limit the requirement that insurers issuing coverage to small business health plans shall be licensed in

each State in which the small business health plans operate.

''(D) SERVICING BY LICENSED INSURERS.—Notwithstanding subparagraph (C), the requirements of this subsection may also be satisfied if the participating employers of a small business health plan are serviced by a licensed insurer in that State, even where such insurer is not the insurer of such small business health plan in the State in which such small business health plan is domiciled.

''SEC. 807. REQUIREMENTS FOR APPLICATION AND RELATED REQUIREMENTS.

''(a) FILING FEE.—Under the procedure prescribed pursuant to section 802(a), a small business health plan shall pay to the applicable authority at the time of filing an application for certification under this part a filing fee in the amount of $5,000, which shall be available in the case of the Secretary, to the extent provided in appropriation Acts, for the sole purpose of administering the certification procedures applicable with respect to small business health plans.

''(b) INFORMATION TO BE INCLUDED IN APPLICATION FOR CERTIFICATION.—An application for certification under this part meets the requirements of this section only if it includes, in a manner and form which shall be prescribed by the applicable authority by regulation, at least the following information:

''(1) IDENTIFYING INFORMATION.—The names and addresses of—

''(A) the sponsor; and

''(B) the members of the board of trustees of the plan.

''(2) STATES IN WHICH PLAN INTENDS TO DO BUSINESS.—The States in which participants and beneficiaries under the plan are to be located and the number of them expected to be located in each such State.

''(3) BONDING REQUIREMENTS.—Evidence provided by the board of trustees that the bonding requirements of section 412 will be met as of the date of the application or (if later) commencement of operations.

''(4) PLAN DOCUMENTS.—A copy of the documents governing the plan (including any bylaws and trust agreements), the summary plan description, and other material describing the benefits that will be provided to participants and beneficiaries under the plan.

''(5) AGREEMENTS WITH SERVICE PROVIDERS.—A copy of any agreements between the plan, health insurance issuer, and contract administrators and other service providers.

''(c) FILING NOTICE OF CERTIFICATION WITH STATES.—A certification granted under this part to a small business health plan shall not be effective unless written notice of such certification is filed with the applicable State authority of each State in which the small business health plans operate.

''(d) NOTICE OF MATERIAL CHANGES.—In the case of any small business health plan certified under this part, descriptions of material changes in any information which was required to be submitted with the application for the certification under this part shall be filed in such form and manner as shall be prescribed by the applicable authority by regulation. The applicable authority may require by regulation prior notice of material changes with respect to specified matters which might serve as the basis for suspension or revocation of the certification.

''SEC. 808. NOTICE REQUIREMENTS FOR VOLUNTARY TERMINATION.

''A small business health plan which is or has been certified under this part may terminate (upon or at any time after cessation of accruals in benefit liabilities) only if the board of trustees, not less than 60 days before the proposed termination date—

''(1) provides to the participants and beneficiaries a written notice of intent to terminate stating that such termination is intended and the proposed termination date;

''(2) develops a plan for winding up the affairs of the plan in connection with such termination in a manner which will result in timely payment of all benefits for which the plan is obligated; and

''(3) submits such plan in writing to the applicable authority.

Actions required under this section shall be taken in such form and manner as may be prescribed by the applicable authority by regulation.

''SEC. 809. IMPLEMENTATION AND APPLICATION AUTHORITY BY SECRETARY.

''The Secretary shall, through promulgation and implementation of such regulations as the Secretary may reasonably determine necessary or appropriate, and in consultation with a balanced spectrum of effected entities and persons, modify the implementation and application of this part to accommodate with minimum disruption such changes to State or Federal law provided in this part and the (and the amendments made by such Act) or in regulations issued thereto.

''SEC. 810. DEFINITIONS AND RULES OF CONSTRUCTION.

''(a) DEFINITIONS.—For purposes of this part—

''(1) AFFILIATED MEMBER.—The term 'affiliated member' means, in connection with a sponsor—

''(A) a person who is otherwise eligible to be a member of the sponsor but who elects an affiliated status with the sponsor, or

''(B) in the case of a sponsor with members which consist of associations, a person who is a member or employee of any such association and elects an affiliated status with the sponsor.

''(2) APPLICABLE AUTHORITY.—The term 'applicable authority' means the Secretary of Labor, except that, in connection with any exercise of the Secretary's authority with respect to which the Secretary is required under section 506(d) to consult with a State, such term means the Secretary, in consultation with such State.

''(3) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of title XXVII of the Public Health Service Act for the State involved with respect to such issuer.

''(4) GROUP HEALTH PLAN.—The term 'group health plan' has the meaning provided in section 733(a)(1) (after applying subsection (b) of this section).

''(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' has the meaning provided in section 733(b)(1), except that such term shall not include excepted benefits (as defined in section 733(c)).

''(6) HEALTH INSURANCE ISSUER.—The term 'health insurance issuer' has the meaning provided in section 733(b)(2).

''(7) INDIVIDUAL MARKET.—

''(A) IN GENERAL.—The term 'individual market' means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

''(B) TREATMENT OF VERY SMALL GROUPS.—

''(i) IN GENERAL.—Subject to clause (ii), such term includes coverage offered in connection with a group health plan that has fewer than 2 participants as current employees or participants described in section 732(d)(3) on the first day of the plan year.

''(ii) STATE EXCEPTION.—Clause (i) shall not apply in the case of health insurance coverage offered in a State if such State regulates the coverage described in such clause in the same manner and to the same extent as coverage in the small group market (as defined in section 2791(e)(5) of the Public Health Service Act) is regulated by such State.

''(8) MEDICAL CARE.—The term 'medical care' has the meaning provided in section 733(a)(2).

''(9) PARTICIPATING EMPLOYER.—The term 'participating employer' means, in connection with a small business health plan, any employer, if any individual who is an employee of such employer, a partner in such employer, or a self-employed individual who is such employer (or any dependent, as defined under the terms of the plan, of such individual) is or was covered under such plan in connection with the status of such individual as such an employee, partner, or self-employed individual in relation to the plan.

''(10) SMALL EMPLOYER.—The term 'small employer' means, in connection with a group health plan with respect to a plan year, a small employer as defined in section 2791(e)(4).

''(11) TRADE ASSOCIATION AND PROFESSIONAL ASSOCIATION.—The terms 'trade association' and 'professional association' mean an entity that meets the requirements of section 1.501(c)(6)–1 of title 26, Code of Federal Regulations (as in effect on the date of enactment of this Act).

''(b) RULE OF CONSTRUCTION.—For purposes of determining whether a plan, fund, or program is an employee welfare benefit plan which is a small business health plan, and for purposes of applying this title in connection with such plan, fund, or program so determined to be such an employee welfare benefit plan—

''(1) in the case of a partnership, the term 'employer' (as defined in section 3(5)) includes the partnership in relation to the partners, and the term 'employee' (as defined in section 3(6)) includes any partner in relation to the partnership; and

''(2) in the case of a self-employed individual, the term 'employer' (as defined in section 3(5)) and the term 'employee' (as defined in section 3(6)) shall include such individual.

''(c) RENEWAL.—Notwithstanding any provision of law to the contrary, a participating employer in a small business health plan shall not be deemed to be a plan sponsor in applying requirements relating to coverage renewal.

''(d) HEALTH SAVINGS ACCOUNTS.—Nothing in this part shall be construed to create any mandates for coverage of benefits for HSA-qualified health plans that would require reimbursements in violation of section 223(c)(2) of the Internal Revenue Code of 1986.''.

(b) CONFORMING AMENDMENTS TO PREEMPTION RULES.—

(1) Section 514(b)(6) of such Act (29 U.S.C. 1144(b)(6)) is amended by adding at the end the following new subparagraph:

''(E) The preceding subparagraphs of this paragraph do not apply with respect to any State law in the case of a small business health plan which is certified under part 8.''.

(2) Section 514 of such Act (29 U.S.C. 1144) is amended—

(A) in subsection (b)(4), by striking ''Subsection (a)'' and inserting ''Subsections (a) and (d)'';

(B) in subsection (b)(5), by striking ''subsection (a)'' in subparagraph (A) and inserting ''subsection (a) of this section and subsections (a)(2)(B) and (b) of section 805'', and by striking ''subsection (a)'' in subparagraph (B) and inserting ''subsection (a) of this section or subsection (a)(2)(B) or (b) of section 805'';

(C) by redesignating subsection (d) as subsection (e); and

(D) by inserting after subsection (c) the following new subsection:

''(d)(1) Except as provided in subsection (b)(4), the provisions of this title shall supersede any and all State laws insofar as they may now or hereafter preclude a health insurance issuer from offering health insurance coverage in connection with a small business health plan which is certified under part 8.

''(2) In any case in which health insurance coverage of any policy type is offered under a small business health plan certified under part 8 to a participating employer operating in such State, the provisions of this title shall supersede any and all laws of such State insofar as they may establish rating and benefit requirements that would otherwise apply to such coverage, provided the requirements of subtitle A of title XXIX of the Public Health Service Act (as added by title II of the Health Insurance Marketplace Modernization and Affordability Act of 2007) (concerning health plan rating and benefits) are met.''.

(c) PLAN SPONSOR.—Section 3(16)(B) of such Act (29 U.S.C. 102(16)(B)) is amended by adding at the end the following new sentence: ''Such term also includes a person serving as the sponsor of a small business health plan under part 8.''.

(d) SAVINGS CLAUSE.—Section 731(c) of such Act is amended by inserting ''or part 8'' after ''this part''.

(e) CLERICAL AMENDMENT.—The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 734 the following new items:

''PART 8—RULES GOVERNING SMALL BUSINESS HEALTH PLANS

''801. Small business health plans.
''802. Alternative market pooling organizations.
''803. Certification of small business health plans.
''804. Requirements relating to sponsors and boards of trustees.
''805. Participation and coverage requirements.
''806. Other requirements relating to plan documents, contribution rates, and benefit options.
''807. Requirements for application and related requirements.
''808. Notice requirements for voluntary termination.
''809. Implementation and application authority by Secretary.
''810. Definitions and rules of construction.''.

SEC. 102. COOPERATION BETWEEN FEDERAL AND STATE AUTHORITIES.

Section 506 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1136) is amended by adding at the end the following new subsection:

''(d) CONSULTATION WITH STATES WITH RESPECT TO SMALL BUSINESS HEALTH PLANS.—

''(1) AGREEMENTS WITH STATES.—The Secretary shall consult with the State recognized under paragraph (2) with respect to a small business health plan regarding the exercise of—

''(A) the Secretary's authority under sections 502 and 504 to enforce the requirements for certification under part 8; and

''(B) the Secretary's authority to certify small business health plans under part 8 in accordance with regulations of the Secretary applicable to certification under part 8.

''(2) RECOGNITION OF DOMICILE STATE.—In carrying out paragraph (1), the Secretary shall ensure that only one State will be recognized, with respect to any particular small business health plan, as the State with which consultation is required. In carrying out this paragraph such State shall be the domicile State, as defined in section 805(c).''.

SEC. 103. EFFECTIVE DATE AND TRANSITIONAL AND OTHER RULES.

(a) EFFECTIVE DATE.—The amendments made by this title shall take effect 12 months after the date of the enactment of this Act. The Secretary of Labor shall first issue all regulations necessary to carry out the amendments made by this title within 6 months after the date of the enactment of this Act.

(b) TREATMENT OF CERTAIN EXISTING HEALTH BENEFITS PROGRAMS.—

(1) IN GENERAL.—In any case in which, as of the date of the enactment of this Act, an arrangement is maintained in a State for the purpose of providing benefits consisting of medical care for the employees and beneficiaries of its participating employers, at least 200 participating employers make contributions to such arrangement, such arrangement has been in existence for at least 10 years, and such arrangement is licensed under the laws of one or more States to provide such benefits to its participating employers, upon the filing with the applicable authority (as defined in section 808(a)(2) of the Employee Retirement Income Security Act of 1974 (as amended by this subtitle)) by the arrangement of an application for certification of the arrangement under part 8 of subtitle B of title I of such Act—

(A) such arrangement shall be deemed to be a group health plan for purposes of title I of such Act;

(B) the requirements of sections 801(a) and 803(a) of the Employee Retirement Income Security Act of 1974 shall be deemed met with respect to such arrangement;

(C) the requirements of section 803(b) of such Act shall be deemed met, if the arrangement is operated by a board of trustees which has control over the arrangement;

(D) the requirements of section 804(a) of such Act shall be deemed met with respect to such arrangement; and

(E) the arrangement may be certified by any applicable authority with respect to its operations in any State only if it operates in such State on the date of certification.

The provisions of this subsection shall cease to apply with respect to any such arrangement at such time after the date of the enactment of this Act as the applicable requirements of this subsection are not met with respect to such arrangement or at such time that the arrangement provides coverage to participants and beneficiaries in any State other than the States in which coverage is provided on such date of enactment.

(2) DEFINITIONS.—For purposes of this subsection, the terms ''group health plan'', ''medical care'', and ''participating employer'' shall have the meanings provided in section 808 of the Employee Retirement Income Security Act of 1974, except that the reference in paragraph (7) of such section to an ''small business health plan'' shall be deemed a reference to an arrangement referred to in this subsection.

TITLE II—MARKET RELIEF

SEC. 301. MARKET RELIEF.

The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

''TITLE XXIX—HEALTH CARE INSURANCE MARKETPLACE MODERNIZATION

''SEC. 2901. GENERAL INSURANCE DEFINITIONS.

''In this title, the terms 'health insurance coverage', 'health insurance issuer', 'group health plan', and 'individual health insurance' shall have the meanings given such terms in section 2791.

''SEC. 2902. IMPLEMENTATION AND APPLICATION AUTHORITY BY SECRETARY.

''The Secretary shall, through promulgation and implementation of such regulations as the Secretary may reasonably determine necessary or appropriate, and in consultation with a balanced spectrum of effected entities and persons, modify the implementation and application of this title to accommodate with minimum disruption such changes to State or Federal law provided in this title and the (and the amendments made by such Act) or in regulations issued thereto.

''Subtitle A—Market Relief

''PART I—RATING REQUIREMENTS

''SEC. 2911. DEFINITIONS.

''In this part:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that, with respect to the small group market, has enacted small group rating rules that meet the minimum standards set forth in section 2912(a)(1) or, as applicable, transitional small group rating rules set forth in section 2912(b).

''(2) APPLICABLE STATE AUTHORITY.—The term 'applicable State authority' means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the insurance laws of such State.

''(3) BASE PREMIUM RATE.—The term 'base premium rate' means, for each class of business with respect to a rating period, the lowest premium rate charged or that could have been charged under a rating system for that class of business by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

''(4) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a State and that—

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the Model Small Group Rating Rules or, as applicable, transitional small group rating rules in a State;

''(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer small group health insurance coverage in that State consistent with the Model Small Group Rating Rules, and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency); and

''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State pursuant to subparagraph (B), a description in the insurer's contract of the Model Small Group Rating Rules and an affirmation that such Rules are included in the terms of such contract.

''(5) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the small group health insurance market, except that such term shall not include excepted benefits (as defined in section 2791(c)).

''(6) INDEX RATE.—The term 'index rate' means for each class of business with respect to the rating period for small employers with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

''(7) MODEL SMALL GROUP RATING RULES.—The term 'Model Small Group Rating Rules' means the rules set forth in section 2912(a)(2).

''(8) NONADOPTING STATE.—The term 'non-adopting State' means a State that is not an adopting State.

''(9) SMALL GROUP INSURANCE MARKET.—The term 'small group insurance market' shall have the meaning given the term 'small group market' in section 2791(e)(5).

''(10) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

''(11) VARIATION LIMITS.—

''(A) COMPOSITE VARIATION LIMIT.—

''(i) IN GENERAL.—The term 'composite variation limit' means the total variation in premium rates charged by a health insurance issuer in the small group market as permitted under applicable State law based on the following factors or case characteristics:

''(I) Age.

''(II) Duration of coverage.

''(III) Claims experience.

''(IV) Health status.

''(ii) USE OF FACTORS.—With respect to the use of the factors described in clause (i) in setting premium rates, a health insurance issuer shall use one or both of the factors described in subclauses (I) or (IV) of such clause and may use the factors described in subclauses (II) or (III) of such clause.

''(B) TOTAL VARIATION LIMIT.—The term 'total variation limit' means the total variation in premium rates charged by a health insurance issuer in the small group market as permitted under applicable State law based on all factors and case characteristics (as described in section 2912(a)(1)).

''SEC. 2912. RATING RULES.

''(a) ESTABLISHMENT OF MINIMUM STANDARDS FOR PREMIUM VARIATIONS AND MODEL SMALL GROUP RATING RULES.—Not later than 6 months after the date of enactment of this title, the Secretary shall promulgate regulations establishing the following Minimum Standards and Model Small Group Rating Rules:

''(1) MINIMUM STANDARDS FOR PREMIUM VARIATIONS.—

''(A) COMPOSITE VARIATION LIMIT.—The composite variation limit shall not be less than 3:1.

''(B) TOTAL VARIATION LIMIT.—The total variation limit shall not be less than 5:1.

''(C) PROHIBITION ON USE OF CERTAIN CASE CHARACTERISTICS.—For purposes of this paragraph, in calculating the total variation limit, the State shall not use case characteristics other than those used in calculating the composite variation limit and industry, geographic area, group size, participation rate, class of business, and participation in wellness programs.

''(2) MODEL SMALL GROUP RATING RULES.—The following apply to an eligible insurer in a non-adopting State:

''(A) PREMIUM RATES.—Premium rates for small group health benefit plans to which this title applies shall comply with the following provisions relating to premiums, except as provided for under subsection (b):

''(i) VARIATION IN PREMIUM RATES.—The plan may not vary premium rates by more than the minimum standards provided for under paragraph (1).

''(ii) INDEX RATE.—The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than 20 percent, excluding those classes of business related to association groups under this title.

''(iii) CLASS OF BUSINESSES.—With respect to a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than 25 percent of the index rate under clause (ii).

''(iv) INCREASES FOR NEW RATING PERIODS.—The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

''(I) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a health benefit plan into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate, except that such change shall not exceed, on a percentage basis, the change in the new business premium rate for the most similar health benefit plan into which the small employer carrier is actively enrolling new small employers.

''(II) Any adjustment, not to exceed 15 percent annually and adjusted pro rata for rating periods of less then 1 year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business involved.

''(III) Any adjustment due to change in coverage or change in the case characteristics of the small employer as determined from the small employer carrier's rate manual for the class of business.

''(v) UNIFORM APPLICATION OF ADJUSTMENTS.—Adjustments in premium rates for claim experience, health status, or duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

''(vi) PROHIBITION ON USE OF CERTAIN CASE CHARACTERISTIC.—A small employer carrier shall not utilize case characteristics, other than those permitted under paragraph (1)(C), without the prior approval of the applicable State authority.

''(vii) CONSISTENT APPLICATION OF FACTORS.—Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business. Rating factors shall produce premiums for identical groups which differ only by the amounts attributable to plan design and do not reflect differences due to the nature of the groups assumed to select particular health benefit plans.

''(viii) TREATMENT OF PLANS AS HAVING SAME RATING PERIOD.—A small employer carrier shall treat all health benefit plans issued or renewed in the same calendar month as having the same rating period.

''(ix) REQUIRE COMPLIANCE.—Premium rates for small business health benefit plans shall comply with the requirements of this subsection notwithstanding any assessments paid or payable by a small employer carrier as required by a State's small employer carrier reinsurance program.

''(B) ESTABLISHMENT OF SEPARATE CLASS OF BUSINESS.—Subject to subparagraph (C), a small employer carrier may establish a separate class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following:

''(i) The small employer carrier uses more than one type of system for the marketing and sale of health benefit plans to small employers.

''(ii) The small employer carrier has acquired a class of business from another small employer carrier.

''(iii) The small employer carrier provides coverage to one or more association groups that meet the requirements of this title.

''(C) LIMITATION.—A small employer carrier may establish up to 9 separate classes of business under subparagraph (B), excluding those classes of business related to association groups under this title.

''(D) LIMITATION ON TRANSFERS.—A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage since issue.

''(b) TRANSITIONAL MODEL SMALL GROUP RATING RULES.—

''(1) IN GENERAL.—Not later than 6 months after the date of enactment of this title and to the extent necessary to provide for a graduated transition to the minimum standards for premium variation as provided for in subsection (a)(1), the Secretary, in consultation with the National Association of Insurance Commissioners (NAIC), shall promulgate State-specific transitional small group rating rules in accordance with this subsection, which shall be applicable with respect to non-adopting States and eligible insurers operating in such States for a period of not to exceed 3 years from the date of the promulgation of the minimum standards for premium variation pursuant to subsection (a).

''(2) COMPLIANCE WITH TRANSITIONAL MODEL SMALL GROUP RATING RULES.—During the transition period described in paragraph (1), a State that, on the date of enactment of this title, has in effect a small group rating rules methodology that allows for a variation that is less than the variation provided for under subsection (a)(1) (concerning minimum standards for premium variation), shall be deemed to be an adopting State if the State complies with the transitional small group rating rules as promulgated by the Secretary pursuant to paragraph (1).

''(3) TRANSITIONING OF OLD BUSINESS.—

''(A) IN GENERAL.—In developing the transitional small group rating rules under paragraph (1), the Secretary shall, after consultation with the National Association of Insurance Commissioners and representatives of insurers operating in the small group health insurance market in non-adopting States, promulgate special transition standards with respect to independent rating classes for old and new business, to the extent reasonably necessary to protect health insurance consumers and to ensure a stable and fair transition for old and new market entrants.

''(B) PERIOD FOR OPERATION OF INDEPENDENT RATING CLASSES.—In developing the special transition standards pursuant to subparagraph (A), the Secretary shall permit a carrier in a non-adopting State, at its option, to maintain independent rating classes for old and new business for a period of up to 5 years, with the commencement of such 5-year period to begin at such time, but not later than the date that is 3 years after the date of enactment of this title, as the carrier offers a book of business meeting the minimum standards for premium variation provided for in subsection (a)(1) or the transitional small group rating rules under paragraph (1).

''(4) OTHER TRANSITIONAL AUTHORITY.—In developing the transitional small group rating rules under paragraph (1), the Secretary shall provide for the application of the transitional small group rating rules in transition States as the Secretary may determine necessary for a an effective transition.

''(c) MARKET RE-ENTRY.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, a health insurance issuer that has voluntarily withdrawn from providing coverage in the small group market prior to the date of enactment of the Small Business Health Plans Act of 2009 shall not be excluded from re-entering such market on a date that is more than 180 days after such date of enactment.

''(2) TERMINATION.—The provision of this subsection shall terminate on the date that is 24 months after the date of enactment of the Small Business Health Plans Act of 2009.

''SEC. 2913. APPLICATION AND PREEMPTION.

''(a) SUPERSEDING OF STATE LAW.—

''(1) IN GENERAL.—This part shall supersede any and all State laws of a non-adopting State insofar as such State laws (whether enacted prior to or after the date of enactment of this subtitle) relate to rating in the small group insurance market as applied to an eligible insurer, or small group health insurance coverage issued by an eligible insurer, including with respect to coverage issued to a small employer through a small business health plan, in a State.

''(2) NONADOPTING STATES.—This part shall supersede any and all State laws of a nonadopting State insofar as such State laws (whether enacted prior to or after the date of enactment of this subtitle)—

''(A) prohibit an eligible insurer from offering, marketing, or implementing small group health insurance coverage consistent with the Model Small Group Rating Rules or transitional model small group rating rules; or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing small group health insurance coverage consistent with the Model Small Group Rating Rules or transitional model small group rating rules.

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting states.

''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers that offer small group health insurance coverage in a nonadopting State.

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supercede any State law in a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the Model Small Group Rating Rules or transitional model small group rating rules.

''(4) NO EFFECT ON PREEMPTION.—In no case shall this part be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this part be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

''(5) PREEMPTION LIMITED TO RATING.—Subsection (a) shall not preempt any State law that does not have a reference to or a connection with State rating rules that would otherwise apply to eligible insurers.

''(c) EFFECTIVE DATE.—This section shall apply, at the election of the eligible insurer, beginning in the first plan year or the first calendar year following the issuance of the final rules by the Secretary under the Model Small Group Rating Rules or, as applicable, the Transitional Model Small Group Rating Rules, but in no event earlier than the date that is 12 months after the date of enactment of this title.

''SEC. 2914. CIVIL ACTIONS AND JURISDICTION.

''(a) IN GENERAL.—The courts of the United States shall have exclusive jurisdiction over civil actions involving the interpretation of this part.

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2913.

''(c) DIRECT FILING IN COURT OF APPEALS.—At the election of the eligible insurer, an action may be brought under subsection (b) directly in the United States Court of Appeals for the circuit in which the nonadopting State is located by the filing of a petition for review in such Court.

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

''(e) STANDARD OF REVIEW.—A court in an action filed under this section, shall render a judgment based on a review of the merits of all questions presented in such action and shall not defer to any conduct or action, or proposed conduct or action, of a nonadopting State.

''SEC. 2915. ONGOING REVIEW.

''Not later than 5 years after the date on which the Model Small Group Rating Rules are issued under this part, and every 5 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners, shall prepare and submit to the appropriate committees of Congress a report that assesses the effect of the Model Small Group Rating Rules on access, cost, and market functioning in the small group market. Such report may, if the Secretary, in consultation with the National Association of Insurance Commissioners, determines such is appropriate for improving access, costs, and market functioning, contain legislative proposals for recommended modification to such Model Small Group Rating Rules.

''PART II—AFFORDABLE PLANS

''SEC. 2921. DEFINITIONS.

''In this part:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted a law providing that small group, individual, and large group health insurers in such State may offer and sell products in accordance with the List of Required Benefits and the Terms of Application as provided for in section 2922(b).

''(2) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a nonadopting State and that—

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the List of Required Benefits and Terms of Application in a nonadopting State;

''(B) notifies the insurance department of a nonadopting State (or other applicable State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage in that State consistent with the List of Required Benefits and Terms of Application, and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency) by the Secretary in regulations; and

''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such group health coverage) and filed with the State pursuant to subparagraph (B), a description in the insurer's contract of the List of Required Benefits and a description of the Terms of Application, including a description of the benefits to be provided, and that adherence to such standards is included as a term of such contract.

''(3) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the small group, individual, or large group health insurance markets, including with respect to small business health plans, except that such term shall not include excepted benefits (as defined in section 2791(c)).

''(4) LIST OF REQUIRED BENEFITS.—The term 'List of Required Benefits' means the List issued under section 2922(a).

''(5) NONADOPTING STATE.—The term 'nonadopting State' means a State that is not an adopting State.

''(6) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

''(7) STATE PROVIDER FREEDOM OF CHOICE LAW.—The term 'State Provider Freedom of Choice Law' means a State law requiring that a health insurance issuer, with respect to health insurance coverage, not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law.

''(8) TERMS OF APPLICATION.—The term 'Terms of Application' means terms provided under section 2922(a).

''SEC. 2922. OFFERING AFFORDABLE PLANS.

''(a) LIST OF REQUIRED BENEFITS.—Not later than 3 months after the date of enactment of this title, the Secretary, in consultation with the National Association of Insurance Commissioners, shall issue by interim final rule a list (to be known as the 'List of Required Benefits') of covered benefits, services, or categories of providers that are required to be provided by health insurance issuers, in each of the small group, individual, and large group markets, in at least 26 States as a result of the application of State covered benefit, service, and category of provider mandate laws. With respect to plans sold to or through small business health plans, the List of Required Benefits applicable to the small group market shall apply.

''(b) TERMS OF APPLICATION.—

''(1) STATE WITH MANDATES.—With respect to a State that has a covered benefit, service, or category of provider mandate in effect that is covered under the List of Required

Benefits under subsection (a), such State mandate shall, subject to paragraph (3) (concerning uniform application), apply to a coverage plan or plan in, as applicable, the small group, individual, or large group market or through a small business health plan in such State.

''(2) STATES WITHOUT MANDATES.—With respect to a State that does not have a covered benefit, service, or category of provider mandate in effect that is covered under the List of Required Benefits under subsection (a), such mandate shall not apply, as applicable, to a coverage plan or plan in the small group, individual, or large group market or through a small business health plan in such State.

''(3) UNIFORM APPLICATION OF LAWS.—

''(A) IN GENERAL.—With respect to a State described in paragraph (1), in applying a covered benefit, service, or category of provider mandate that is on the List of Required Benefits under subsection (a) the State shall permit a coverage plan or plan offered in the small group, individual, or large group market or through a small business health plan in such State to apply such benefit, service, or category of provider coverage in a manner consistent with the manner in which such coverage is applied under one of the three most heavily subscribed national health plans offered under the Federal Employee Health Benefits Program under chapter 89 of title 5, United States Code (as determined by the Secretary in consultation with the Director of the Office of Personnel Management), and consistent with the Publication of Benefit Applications under subsection (c). In the event a covered benefit, service, or category of provider appearing in the List of Required Benefits is not offered in one of the three most heavily subscribed national health plans offered under the Federal Employees Health Benefits Program, such covered benefit, service, or category of provider requirement shall be applied in a manner consistent with the manner in which such coverage is offered in the remaining most heavily subscribed plan of the remaining Federal Employees Health Benefits Program plans, as determined by the Secretary, in consultation with the Director of the Office of Personnel Management.

''(B) EXCEPTION REGARDING STATE PROVIDER FREEDOM OF CHOICE LAWS.—Notwithstanding subparagraph (A), in the event a category of provider mandate is included in the List of Covered Benefits, any State Provider Freedom of Choice Law (as defined in section 2921(7)) that is in effect in any State in which such category of provider mandate is in effect shall not be preempted, with respect to that category of provider, by this part.

''(c) PUBLICATION OF BENEFIT APPLICATIONS.—Not later than 3 months after the date of enactment of this title, and on the first day of every calendar year thereafter, the Secretary, in consultation with the Director of the Office of Personnel Management, shall publish in the Federal Register a description of such covered benefits, services, and categories of providers covered in that calendar year by each of the three most heavily subscribed nationally available Federal Employee Health Benefits Plan options which are also included on the List of Required Benefits.

''(d) EFFECTIVE DATES.—

''(1) SMALL BUSINESS HEALTH PLANS.—With respect to health insurance provided to participating employers of small business health plans, the requirements of this part (concerning lower cost plans) shall apply beginning on the date that is 12 months after the date of enactment of this title.

''(2) NON-ASSOCIATION COVERAGE.—With respect to health insurance provided to groups or individuals other than participating employers of small business health plans, the requirements of this part shall apply beginning on the date that is 15 months after the date of enactment of this title.

''(e) UPDATING OF LIST OF REQUIRED BENEFITS.—Not later than 2 years after the date on which the list of required benefits is issued under subsection (a), and every 2 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners, shall update the list based on changes in the laws and regulations of the States. The Secretary shall issue the updated list by regulation, and such updated list shall be effective upon the first plan year following the issuance of such regulation.

''SEC. 2923. APPLICATION AND PREEMPTION.

''(a) SUPERSEDING OF STATE LAW.—

''(1) IN GENERAL.—This part shall supersede any and all State laws insofar as such laws relate to mandates relating to covered benefits, services, or categories of provider in the health insurance market as applied to an eligible insurer, or health insurance coverage issued by an eligible insurer, including with respect to coverage issued to a small business health plan, in a nonadopting State.

''(2) NONADOPTING STATES.—This part shall supersede any and all State laws of a nonadopting State (whether enacted prior to or after the date of enactment of this title) insofar as such laws—

''(A) prohibit an eligible insurer from offering, marketing, or implementing health insurance coverage consistent with the Benefit Choice Standards, as provided for in section 2922(a); or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing health insurance coverage consistent with the Benefit Choice Standards.

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting States.

''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers who offer health insurance coverage in a nonadopting State.

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supersede any State law of a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the Benefit Choice Standards.

''(4) NO EFFECT ON PREEMPTION.—In no case shall this part be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this part be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

''(5) PREEMPTION LIMITED TO BENEFITS.—Subsection (a) shall not preempt any State law that does not have a reference to or a connection with State mandates regarding covered benefits, services, or categories of providers that would otherwise apply to eligible insurers.

''SEC. 2924. CIVIL ACTIONS AND JURISDICTION.

''(a) IN GENERAL.—The courts of the United States shall have exclusive jurisdiction over civil actions involving the interpretation of this part.

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2923.

''(c) DIRECT FILING IN COURT OF APPEALS.—At the election of the eligible insurer, an action may be brought under subsection (b) directly in the United States Court of Appeals for the circuit in which the nonadopting State is located by the filing of a petition for review in such Court.

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

''(e) STANDARD OF REVIEW.—A court in an action filed under this section, shall render a judgment based on a review of the merits of all questions presented in such action and shall not defer to any conduct or action, or proposed conduct or action, of a nonadopting State.

''SEC. 2925. RULES OF CONSTRUCTION.

''(a) IN GENERAL.—Notwithstanding any other provision of Federal or State law, a health insurance issuer in an adopting State or an eligible insurer in a non-adopting State may amend its existing policies to be consistent with the terms of this subtitle (concerning rating and benefits).

''(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this subtitle shall be construed to create any mandates for coverage of benefits for HSA-qualified health plans that would require reimbursements in violation of section 223(c)(2) of the Internal Revenue Code of 1986.''.

TITLE III—HARMONIZATION OF HEALTH INSURANCE STANDARDS

SEC. 301. HEALTH INSURANCE STANDARDS HARMONIZATION.

Title XXIX of the Public Health Service Act (as added by section 201) is amended by adding at the end the following:

''Subtitle B—Standards Harmonization

''SEC. 2931. DEFINITIONS.

''In this subtitle:

''(1) ADOPTING STATE.—The term 'adopting State' means a State that has enacted the harmonized standards adopted under this subtitle in their entirety and as the exclusive laws of the State that relate to the harmonized standards.

''(2) ELIGIBLE INSURER.—The term 'eligible insurer' means a health insurance issuer that is licensed in a nonadopting State and that—

''(A) notifies the Secretary, not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage consistent with the harmonized standards in a nonadopting State;

''(B) notifies the insurance department of a nonadopting State (or other State agency), not later than 30 days prior to the offering of coverage described in this subparagraph, that the issuer intends to offer health insurance coverage in that State consistent with

the harmonized standards published pursuant to section 2933(d), and provides with such notice a copy of any insurance policy that it intends to offer in the State, its most recent annual and quarterly financial reports, and any other information required to be filed with the insurance department of the State (or other State agency) by the Secretary in regulations; and

''(C) includes in the terms of the health insurance coverage offered in nonadopting States (including in the terms of any individual certificates that may be offered to individuals in connection with such health coverage) and filed with the State pursuant to subparagraph (B), a description of the harmonized standards published pursuant to section 2933(g)(2) and an affirmation that such standards are a term of the contract.

''(3) HARMONIZED STANDARDS.—The term 'harmonized standards' means the standards certified by the Secretary under section 2933(d).

''(4) HEALTH INSURANCE COVERAGE.—The term 'health insurance coverage' means any coverage issued in the health insurance market, except that such term shall not include excepted benefits (as defined in section 2791(c).

''(5) NONADOPTING STATE.—The term 'nonadopting State' means a State that fails to enact, within 18 months of the date on which the Secretary certifies the harmonized standards under this subtitle, the harmonized standards in their entirety and as the exclusive laws of the State that relate to the harmonized standards.

''(6) STATE LAW.—The term 'State law' means all laws, decisions, rules, regulations, or other State actions (including actions by a State agency) having the effect of law, of any State.

''SEC. 2932. HARMONIZED STANDARDS.

''(a) BOARD.—

''(1) ESTABLISHMENT.—Not later than 3 months after the date of enactment of this title, the Secretary, in consultation with the NAIC, shall establish the Health Insurance Consensus Standards Board (referred to in this subtitle as the 'Board') to develop recommendations that harmonize inconsistent State health insurance laws in accordance with the procedures described in subsection (b).

''(2) COMPOSITION.—

''(A) IN GENERAL.—The Board shall be composed of the following voting members to be appointed by the Secretary after considering the recommendations of professional organizations representing the entities and constituencies described in this paragraph:

''(i) Four State insurance commissioners as recommended by the National Association of Insurance Commissioners, of which 2 shall be Democrats and 2 shall be Republicans, and of which one shall be designated as the chairperson and one shall be designated as the vice chairperson.

''(ii) Four representatives of State government, two of which shall be governors of States and two of which shall be State legislators, and two of which shall be Democrats and two of which shall be Republicans.

''(iii) Four representatives of health insurers, of which one shall represent insurers that offer coverage in the small group market, one shall represent insurers that offer coverage in the large group market, one shall represent insurers that offer coverage in the individual market, and one shall represent carriers operating in a regional market.

''(iv) Two representatives of insurance agents and brokers.

''(v) Two independent representatives of the American Academy of Actuaries who have familiarity with the actuarial methods applicable to health insurance.

''(B) EX OFFICIO MEMBER.—A representative of the Secretary shall serve as an ex officio member of the Board.

''(3) ADVISORY PANEL.—The Secretary shall establish an advisory panel to provide advice to the Board, and shall appoint its members after considering the recommendations of professional organizations representing the entities and constituencies identified in this paragraph:

''(A) Two representatives of small business health plans.

''(B) Two representatives of employers, of which one shall represent small employers and one shall represent large employers.

''(C) Two representatives of consumer organizations.

''(D) Two representatives of health care providers.

''(4) QUALIFICATIONS.—The membership of the Board shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health plans, providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

''(5) ETHICAL DISCLOSURE.—The Secretary shall establish a system for public disclosure by members of the Board of financial and other potential conflicts of interest relating to such members. Members of the Board shall be treated as employees of Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95–521).

''(6) DIRECTOR AND STAFF.—Subject to such review as the Secretary deems necessary to assure the efficient administration of the Board, the chair and vice-chair of the Board may—

''(A) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(B) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

''(C) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Board (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(D) make advance, progress, and other payments which relate to the work of the Board;

''(E) provide transportation and subsistence for persons serving without compensation; and

''(F) prescribe such rules as it deems necessary with respect to the internal organization and operation of the Board.

''(7) TERMS.—The members of the Board shall serve for the duration of the Board. Vacancies in the Board shall be filled as needed in a manner consistent with the composition described in paragraph (2).

''(b) DEVELOPMENT OF HARMONIZED STANDARDS.—

''(1) IN GENERAL.—In accordance with the process described in subsection (c), the Board shall identify and recommend nationally harmonized standards for each of the following process categories:

''(A) FORM FILING AND RATE FILING.—Form and rate filing standards shall be established which promote speed to market and include the following defined areas for States that require such filings:

''(i) Procedures for form and rate filing pursuant to a streamlined administrative filing process.

''(ii) Timeframes for filings to be reviewed by a State if review is required before they are deemed approved.

''(iii) Timeframes for an eligible insurer to respond to State requests following its review.

''(iv) A process for an eligible insurer to self-certify.

''(v) State development of form and rate filing templates that include only non-preempted State law and Federal law requirements for eligible insurers with timely updates.

''(vi) Procedures for the resubmission of forms and rates.

''(vii) Disapproval rationale of a form or rate filing based on material omissions or violations of non-preempted State law or Federal law with violations cited and explained.

''(viii) For States that may require a hearing, a rationale for hearings based on violations of non-preempted State law or insurer requests.

''(B) MARKET CONDUCT REVIEW.—Market conduct review standards shall be developed which provide for the following:

''(i) Mandatory participation in national databases.

''(ii) The confidentiality of examination materials.

''(iii) The identification of the State agency with primary responsibility for examinations.

''(iv) Consultation and verification of complaint data with the eligible insurer prior to State actions.

''(v) Consistency of reporting requirements with the recordkeeping and administrative practices of the eligible insurer.

''(vi) Examinations that seek to correct material errors and harmful business practices rather than infrequent errors.

''(vii) Transparency and publishing of the State's examination standards.

''(viii) Coordination of market conduct analysis.

''(ix) Coordination and nonduplication between State examinations of the same eligible insurer.

''(x) Rationale and protocols to be met before a full examination is conducted.

''(xi) Requirements on examiners prior to beginning examinations such as budget planning and work plans.

''(xii) Consideration of methods to limit examiners' fees such as caps, competitive bidding, or other alternatives.

''(xiii) Reasonable fines and penalties for material errors and harmful business practices.

''(C) PROMPT PAYMENT OF CLAIMS.—The Board shall establish prompt payment standards for eligible insurers based on standards similar to those applicable to the Social Security Act as set forth in section 1842(c)(2) of such Act (42 U.S.C. 1395u(c)(2)). Such prompt payment standards shall be consistent with the timing and notice requirements of the claims procedure rules to be specified under subparagraph (D), and shall include appropriate exceptions such as for fraud, nonpayment of premiums, or late submission of claims.

''(D) INTERNAL REVIEW.—The Board shall establish standards for claims procedures for eligible insurers that are consistent with the requirements relating to initial claims for benefits and appeals of claims for benefits under the Employee Retirement Income Security Act of 1974 as set forth in section 503 of such Act (29 U.S.C. 1133) and the regulations thereunder.

''(2) RECOMMENDATIONS.—The Board shall recommend harmonized standards for each element of the categories described in subparagraph (A) through (D) of paragraph (1) within each such market. Notwithstanding

the previous sentence, the Board shall not recommend any harmonized standards that disrupt, expand, or duplicate the benefit, service, or provider mandate standards provided in the Benefit Choice Standards pursuant to section 2922(a).

''(c) PROCESS FOR IDENTIFYING HARMONIZED STANDARDS.—

''(1) IN GENERAL.—The Board shall develop recommendations to harmonize inconsistent State insurance laws with respect to each of the process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(2) REQUIREMENTS.—In adopting standards under this section, the Board shall consider the following:

''(A) Any model acts or regulations of the National Association of Insurance Commissioners in each of the process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(B) Substantially similar standards followed by a plurality of States, as reflected in existing State laws, relating to the specific process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(C) Any Federal law requirement related to specific process categories described in subparagraphs (A) through (D) of subsection (b)(1).

''(D) In the case of the adoption of any standard that differs substantially from those referred to in subparagraphs (A), (B), or (C), the Board shall provide evidence to the Secretary that such standard is necessary to protect health insurance consumers or promote speed to market or administrative efficiency.

''(E) The criteria specified in clauses (i) through (iii) of subsection (d)(2)(B).

''(d) RECOMMENDATIONS AND CERTIFICATION BY SECRETARY.—

''(1) RECOMMENDATIONS.—Not later than 18 months after the date on which all members of the Board are selected under subsection (a), the Board shall recommend to the Secretary the certification of the harmonized standards identified pursuant to subsection (c).

''(2) CERTIFICATION.—

''(A) IN GENERAL.—Not later than 120 days after receipt of the Board's recommendations under paragraph (1), the Secretary shall certify the recommended harmonized standards as provided for in subparagraph (B), and issue such standards in the form of an interim final regulation.

''(B) CERTIFICATION PROCESS.—The Secretary shall establish a process for certifying the recommended harmonized standard, by category, as recommended by the Board under this section. Such process shall—

''(i) ensure that the certified standards for a particular process area achieve regulatory harmonization with respect to health plans on a national basis;

''(ii) ensure that the approved standards are the minimum necessary, with regard to substance and quantity of requirements, to protect health insurance consumers and maintain a competitive regulatory environment; and

''(iii) ensure that the approved standards will not limit the range of group health plan designs and insurance products, such as catastrophic coverage only plans, health savings accounts, and health maintenance organizations, that might otherwise be available to consumers.

''(3) APPLICATION AND EFFECTIVE DATE.—The standards certified by the Secretary under paragraph (2) shall apply and become effective on the date that is 18 months after the date on which the Secretary certifies the harmonized standards.

''(e) TERMINATION.—The Board shall terminate and be dissolved after making the recommendations to the Secretary pursuant to subsection (d)(1).

''(f) ONGOING REVIEW.—Not earlier than 3 years after the termination of the Board under subsection (e), and not earlier than every 3 years thereafter, the Secretary, in consultation with the National Association of Insurance Commissioners and the entities and constituencies represented on the Board and the Advisory Panel, shall prepare and submit to the appropriate committees of Congress a report that assesses the effect of the harmonized standards applied under this section on access, cost, and health insurance market functioning. The Secretary may, based on such report and applying the process established for certification under subsection (d)(2)(B), in consultation with the National Association of Insurance Commissioners and the entities and constituencies represented on the Board and the Advisory Panel, update the harmonized standards through notice and comment rulemaking.

''(g) PUBLICATION.—

''(1) LISTING.—The Secretary shall maintain an up to date listing of all harmonized standards certified under this section on the Internet website of the Department of Health and Human Services.

''(2) SAMPLE CONTRACT LANGUAGE.—The Secretary shall publish on the Internet website of the Department of Health and Human Services sample contract language that incorporates the harmonized standards certified under this section, which may be used by insurers seeking to qualify as an eligible insurer. The types of harmonized standards that shall be included in sample contract language are the standards that are relevant to the contractual bargain between the insurer and insured.

''(h) STATE ADOPTION AND ENFORCEMENT.—Not later than 18 months after the certification by the Secretary of harmonized standards under this section, the States may adopt such harmonized standards (and become an adopting State) and, in which case, shall enforce the harmonized standards pursuant to State law.

''SEC. 2933. APPLICATION AND PREEMPTION.

''(a) SUPERSEDING OF STATE LAW.—

''(1) IN GENERAL.—The harmonized standards certified under this subtitle and applied as provided for in section 2933(d)(3), shall supersede any and all State laws of a nonadopting State insofar as such State laws relate to the areas of harmonized standards as applied to an eligible insurer, or health insurance coverage issued by a eligible insurer, including with respect to coverage issued to a small business health plan, in a nonadopting State.

''(2) NONADOPTING STATES.—This subtitle shall supersede any and all State laws of a nonadopting State (whether enacted prior to or after the date of enactment of this title) insofar as they may—

''(A) prohibit an eligible insurer from offering, marketing, or implementing health insurance coverage consistent with the harmonized standards; or

''(B) have the effect of retaliating against or otherwise punishing in any respect an eligible insurer for offering, marketing, or implementing health insurance coverage consistent with the harmonized standards under this subtitle.

''(b) SAVINGS CLAUSE AND CONSTRUCTION.—

''(1) NONAPPLICATION TO ADOPTING STATES.—Subsection (a) shall not apply with respect to adopting States.

''(2) NONAPPLICATION TO CERTAIN INSURERS.—Subsection (a) shall not apply with respect to insurers that do not qualify as eligible insurers who offer health insurance coverage in a nonadopting State.

''(3) NONAPPLICATION WHERE OBTAINING RELIEF UNDER STATE LAW.—Subsection (a)(1) shall not supersede any State law of a nonadopting State to the extent necessary to permit individuals or the insurance department of the State (or other State agency) to obtain relief under State law to require an eligible insurer to comply with the harmonized standards under this subtitle.

''(4) NO EFFECT ON PREEMPTION.—In no case shall this subtitle be construed to limit or affect in any manner the preemptive scope of sections 502 and 514 of the Employee Retirement Income Security Act of 1974. In no case shall this subtitle be construed to create any cause of action under Federal or State law or enlarge or affect any remedy available under the Employee Retirement Income Security Act of 1974.

''(c) EFFECTIVE DATE.—This section shall apply beginning on the date that is 18 months after the date on harmonized standards are certified by the Secretary under this subtitle.

''SEC. 2934. CIVIL ACTIONS AND JURISDICTION.

''(a) IN GENERAL.—The district courts of the United States shall have exclusive jurisdiction over civil actions involving the interpretation of this subtitle.

''(b) ACTIONS.—An eligible insurer may bring an action in the district courts of the United States for injunctive or other equitable relief against any officials or agents of a nonadopting State in connection with any conduct or action, or proposed conduct or action, by such officials or agents which violates, or which would if undertaken violate, section 2933.

''(c) DIRECT FILING IN COURT OF APPEALS.—At the election of the eligible insurer, an action may be brought under subsection (b) directly in the United States Court of Appeals for the circuit in which the nonadopting State is located by the filing of a petition for review in such Court.

''(d) EXPEDITED REVIEW.—

''(1) DISTRICT COURT.—In the case of an action brought in a district court of the United States under subsection (b), such court shall complete such action, including the issuance of a judgment, prior to the end of the 120-day period beginning on the date on which such action is filed, unless all parties to such proceeding agree to an extension of such period.

''(2) COURT OF APPEALS.—In the case of an action brought directly in a United States Court of Appeal under subsection (c), or in the case of an appeal of an action brought in a district court under subsection (b), such Court shall complete all action on the petition, including the issuance of a judgment, prior to the end of the 60-day period beginning on the date on which such petition is filed with the Court, unless all parties to such proceeding agree to an extension of such period.

''(e) STANDARD OF REVIEW.—A court in an action filed under this section, shall render a judgment based on a review of the merits of all questions presented in such action and shall not defer to any conduct or action, or proposed conduct or action, of a nonadopting State.

''SEC. 2935. AUTHORIZATION OF APPROPRIATIONS; RULE OF CONSTRUCTION.

''(a) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this subtitle.

''(b) HEALTH SAVINGS ACCOUNTS.—Nothing in this subtitle shall be construed to create any mandates for coverage of any benefits below the deductible levels set for any health savings account-qualified health plan pursuant to section 223 of the Internal Revenue Code of 1986.''.

SA 3198. Mr. CORNYN (for himself and Mr. LEMIEUX) submitted an amendment intended to be proposed to

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

Strike all after the first word and insert the following:

1. SHORT TITLE.

This Act may be cited as the ''Seniors and Taxpayers Obligation Protection Act of 2009''.

SEC. 2. REQUIRING THE SECRETARY OF HEALTH AND HUMAN SERVICES TO CHANGE THE MEDICARE BENEFICIARY IDENTIFIER USED TO IDENTIFY MEDICARE BENEFICIARIES UNDER THE MEDICARE PROGRAM.

(a) PROCEDURES.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, in order to protect beneficiaries from identity theft, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish and implement procedures to change the Medicare beneficiary identifier used to identify individuals entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title so that such an individual's social security account number is not used.

(2) MAINTAINING EXISTING HICN STRUCTURE.—In order to minimize the impact of the change under paragraph (1) on systems that communicate with Medicare beneficiary eligibility systems, the procedures under paragraph (1) shall provide that the new Medicare beneficiary identifier maintain the existing Health Insurance Claim Number structure.

(3) PROTECTION AGAINST FRAUD.—The procedures under paragraph (1) shall provide for a process for changing the Medicare beneficiary identifier for an individual to a different identifier in the case of the discovery of fraud, including identity theft.

(4) PHASE-IN AUTHORITY.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the Secretary may phase in the change under paragraph (1) in such manner as the Secretary determines appropriate.

(B) LIMIT.—The phase-in period under subparagraph (A) shall not exceed 10 years.

(C) NEWLY ENTITLED AND ENROLLED INDIVIDUALS.—The Secretary shall ensure that the change under paragraph (1) is implemented not later than January 1, 2010, with respect to any individual who first becomes entitled to benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title on or after such date.

(b) EDUCATION AND OUTREACH.—The Secretary shall establish a program of education and outreach for individuals entitled to, or enrolled for, benefits under part A of title XVIII of the Social Security Act or enrolled under part B of such title, providers of services (as defined in subsection (u) of section 1861 of such Act (42 U.S.C. 1395x)), and suppliers (as defined in subsection (d) of such section) on the change under paragraph (1).

(c) DATA MATCHING.—

(1) ACCESS TO CERTAIN INFORMATION.—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, upon the request of the Secretary—

''(i) enter into an agreement with the Secretary for the purpose of matching data in the system of records of the Commissioner with data in the system of records of the Secretary, so long as the requirements of subparagraphs (A) and (B) of paragraph (3) are met, in order to determine—

''(I) whether a beneficiary under the program under title XVIII, XIX, or XXI is dead, imprisoned, or otherwise not eligible for benefits under such program; and

''(II) whether a provider of services or a supplier under the program under title XVIII, XIX, or XXI is dead, imprisoned, or otherwise not eligible to furnish or receive payment for furnishing items and services under such program; and

''(ii) include in such agreement safeguards to assure the maintenance of the confidentiality of any information disclosed and procedures to permit the Secretary to use such information for the purpose described in clause (i).

''(B) Information provided pursuant to an agreement under this paragraph shall be provided at such time, in such place, and in such manner as the Commissioner determines appropriate.

''(C) Information provided pursuant to an agreement under this paragraph shall include information regarding whether—

''(i) the name (including the first name and any family name or surname), the date of birth (including the month, day, and year), and social security number of an individual provided to the Commissioner match the information contained in the Commissioner's records, and

''(ii) such individual is shown on the records of the Commissioner as being deceased.''.

(2) INVESTIGATION BASED ON CERTAIN INFORMATION.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128F the following new section:

''SEC. 1128G. ACCESS TO CERTAIN DATA AND INVESTIGATION OF CLAIMS INVOLVING INDIVIDUALS WHO ARE NOT ELIGIBLE FOR BENEFITS OR ARE NOT ELIGIBLE PROVIDERS OF SERVICES OR SUPPLIERS.

''(a) DATA AGREEMENT.—The Secretary shall enter into an agreement with the Commissioner of Social Security pursuant to section 205(r)(9).

''(b) INVESTIGATION OF CLAIMS INVOLVING CERTAIN INDIVIDUALS WHO ARE NOT ELIGIBLE FOR BENEFITS OR ARE NOT ELIGIBLE PROVIDERS OF SERVICES OR SUPPLIERS.—

''(1) IN GENERAL.—The Secretary shall, in the case where a provider of services or a supplier under the program under title XVIII, XIX, or XXI submits a claim for payment for items or services furnished to an individual who the Secretary determines, as a result of information provided pursuant to such agreement, is not eligible for benefits under such program, or where the Secretary determines, as a result of such information, that such provider of services or supplier is not eligible to furnish or receive payment for furnishing such items or services, conduct an investigation with respect to the provider of services or supplier. If the Secretary determines further action is appropriate, the Secretary shall refer the investigation to the Inspector General of the Department of Health and Human Services.

''(2) ASSESSMENT OF IMPLEMENTATION AND EFFECTIVENESS BY THE OIG.—The Inspector General of the Department of Health and Human Services shall test the implementation of the provisions of this section (including the implementation of the agreement under section 205(r)(9)) and conduct such period assessments of such implementation as the Inspector General determines necessary to determine the effectiveness of such implementation.''.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 3. MONTHLY VERIFICATION OF ACCURACY OF CLAIMS FOR PAYMENT FOR PHYSICIANS' SERVICES.

(a) IN GENERAL.—Section 1893 of the Social Security Act (42 U.S.C. 1395ddd) is amended—

(1) in subsection (b), by adding at the end the following new paragraph:

''(7) The monthly verification of the accuracy of claims for payment for physicians' services under the system under subsection (i).''; and

(2) by adding at the end the following new subsection:

''(i) MONTHLY VERIFICATION OF ACCURACY OF CLAIMS FOR PAYMENT FOR PHYSICIANS' SERVICES.—

''(1) SYSTEM.—

''(A) IN GENERAL.—Not later than 1 year after the date of the enactment of this subsection, the Secretary shall establish and implement a system to verify (electronically or otherwise, taking into consideration the administrative burden of such verification on physicians and group practices) on a monthly basis that the claims for payment under part B for physicians' services furnished in high risk areas are—

''(i) for physicians' services actually furnished by the physician or the physician's group practice; and

''(ii) otherwise accurate.

''(B) NO DETERMINATION OF MEDICAL NECESSITY.—In no case shall any verification conducted under the system established under subparagraph (A) include a determination of the medical necessity of the physicians' service.

''(2) VERIFICATION.—Under the system, the Secretary, at the end of each month, shall provide the physician or the group practice with a detailed list of such claims for payment that were submitted during the month in order for the physician or the group practice to review and verify the list. In providing the detailed list, the Secretary shall use the provider number of the physician or the group practice.

''(3) AUDITS.—The Secretary shall conduct audits of the review and verification by physicians and group practices of the detailed list provided under paragraph (2). Such audits shall assess whether the physician or group practice conducted such review and verification in a fraudulent manner. In the case where the Secretary determines such review and verification was conducted in a fraudulent manner, the Secretary shall recoup any payments resulting from the fraudulent review and verification and impose a civil money penalty in an amount determined appropriate by the Secretary on the physician or group practice who conducted the fraudulent review and verification. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

''(4) HIGH RISK AREAS DEFINED.—In this subsection, the term 'high risk area' means a county designated as a high risk area under subsection (j)(1).

''(5) REPORT BY THE SECRETARY.—Not later than 1 year after implementation of the system established under paragraph (1), the Secretary shall submit a report to Congress on the progress of such implementation. Such report shall include recommendations—

''(A) on how to improve such implementation, including whether the system should be expanded to include verification of claims for payment under part B for physicians' services furnished in additional areas; and

''(B) for such legislation and administrative action as the Secretary determines appropriate.''.

(b) AUTHORIZATION OF APPROPRIATIONS.—To carry out the amendments made by this section, there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2014.

SEC. 4. DETECTION OF MEDICARE FRAUD AND ABUSE.

(a) IN GENERAL.—Section 1893 of the Social Security Act (42 U.S.C. 1395ddd), as amended by section 3, is amended—

(1) in subsection (b), by adding at the end the following new paragraph:

''(8) Implementation of fraud and abuse detection methods under subsection (j).'';

(2) in subsection (c), by adding at the end of the flush matter following paragraph (4), the following new sentence ''In the case of an activity described in subsection (b)(8), an entity shall only be eligible to enter into a contract under the Program to carry out the activity if the entity is selected through a competitive bidding process in accordance with subsection (j)(3).''; and

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

''(j) DETECTION OF MEDICARE FRAUD AND ABUSE.—

''(1) ESTABLISHMENT OF SYSTEM TO IDENTIFY COUNTIES MOST VULNERABLE TO FRAUD.—Not later than 6 months after the date of enactment of this subsection, the Secretary shall establish a system to identify the 50 counties most vulnerable to fraud with respect to items and services furnished by providers of services (other than hospitals and critical access hospitals) and suppliers based on the degree of county-specific reimbursement and analysis of payment trends under this title. The Secretary shall designate the counties identified under the preceding sentence as 'high risk areas'.

''(2) FRAUD AND ABUSE DETECTION.—

''(A) INITIAL IMPLEMENTATION.—The Secretary shall establish procedures for the implementation of fraud and abuse detection methods under this title with respect to items and services furnished by such providers of services and suppliers in high risk areas designated under paragraph (1) (and, beginning not later than 18 months after the date of enactment of this subsection, with respect to items and services furnished by such providers of services and suppliers in areas not so designated) including the following:

''(i) In the case of a new applicant to be a supplier, a background check, a pre-enrollment site visit, and random unannounced site visits after enrollment.

''(ii) Not less than 5 years after the date of enactment of this subsection, in the case of a supplier who is not a new applicant, re-enrollment under this title, including a background check and a site-visit as part of the application process for such re-enrollment, and random unannounced site visits after such re-enrollment.

''(iii) Data analysis to establish prepayment claim edits designed to target the claims for payment under this title for such items and services that are most likely to be fraudulent.

''(iv) Prepayment benefit integrity reviews for claims for payment under this title for such items and services that are suspended as a result of such edits.

''(B) REQUIREMENT FOR PARTICIPATION.—In no case may a provider of services or supplier who does not meet the requirements under subparagraph (A) (including, in the case of a supplier, the requirement of a background check) participate in the program under this title.

''(C) BACKGROUND CHECKS.—The Secretary shall determine the extent of the background check conducted under subparagraph (A), including whether—

''(i) a fingerprint check is necessary;

''(ii) a background check shall be conducted with respect to additional employees, board members, contractors or other interested parties of the supplier; and

''(iii) any additional national background checks regarding exclusion from participation in Federal programs (such as the program under this title, title XIX, or title XXI), adverse actions taken by State licensing boards, bankruptcies, outstanding taxes, or other indications identified by the Inspector General of the Department of Health and Human Services are necessary.

''(D) EXPANDED IMPLEMENTATION.—Not later than 24 months after the date of enactment of this subsection, the Secretary shall establish procedures for the implementation of such fraud and abuse detection methods under this title with respect to items and services furnished by all providers of services and suppliers, including those not in high risk areas designated under paragraph (1).

''(3) COMPETITIVE BIDDING.—In selecting entities to carry out this subsection, the Secretary shall use a competitive bidding process.

''(4) REPORT TO CONGRESS.—The Secretary shall submit to Congress an annual report on the effectiveness of activities conducted under this subsection, including a description of any savings to the program under this title as a result of such activities and the overall administrative cost of such activities and a determination as to the amount of funding needed to carry out this subsection for subsequent fiscal years, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.''.

(b) AUTHORIZATION OF APPROPRIATIONS.—To carry out the amendments made by this section, there are authorized to be appropriated—

(1) such sums as may be necessary, not to exceed $50,000,000, for each of fiscal years 2010 through 2014; and

(2) such sums as may be necessary, not to exceed an amount the Secretary determines appropriate in the most recent report submitted to Congress under section 1893(j)(4) of the Social Security Act, as added by subsection (a), for each subsequent fiscal year.

SEC. 5. USE OF TECHNOLOGY FOR REAL-TIME DATA REVIEW.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''SEC. 1899. USE OF TECHNOLOGY FOR REAL-TIME DATA REVIEW.

''(a) IN GENERAL.—The Secretary of Health and Human Services shall establish procedures for the use of technology (similar to that used with respect to the analysis of credit card charging patterns) to provide real-time data analysis of claims for payment under the Medicare program under title XVIII of the Social Security Act to identify and investigate unusual billing or order practices under the Medicare program that could indicate fraud or abuse.

''(b) COMPETITIVE BIDDING.—The procedures established under subsection (a) shall ensure that the implementation of such technology is conducted through a competitive bidding process.''.

SEC. 6. EDITS ON 855S MEDICARE ENROLLMENT APPLICATION.

Section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)) is amended by adding at the end the following new paragraph:

''(22) CONFIRMATION WITH NATIONAL SUPPLIER CLEARINGHOUSE PRIOR TO PAYMENT.—

''(A) IN GENERAL.—Not later than 1 year after the date of enactment of this paragraph, the Secretary shall establish procedures to require carriers, prior to paying a claim for payment for durable medical equipment, prosthetics, orthotics, and supplies under this title, to confirm with the National Supplier Clearinghouse—

''(i) that the National Provider Identifier of the physician or practitioner prescribing or ordering the item or service is valid and active;

''(ii) that the Medicare identification number of the supplier is valid and active; and

''(iii) that the item or service for which the claim for payment is submitted was properly identified on the CMS–855S Medicare enrollment application.

''(B) ONLINE DATABASE FOR IMPLEMENTATION.—Not later than 18 months after the date of enactment of this paragraph, the Secretary shall establish an online database similar to that used for the National Provider Identifier to enable providers of services, accreditors, carriers, and the National Supplier Clearinghouse to view information on specialties and the types of items and services each supplier has indicated on the CMS–855S Medicare enrollment application submitted by the supplier.

''(C) NOTIFICATION OF CLAIM DENIAL AND RESUBMISSION.—In the case where a claim for payment for durable medical equipment, prosthetics, orthotics, and supplies under this title is denied because the item or service furnished does not correctly match up with the information on file with the National Supplier Clearinghouse—

''(i) the National Supplier Clearinghouse shall—

''(I) provide the supplier written notification of the reason for such denial; and

''(II) allow the supplier 60 days to provide the National Supplier Clearinghouse with appropriate certification, licensing, or accreditation; and

''(ii) the Secretary shall waive applicable requirements relating to the time frame for the submission of claims for payment under this title in order to permit the resubmission of such claim if payment of such claim would otherwise be allowed under this title.''.

SEC. 7. STRATEGIC PLAN FOR THE DEVELOPMENT OF A SERIAL NUMBER TRACKING SYSTEM FOR DURABLE MEDICAL EQUIPMENT.

Section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)), as amended by section 6(a), is amended by adding at the end the following new paragraph:

''(23) STRATEGIC PLAN FOR THE DEVELOPMENT OF A SERIAL NUMBER TRACKING SYSTEM FOR DURABLE MEDICAL EQUIPMENT.—

''(A) IN GENERAL.—Not later than 1 year after the date of enactment of this paragraph, the Secretary shall develop a strategic plan for the development and implementation of a serial number tracking system for durable medical equipment.

''(B) SERIAL NUMBER TRACKING SYSTEM FOR DURABLE MEDICAL EQUIPMENT.—The plan developed under subparagraph (A) shall include mechanisms to ensure that an item of durable medical equipment which has not been issued a unique identifier under the unique device identification system established under section 519(f) of the Federal Food, Drug, and Cosmetic Act bears a unique identifier, unless the Secretary already requires an alternative placement or provides an exception for a particular item or type of durable medical equipment under such section 519(f).

''(C) PROVISION OF UNIQUE IDENTIFIER TO THE SECRETARY.—The plan developed under subparagraph (A) shall include appropriate mechanisms for manufacturers of items of durable medical equipment to submit to the Secretary unique identifiers issued under subparagraph (B) or such section 519(f) with

respect to such items. The plan shall include mechanisms for the Secretary to provide for the storage of such unique identifier in accordance with subparagraph (F)(i).

''(D) REQUIREMENTS FOR MANUFACTURERS AND WHOLESALERS.—The plan developed under subparagraph (A) shall include mechanisms for manufacturers of items of durable medical equipment, or, in the case where a wholesaler provides an item of durable medical equipment to suppliers, wholesalers, to—

''(i) upon issuing an item to a supplier, develop a product description for the item which includes—

''(I) the unique identifier of the item;

''(II) the specific Healthcare Common Procedure Coding System (HCPCS) code for the item;

''(III) the name of the supplier the item was shipped to; and

''(IV) the supplier's Medicare identification number; and

''(ii) submit the product description developed under clause (i) to the Secretary for storage in the unique identifier database in accordance with subparagraph (F)(i).

''(E) REQUIREMENTS FOR SUPPLIERS.—The plan developed under subparagraph (A) shall include mechanisms to ensure that suppliers of items of durable medical equipment—

''(i) upon issuing the item to a beneficiary, note the unique identifier of such item on—

''(I) the claim form submitted for such item; and

''(II) when appropriate or otherwise required, the detailed product description of the item;

''(ii) in the case where the item is issued to a beneficiary on a rental basis, designate the unique identifier with an 'R' after the number to indicate that the item was rented, and not purchased, by the beneficiary; and

''(iii) upon return of the item to the supplier, notify the Secretary—

''(I) before reissuing that item and resubmitting that number on such a claim form; or

''(II) upon resubmitting that number on such a claim form.

''(F) RESPONSIBILITIES FOR THE SECRETARY.—

''(i) MAINTENANCE OF DATABASE OF SERIAL NUMBERS.—The plan developed under subparagraph (A) shall include the responsibility of the Secretary to establish and maintain a database containing the unique identifiers submitted by manufacturers of items of durable medical equipment under subparagraph (C).

''(ii) PAYMENT.—

''(I) LIMITATION.—Subject to subclause (II), the plan developed under subparagraph (A) shall include mechanisms to ensure that payment may only be made for an item of durable medical equipment if the unique identifier on the claim form submitted for such item matches the unique identifier submitted by the manufacturer of such item under subparagraph (C).

''(II) EXCEPTION TO LIMITATION AFTER VERIFICATION OF RECEIPT.—The plan developed under subparagraph (A) shall include mechanisms to ensure that in the case where the unique identifier is not on the claim form submitted for such item or does not match the unique identifier submitted by the manufacturer of such item under subparagraph (C), no payment shall be made under this part for the item of durable medical equipment until the Secretary has verified that the beneficiary has received such item in accordance with subclause (IV).

''(III) DUPLICATIVE UNIQUE IDENTIFIERS.—The plan developed under subparagraph (A) shall include mechanisms to ensure that in the case where a unique identifier is submitted on more than 1 claim form submitted for such an item and there is no indication from the supplier that the item of durable medical equipment has been returned by 1 beneficiary and is now being used by another beneficiary, no payment shall be made under this part for such item of durable medical equipment unless the Secretary has verified that the beneficiary has received such item in accordance with subclause (IV).

''(IV) VERIFICATION.—The plan developed under subparagraph (A) shall include provisions for the Secretary to conduct any verification required under subclause (II) or (III) within 30 days after receipt by the Secretary of the relevant claim form. In the case where such verification is not completed within such time period, the Secretary shall pay such claim, complete the verification, and, in the case where the Secretary has entered into a contract with an entity for the conduct of such verification, recover any payments that would not have been made if the verification had been completed within such time period from such entity.

''(iii) QUALITY CONTROL AUDITS.—The plan developed under subparagraph (A) shall include a requirement that the Secretary conduct quality control audits to identify unusual billing patterns with respect to items of durable medical equipment for which payment is made under this part and may provide that the Secretary conduct unannounced site visits or commission other agencies to conduct such site visits as part of such quality control audits.

''(iv) NO USE AS A PRECERTIFICATION MECHANISM.—The plan developed under subparagraph (A) shall include mechanisms to ensure that in no case shall a unique identifier issued under subparagraph (B) or section 519(f) of the Federal Food, Drug, and Cosmetic Act be used as a precertification mechanism for the supply of an item of durable medical equipment or the payment of a claim for such an item under this part.''.

SEC. 8. GAO STUDY AND REPORT ON EFFECTIVENESS OF SURETY BOND REQUIREMENTS FOR SUPPLIERS OF DURABLE MEDICAL EQUIPMENT IN COMBATING FRAUD.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on the effectiveness of the surety bond requirement under section 1834(a)(16) of the Social Security Act (42 U.S.C. 1395m(a)(16)) in combating fraud.

(b) REPORT.—Not later than 18 months 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.

NOTICE OF HEARING

Mr. BINGAMAN. Mr. President, I would like to announce for the information of the Senate and the public that a business meeting has been scheduled before Committee on Energy and Natural Resources. The business meeting will be held on Wednesday, December 16, 2009, at 11:30 a.m., in room SD–366 of the Dirksen Senate Office.

The purpose of the business meeting is to consider pending legislation.

For further information, please contact Sam Fowler at (202) 224–7571 or Amanda Kelly at (202) 224–6836.

PRIVILEGES OF THE FLOOR

Mrs. MURRAY. Mr. President, I ask unanimous consent that Richard Burkard, a detailee from the Government Accountability Office to the Appropriations Committee, be granted the privilege of the floor during consideration of the consolidated appropriations bill.

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

ORDERS FOR SATURDAY, DECEMBER 12, 2009

Mr. MENENDEZ. Mr. President, I ask unanimous consent that when the Senate completes its business today, it adjourn until 9 a.m., Saturday, December 12; that following the prayer and pledge, the Journal of proceedings be approved to date, the morning hour be deemed expired, the time for the two leaders be reserved for their use later in the day, and the Senate resume consideration of the conference report accompanying H.R. 3288, the consolidated appropriations bill, as provided for under the previous order.

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

PROGRAM

Mr. MENENDEZ. Mr. President, at 9:30 a.m., the Senate will proceed to a cloture vote on the consolidated appropriations conference report. If cloture is invoked, the Senate will proceed to vote on the adoption of the conference report at 2 p.m. on Sunday.

ORDER FOR ADJOURNMENT

Mr. MENENDEZ. Finally, I ask unanimous consent that following the remarks of the distinguished Senator from Nevada, Senator ENSIGN, the Senate adjourn under the previous order.

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

Mr. MENENDEZ. Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. ENSIGN. I ask unanimous consent that I be able to speak as long as I take tonight and then following my comments, the Senate stand in adjournment.

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

Mr. ENSIGN. Mr. President, first, I wish to say to my friend from New Jersey, I appreciate the remarks he has made. I have stood with the Cuban people and especially with the dissidents down there for years, many times with my friend from New Jersey. I appreciate the issue he is bringing up and fighting for those folks.

There have been those cases over the years where American voices have reached all the way into those gulags, whether it was the old Soviet Union or North Korea or wherever it may be. America being the beacon of hope for so many people around the world, it is critical that Members of this body, as well as the President of the United